Exploring how to enhance healthcare worker wellbeing on a Labour Ward: insider participatory action research

Claire M WOOD

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Abstract

Background Good healthcare worker (HCW) wellbeing impacts positively on patient experience and outcomes, yet there are long-standing global concerns for HCW welfare. Excessive workloads are leading to burnout and retention issues, with consequent impact on quality of service. As a practising midwife on a National Health Service (NHS) Labour Ward, I had witnessed the impacts of the challenging workplace environment on my colleagues. A review of the literature proposed participatory interventions for effecting favourable change.

Research question How can we as maternity HCWs enhance our individual and collective wellbeing?

Methodology This qualitative *Wellbeing Project* used Insider Participatory Action Research to identify and build on experiences which uplifted colleagues' workplace wellbeing. All grades of every HCW group were invited to participate. Data were generated from individual and group interviews, questionnaires, data displays, Action Groups (AG), and peer participant data reviews. Ethical approval was granted by the Health Research Authority and Health and Care Research Wales (HCRW).

Analysis and Findings Thematic analysis found emotional, physical, and professional nourishment fuelled wellbeing. Three main areas of impact were reported. Firstly, heightened attention on wellbeing prompted a currency of conversation around these factors. Positivity and morale increased as the culture shifted towards adopting more compassionate and inclusive behaviours. Secondly, new interdisciplinary AG dialogues initiated many change projects for colleagues' and childbearing women's benefit. Thirdly, the insider-researcher presence was reported to have independently benefitted wellbeing. A new Colleague Support Worker role was established, providing an informal wellbeing resource during duty periods. Many wide-ranging activities continue, including wellbeing sessions in Preceptorship Midwife programmes, and an interdisciplinary Wellbeing Group.

Conclusion The *Wellbeing Project* heightened awareness of factors which nurtured HCW wellbeing. Caring behaviours, within and between occupational groups increased and a culture orientated to enhancing wellbeing developed. This bottom-up, positive, participatory initiative offers a practical example of a readily implementable and low-cost strategy for cultivating compassionate and inclusive cultures in diverse workplaces. It serves as a strategy for the NHS to meet the basic human needs of HCWs and to positively impact on widespread retention and HCW welfare concerns. Recommendations are offered in relation to healthcare policy, practice, education, and research.

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Finally, to my friends who knew me in the previous life, thank you for hanging on in there. It's time to meet again.

Glossary of terms and abbreviations

Anaesthetist or anaesthetic doctor	Specialist doctors providing anaesthesia for patients, including all trainees and consultants
Core midwife	Midwife based in one ward area who rarely rotates outside this setting
Doctors' Mess	A separate sitting room for medical colleagues
Doula	A supportive companion, often to a woman throughout pregnancy, birth, and the postnatal period
HCHSCC	House of Commons Health and Social Care Committee
HCW	Healthcare worker - includes registered and non-registered, and clinical and non-clinical team members in hospital or community settings
Int	Interview
Maternity support worker	A support worker trained in specific skills related to maternity care
Obstetrician or obstetric doctor	A doctor working short- or long-term in the field of pregnancy, childbirth, and the postnatal period, including all trainees and consultants
Operating department practitioner ODP	A practitioner trained to assist patients and obstetric/anaesthetic doctors prior to, during, and after surgery
OQ	Online questionnaire
Organisational development team	Group of practitioners developing change with and through its employees, while promoting organisational values
Peer participant reviewer	HCW colleague who reviews data and contributes to interpretations of meaning
PHE	Public Health England - established to protect and improve England's health and wellbeing. Replaced 2021 by UK Health Security Agency and Office for Health Improvement and Disparities

PMW	Preceptorship midwife - a newly qualified midwife undergoing a structured programme of transition from a student to an accountable midwife, usually 1-year duration
Positive psychology	Strength-based study of factors which make human beings thrive and make life worth living
Practice Development Team	Team providing induction programmes for new-starter and preceptorship midwives, and continuing professional development of all midwives
Q	Questionnaire
Quasi-experimental study	Study based on experimental design of randomised controlled trial but not implementing random assignment of control groups
Randomised controlled trial/study	Study meeting two criteria - manipulation of a variable between two or more groups, and random assignment to those groups
Scoping review	A literature review broadly identifying the nature and extent of evidence related to a research topic
Schwartz round	Structured forum where clinical and non-clinical healthcare workers discuss the emotional and social aspects of working in healthcare
Systematic review	A literature review documenting rigorous search and selection strategy, aiming to synthesise evidence from predetermined criteria to answer a specific research question
Systematised review	A literature review including elements of a systematic review but not implementing all elements
Theatre practitioner	An operating theatre team member, including operating department practitioners, nurses, and healthcare assistants
Trust	A National Health Service hospital providing secondary care

Clarification of terminology - For the purposes of this thesis, the terms ‘woman’ and ‘women’ are used throughout. This terminology includes girls, childbearing people whose gender identity may differ from that at birth, and those who identify as non-binary.

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Chapter 1 Introduction

1.1 Introduction to the thesis

This thesis is an account of a research study undertaken in response to the situation in one Labour Ward (LW) in the National Health Service (NHS), East Midlands, England, United Kingdom (UK). Research activity took place between October 2018 and July 2020. I am a practising midwife on that LW and perceived that colleagues' wellbeing was deteriorating. Those whom I deeply respected, and felt emotionally close to, regularly cried at work and withdrew from LW to either attempt midwifery in alternative services or to leave the profession altogether. High workloads coupled with inadequate respite from the emotional and physical toll of maternity work had exhausted colleagues' ability to maintain a tolerable work-life balance. I knew that healthcare workers (HCWs) from other occupational groups both inside and outside maternity settings were similarly affected, and that diminished HCW wellbeing risked compromising good quality patient experience. The thesis charts the progress of what was, and continues to be, a personal ambition to support practical local change in colleagues' wellbeing, and more widely in other settings. I intermittently use my voice in the first person to acknowledge the subjective nature of the chosen research methodology.

Having provided an overview of the motivation for the initiation of the research study, which came to be known as the Wellbeing Project (WbP), this chapter continues with a description of the setting and my position within it. Thereafter, the national and international situation relating to HCW wellbeing is examined, before considering the value to health of being in employment. A thesis structure and chapter summary conclude the chapter.

1.2 Labour Ward environment

The LW shares the setting with a Birth Centre. The woman's lead professional on LW is an obstetrician, as opposed to the Birth Centre where the lead professional is a midwife. The study involves only the LW, in which approximately 5000 births per year take place. Healthcare workers include (in order of highest numbers) those from midwifery, obstetric, operating theatre practitioner, anaesthetic, health care assistant (HCA), receptionist, housekeeping, and domestic groups. Labour Ward includes 13 birthing rooms (one a bereavement room), a four-bedded High Dependency Unit, a four-bedded Induction Unit, a two-bedded assessment area, two theatres with a Recovery Room, Reception Desk, two anaesthetists' offices, one Training Room, four manager/specialist midwife offices, and two sitting rooms - one for women and one for HCWs - see Figure 1.1. Interdisciplinary liaison

occurs in the Handover Room, an area enclosed by five birthing rooms and known simply as 'Handover'. A senior midwife, known as a coordinator, takes charge of each shift, communicating with all clinical and non-clinical colleagues in managing activity, including organising teams for the operating theatre in emergency situations. Coordinators and medical colleagues base themselves in Handover, monitoring clinical activity displayed on a large board. Healthcare workers meet there to discuss ward activity at shift changeover, and to individually seek assistance or advice as clinically required throughout the shift. Formal changeovers occur four times daily and involve a partial or total shift change and update for all occupational groups. Approximately 20 individuals are scheduled on duty at any one time.

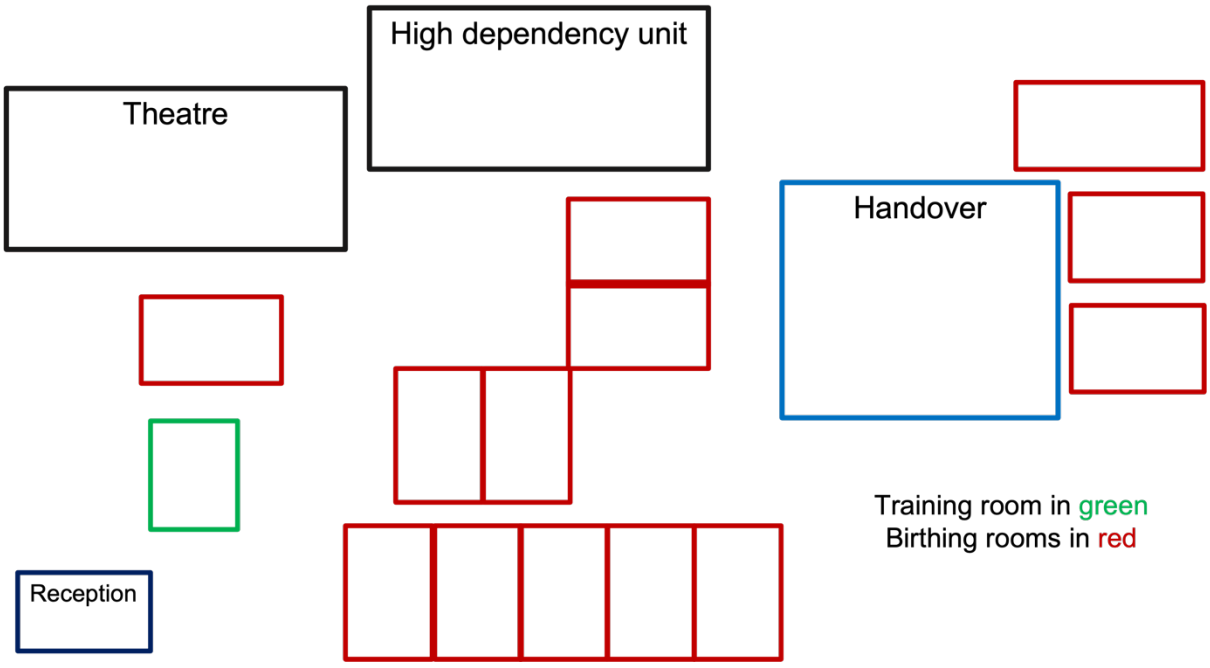

Figure 1.1 Labour Ward plan

Labour Ward activity is typically high and varies from hour to hour. Only women being admitted for induction of labour have a planned arrival time. The most significant degree of workload around labour, birth, and theatre activity cannot be known in advance. The majority of midwives practise alone in individual birthing rooms, providing one-to-one care, and attending Handover only for clinical discussions or short breaks. Critical clinical events occur regularly, particularly around the unborn baby's condition. The immediate involvement of obstetric and anaesthetic colleagues may be required, and potentially a rapid transfer to theatre. A woman's care is thus created by the living dynamic of a group of different teams

working together, with the additional dimension of the membership of individual teams constantly changing throughout the day. A general air of busyness and industry prevails.

1.3 My position as a NHS midwife

Although the initial impetus for the research study derived from increasing concern for my LW HCW colleagues' wellbeing, the final catalyst was my acting as a participant in a research study - the Birth Project (Hogan, 2017). Over the several weeks of the project, birth practitioners' demanding working experiences were explored. Facilitated by a clinical psychologist, I was part of a small group of midwives and a doula who talked together about practice experiences which had affected our sense of wellbeing. In addition to conveying the emotional impact of events verbally, we also created pieces of art expressing our related feelings. I felt unburdened by talking about past incidents and other participants reported feeling similarly. The potential for a focus on wellbeing to more widely benefit the body of HCWs became evident. It had been my first opportunity to dedicate long periods of time to reflecting on how those situations had negatively affected my emotional wellbeing. During the research sessions, I became aware that clinical psychologists engage in regular supportive sessions with a supervisor. These were reportedly aimed at managing the personal feelings evoked during client consultations. I contrasted this with maternity HCWs' enduring direct exposure to challenging and potentially traumatising clinical events, the paucity of related supportive interventions (Pezaro et al., 2017), and the absence of such standard consistent supervision, unless following a particularly serious incident.

For the first time in over 30 years of practice, I perceived an institutionalised expectation to internalise and continue unwaveringly in my role after all but the most serious of incidents. I was aware of the literature exposing the emotional demands of maternity practice (Hunter, 2010) but until that point had not fully appreciated the impact on individuals' wellbeing. I knew also that not only clinical LW HCWs were affected by distressing LW birth outcomes as I had witnessed bereavement touching the lives of diverse HCW groups. Receptionists were required to digitally record such events, and HCA and domestic colleagues to prepare facilities for women's lengthier stays. My experience as a Birth Project participant had reinforced my belief that to mitigate the negative effect of adverse incidents, action on HCW wellbeing needed to be intensified. The emotional impact of maternity work on all HCWs needed to be acknowledged, respected, and practically responded to.

I had spent most of my working life on the same LW. After returning from maternity leave in the 1990s, I chose to work part-time in a less senior role. I found that being involved in

women's birthing experiences gave me the greatest enjoyment. Later, I decided to divide my role between clinical practice and action towards wellbeing, prioritising the latter. In 2016, I registered for the award of Doctor of Philosophy (PhD) with the primary intention of exploring how to enhance LW HCW wellbeing. I was uncertain how to begin influencing the situation, but two drivers served as a rationale for action. Firstly, there was a need to improve wellbeing for those individual HCWs. Secondly, reports of receiving good care correlated with good HCW wellbeing (Maben et al., 2012). Alternatively, midwives' reduced wellbeing had been associated with impoverished birthing experiences for women (Hunter, 2010), and poor general HCWs' welfare to decreased patient reports of good quality care (Maben et al., 2012). As HCW wellbeing was regarded as an antecedent to role performance, raising HCW wellbeing could be anticipated to simultaneously heighten patient experience (Maben et al., 2012). To contextualise HCW experience, details of the wider landscape and the local situation of maternity HCW wellbeing are described.

1.4 Healthcare worker wellbeing

The negative effects of working environments on HCWs' lives had been provoking marked global concern. The World Health Organisation (WHO)(2010) had confirmed the potential for workplace factors to cause and/or worsen mental ill-health. Nationally, interventions were being sought for stress (Department of Health, 2014) and likewise internationally, including throughout America (West et al., 2016), Australia (Gunasingam et al., 2015), Canada (Lemaine and Wallace, 2017), and Sweden (Petterson et al., 2006). A continuing shortage of UK midwives (Royal College of Midwives [RCM], 2016a) had resulted in practitioners leaving the midwifery profession, citing an inability to maintain quality of care in situations of low staffing levels and high workloads (RCM, 2016b). Doctors' discontent with their role had similarly become evident. Investigations into work-life balance had reported that 76% of UK obstetric and gynaecological consultants considered their workload unsustainable (Royal College of Obstetricians and Gynaecologists [RCOG], 2011). The numbers of doctors choosing to train within these specialties had fallen by 10% between 2012 and 2015 (General Medical Council [GMC], 2016). In paediatrics, Qureshi (2017) questioned whether targets to reduce stillborn babies' numbers were realisable within the context of doctor shortages. Wellbeing concerns had also been raised by both midwives and obstetricians experiencing bullying by colleagues (RCM, 2016b; GMC, 2015; Curtis et al., 2006), including victims as senior as consultant obstetricians (Shabazz et al., 2016). Locally, this was evident within the Trust Maternity, Gynaecology and Genito-Urinary departments. In addition to being the third lowest of 11 hospital areas reporting satisfaction in quality of work and patient care offered, 31% of Trust HCWs within these specialties had

reported harassment, bullying and abuse from colleagues in the last year, and 39% had reported work-induced stress (NHS, 2015).

Further concerns related to wider indicators of NHS HCW wellbeing. While England's 2017 average national sickness absence rate was 1.9% (Office for National Statistics, 2018), lack of positive cultures providing respect and engagement were proposed as the source of the NHS HCW rate of 4.3% (Dawson and West, 2018). The local maternity and gynaecology department sickness rate averaged 5.25% in 2018, compared to the Trust average of 4.33% (personal communication). The caring NHS culture appeared undermined by unclear goals and unsatisfactory organisational management and systems (Dixon-Woods et al., 2014). It was suggested that framing healthcare services on an industrial model, prioritising productivity, had left staff feeling akin to *untrustworthy tools* in an immense and uncompassionate system (Ballatt and Campling, 2011, p178). National reports had also connected poor quality of care standards to avoidable patient mortality and morbidity and had severely criticised HCW performance (Kirkup, 2015; Francis, 2013), potentially affecting morale. Local LW colleagues' distress reflected a broader picture of HCW stress, deriving from reduced ability to provide good quality care; demanding workloads due to HCW shortages; and difficult colleague interactions. Having established the national and international situation regarding HCW welfare, a discussion follows on the connection between working and wellbeing.

1.5 Wellbeing and relationship to work

Wellbeing has been described at the most straightforward level as the combination of health and happiness (Tantam, 2014). Other definitions overlap and interrelate. One definition of health derives from the WHO (2018, online) constitution and encompasses a variety of health-related aspects:

> *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*

Alternatively, Keyes (2002) focusses on mental health, describing this as flourishing in life, and proposing this comprises of emotional, psychological, and social wellbeing. To Keyes (2002), emotional wellbeing manifests in positive affect and life satisfaction; psychological wellbeing in self-acceptance, meaningful relationships, and control and purpose in one's lifeworld; and social wellbeing in comprehensible communities which offer acceptance, and

enable personal growth and contribution. Represented in another form, the WHO (2018, online) states mental health is:

> *A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.*

Overall, many common interdependent elements appeared to contribute to feeling well in life. The above excerpt specifically included working as an important factor of wellbeing, as working is considered a source of meaning and purpose (Centers for Disease Control and Prevention, 2016). When workplaces support individuals' autonomy and control, workers actively enjoy the challenge, mastery, and social interaction which working brings (Schwartz, 2015). Contesting the strongly held belief that people work only to obtain income, Schwartz (2015) maintains that meaning brought about through working motivates effort beyond narrow job specification boundaries. A *virtuous cycle* develops in which people find working improves individual wellbeing and improvement in wellbeing effects improvements in working conditions, continually feeding back (Schwartz, 2015, p30). This perspective is widely accepted, with wellbeing extending beyond the individual, to communities and to society (Black, 2012; WHO, 2010).

Flourishing in life appeared an optimum condition for any human being (Keyes, 2002). I had previously experienced positive workplace dynamics and strongly identified with the view that working could support and expand a feeling of flourishing. My sense of purpose was orientated towards Keyes's (2002) and Schwartz's (2015) representation of work wellbeing as a combination of positive emotional, psychological, and social experiences. For the purposes of the study, I adopted my own position that workplace wellbeing constituted:

> *HCWs feeling emotionally buoyed in performing their roles, and psychologically content with their ability to contribute to and be accepted within a socially supportive work community.*

Burnout from working has been defined as feeling significant exhaustion, detachment, and ineffectiveness in one's role (Maslach et al., 2001). Exploring the causes of burnout, including resilience training to strengthen individual coping mechanisms, was a possible strategy to address HCW wellbeing. Ludema and Fry (2008) nevertheless caution that employees identifying the magnitude of problems, and the scale of solutions required, leads to discouragement and blaming. Alternatively, a focus on employees accentuating and building on the productive elements of workplaces encourages an energetic behavioural dynamic. I was inspired by the emphasis Keyes (2002) and Schwartz (2015) placed on the affirming dimensions of workplace wellbeing. Rekindling, emphasising, and building on what was good in working within LW presented itself as a more constructive route to enhancing HCW wellbeing.

I considered that each HCW arrived on LW with their wellbeing dependent on a myriad of prior complex, individual influences. My aspiration was not to define individual levels of wellbeing but to protect and expand whichever factors were amenable to favourable change.

1.6 Study research question and aim

It was clear that HCW wellbeing was causing national and international concern, but less apparent how this situation could be improved. Thus, the research question was constructed to represent an open enquiry into the multi-faceted concept of wellbeing:

> *How can we as maternity healthcare workers enhance our individual and collective wellbeing?*

Although I considered the *how* as the pressing element, I anticipated colleagues' active involvement, as reflected in the research question. This sentiment was similarly encompassed in the study aim:

> *To develop a caring collegial environment within a NHS Labour Ward in which maternity healthcare workers create paths to enhancing their individual and collective wellbeing.*

Specific practical avenues, in terms of objectives towards the aim, awaited a comprehensive literature review of prior interventions undertaken to enhance HCW wellbeing.

1.7 Thesis structure

The thesis structure frames the steps taken towards progressing the study aim and research question:

Chapter 2 - *Literature review* - investigates the types of workplace wellbeing interventions undertaken and how, by amending aspects of methodology, greater impact may be effected. A systematised review explores the role of participatory methodology, and three study objectives are identified.

Chapter 3 - *Methodology* - describes the rationale for the study design and considers ethical research practice in relation to data generation methods.

Chapter 4 - *Analysis and findings* - presents the analysis process and findings according to study objectives. It discusses how a concept model for LW HCW wellbeing evolved from themes identified in nourishing wellbeing; outcomes of actions taken in relation to the data generated; and study impact and process evaluation as related to the chosen methodology.

Chapter 5 - *Discussion* - examines the value of the WbP both locally and beyond the setting, including identified learning points. It reports how study impact may be sustained, and how

WbP experiences may be transferred to other workplaces. Strengths, limitations, dissemination and future research are discussed.

Chapter 6 - *Reflexivity* - considers how the researcher role influenced study processes and consequently study impacts.

The final chapter, Chapter 7 - *Conclusions and going forward* - summarises how ambitions being realised in the WbP offer direction for taking wellbeing interventions forward.

1.8 Chapter summary

This first chapter described the rationale for a research study exploring how LW HCW wellbeing may be enhanced. The dynamics of the setting and my position as a midwife were described within the context of high demand and compromised HCW wellbeing. In inter/national recognition that the situation required a response, a review of related interventions was indicated, as presented in Chapter 2, *Literature review*.

Chapter 2 Literature review

2.1 Introduction

Chapter 1, *Introduction*, established the need for action to improve HCW welfare. This chapter begins with an account of maternity HCWs' state of emotional wellbeing. This is followed by a literature review of interventions undertaken for employee wellbeing, including those for HCWs. As evidence suggested participatory approaches as potentially productive, the chapter continues with a systematised review of participatory action research (PAR) in interventions specific to HCWs. Methodological elements beneficial to outcomes, and modifications towards increased effect, are related to the initiative planned towards enhancing LW HCW wellbeing.

2.2 Maternity workers' emotional wellbeing

A landmark series of research papers, beginning with questioning why midwives leave the profession (Curtis et al., 2006), spearheaded further enquiries into midwives' emotional wellbeing. In addition to being unable to practise in ways in which they felt good care could be provided, midwives reported organisational factors drove their decisions to leave (Curtis et al., 2006). Emotionally stressful elements included inadequate staffing numbers, unsupportive management, and cultures tolerating bullying behaviours (Curtis et al., 2006). Mollart et al. (2013) found almost two-thirds of midwives in an Australian cohort to have moderate to high levels of the emotional exhaustion element of burnout and, in a London, UK cohort, Yoshida and Sandall (2013) found 54% of midwives had significantly higher levels of burnout than comparable reference groups. In a narrative review of work-related distress in global midwifery populations, Pezaro et al. (2016) confirmed similar organisational sources of stress and additionally identified the emotional distress of exposure to termination of pregnancies, and perinatal and neonatal loss scenarios. More recently, a RCM-commissioned report into midwives' work, health, and emotional lives (Hunter et al., 2018) found over two-thirds of almost 2000 respondents to have work-related burnout, confirming the profession's ongoing negative impact on emotional wellbeing.

Although little research has focused on the emotional effect on medical colleagues of maternity work, the existing evidence indicates a similar experience to midwives. Almost 80% of a mixed group of doctors, midwives, and nurses reported moderate to high levels of psychological impact related to pregnancy/postnatal loss events (Wallbank and Robinson, 2013). This followed a RCOG (2011) report into work-life balance which acknowledged

concern for its members' ability to maintain workplace wellbeing. Actions taken by employers in response to HCW wellbeing now follow.

2.3 Literature review

The literature review was undertaken in two parts. The first stage comprised of developing an overview of research interventions implemented for employee benefit, including HCWs. As documented below, findings indicated that participatory approaches merited further investigation. The second stage of the literature review involved a search of participatory interventions specifically applied in healthcare settings. A description of the framework used to evaluate participatory studies' outcomes is included in Section 2.5.1.

In the first stage, interventions for employee wellbeing were sought in systematic reviews (SR), scoping reviews, and syntheses of reviews. Search activity began in 2016 and continued until the WbP started in 2018. An overview of these reviews' findings, which included HCWs in all or a proportion of the included studies, reported variable effects. Most reported small to moderate positive effects as related to mental health, stress, burnout, social/working conditions, performance, and absenteeism (Haggman-Laitila and Romppanen, 2018; Brand et al., 2017; Daniels et al., 2017a/b; Panagioti et al., 2017; Pezaro et al., 2017; Romppanen and Haggman-Laitila, 2017; Public Health England [PHE], 2016; West et al., 2016; McVicar et al., 2013). Others found no, or mixed beneficial effects (Ivandic et al., 2017; Hill et al., 2016; Ruotsalainen et al., 2015; Montano et al., 2014). Studies rarely took place outside North America, Europe or Australasia. The majority emphasised management of ill-health, particularly of stress and burnout (Haggman-Laitila and Romppanen, 2018; Montano et al., 2014). Numerous reviews' conclusions reported meta-analyses being disallowed by heterogeneity in study designs and outcome measures; low quality studies; high bias risk; lack of theoretical foundation; and short-term follow up.

Studies' interventions were classified as organisational, individual, or a combination. Organisational, or primary, interventions mean to be preventative. They embrace the entire work group and address the sources of employees' specific workplace conditions (LaMontagne et al., 2007). These non-prescriptive interventions rationalise that wellbeing derives not from a single source (McVicar et al., 2013), but from multiple components interacting and exerting positive influence (Daniels et al., 2017a/b; Brand et al., 2017; Panagioti et al., 2017; West et al., 2016; Montano et al., 2014; Bambra et al., 2009). Individual employee interventions may be secondary or tertiary. The former intend to ameliorate adverse workplace impacts through coping or therapeutic strategies. The latter

aim to support those so negatively affected by health/workplace conditions that they are absent from the workplace (LaMontagne et al., 2007). Tertiary interventions were excluded from further enquiry, as the WbP planned to engage HCWs who were attending work. Reviews identified diverse organisational interventions, centring on modification of work systems and/or job designs, and on collaborative strategies. Individual interventions were equally varied but were categorised as self-care/development through either education or training (for example, in stress, sleep, depression, resilience), or through physical or psychological activities (for example, in yoga, mindfulness, relaxation).

Individual interventions were more frequently undertaken than those at organisational level. The former's defined, small-group, stress-reduction programmes are suggested to be less costly and more readily organised than the large-scale group engagement required for the latter (Panagioti et al., 2017; Montano et al., 2014). While generally accepted as moderately effective in reducing stress (PHE, 2016; Ruotsalainen et al., 2015), individual interventions risk employees perceiving their poor wellbeing as their own responsibility to manage, rather than it being incumbent on organisations to rectify challenging working conditions (Pezaro et al., 2017; Montano et al., 2014). Additionally, on return to workplaces, any individuals' improvements may be eroded by persistent system-wide stressors (Panagioti et al., 2017; LaMontagne et al., 2007). For these reasons, it has been repeatedly recommended that the two intervention types be combined. Firstly, this is anticipated to enhance outcomes (Brand et al., 2017; Panagioti et al., 2017; PHE, 2016; Montano et al., 2014; LaMontagne and Keegel, 2012; LaMontagne et al., 2007) and, secondly, to prolong effects (PHE, 2016).

Randomised controlled trials (RCTs) or quasi-experimental trials were most frequently undertaken. Nevertheless, participatory study designs were widely promoted for their ability to enable employees to create the most locally appropriate interventions (West et al., 2016; PHE, 2016; Montano et al., 2014; Vaandrager and Koelen, 2013; Bambra et al., 2009). Engagement, autonomy, and democratic dialogue within participatory methodologies such as PAR enable employees to design actions specific to a setting's demands. McNiff (2013, p67) describes the PAR process as a *spiral of spirals* whereby change is effected over time through numerous avenues. Participants collectively agree a research question, plan action, generate data, take action, evaluate outcomes, modify plans, and repeat the process. The process is not rigid but evolves according to feedback from activities, and branches into multiple projects of participant interest. A review of PAR interventions aiming to improve settings' culture and/or quality of care concluded that the approach was optimal for hospital HCWs wishing to adopt a positive orientation to wellbeing development (Montgomery et al.,

2015a). Syntheses of reviews into workplace wellbeing interventions (PHE, 2016; Bambra et al. 2009) and a scoping review of organisational stress interventions (McVicar et al., 2013) provided further support for participatory approaches. Few organisational or individual wellbeing interventions included participatory methodologies (PHE, 2016), and no review was found to explore PAR towards HCW wellbeing in a maternity setting. A review of PAR interventions in enhancing HCW wellbeing was indicated.

2.4 Review of PAR in healthcare worker wellbeing interventions

In the second stage, a systematised literature review was undertaken to evaluate the potential usefulness of PAR methodology in enhancing LW HCW psychosocial wellbeing. Psychosocial influences were expected to include the social, cultural, and environmental impacts of HCW experiences (American Psychological Association, 2021). The review's aim, question, and objectives informed the subsequent direction of the research enquiry, as in Figure 2.1.

Review aim

To systematically assess the evidence related to the potential utility of PAR methodology in enhancement of maternity healthcare worker psychosocial wellbeing.

Review question

Is there sufficient evidence of utility of PAR methodology in enhancement of healthcare worker psychosocial wellbeing to warrant its inclusion in a future NHS Labour Ward wellbeing initiative?

Review objectives

Objective 1: To analyse methodological elements related to effect

Objective 2: To consider processes modifiable to increase effect.

Figure 2.1 Aim, question, and objectives of PAR review

2.4.1 Methods

Following the Health Technology Assessment (HTA) SR on the role of action research in UK healthcare (Waterman et al., 2001), objectives focussed on synthesising interventions' implementation process and outcome data. In contrast to a quantitative analysis comparing studies' relative effectiveness, a narrative approach was adopted, aiming to critically analyse the major points relevant to this systematised review's question (Jahan et al., 2016).

2.4.2 Search strategy

Research literature published between 2000 and 2017 was selected for two reasons. Firstly, the need to undertake the Waterman et al. review in 2001 indicated increased use of action research in contemporary research. Secondly, the 1990s witnessed an upsurge in awareness of HCW stress. Publications included Curtis et al. (2006) related to midwives' wellbeing, and Firth-Cozens (2003) related to physicians' wellbeing. As in 2000, the Royal College of Nursing (RCN) (2006), began surveying its members' health and wellbeing, and in 2008 the Department of Health commissioned the Boorman report (2009) to investigate HCW health, searching between 2000 and 2017 was expected to capture relevant data. Searches continued from November 2016 to January 2018.

2.4.2.1 Data sources

Table 2.1 presents the search strategy and Table 2.2 includes the databases searched. Appendix 1 provides further details of database and journal search strategies.

Table 2.1 Search Strategy

	1	Participatory or participative or action research
And	2	Intervention or evaluation or stress management or wellbeing or well being or well-being
And	3	Health personnel

Table 2.2 Databases searched

Medline
Embase
Cumulative Index to Nursing and Allied Health Literature (CINAHL)
PsycInfo
Web of Science
Health Management Information Consortium (HMIC)
British Nursing Index (BNI)
Health Business Elite (HBE)

2.4.2.2 Inclusion/exclusion criteria

Little consensus was found in definitions of PAR. Reason and Bradbury's (2008) inclusive approach was adopted, selecting all studies with a participatory element addressing

workplace psychosocial wellbeing. English language studies with qualitative and quantitative outcomes were included, and reference lists from included studies and related SRs were searched. Titles of online journals specialising in participatory methodology were screened for articles related to search terms. Table 2.3 details inclusion/exclusion criteria applied to the literature search.

Table 2.3 PAR review inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Evidence of use of participatory methodology	No evidence of enactment of participatory methodology
HCW defined as a member of a team established to provide inpatient healthcare in hospital or community settings	HCW defined as a member of a team established to provide outpatient healthcare in hospital or community settings
Intervention aim included psychosocial wellbeing enhancement	Intervention aim included only physical health enhancement
Participation not based on known mental ill-health diagnosis	Participation based on known mental ill-health diagnosis
English language studies	Non-English language studies

2.4.2.3 Limitations of the search strategy

- Studies not using terminologies of participatory, participative, or action research may have been overlooked.
- One primary reviewer selected included studies (myself). Other reviewers may have identified additional studies.
- English language limits reduced the literature identified.

2.4.3 Results

The search strategy yielded 1445 articles, and 1415 after removing duplicates. Screening titles and abstracts excluded 1384 articles, leaving 31 articles reviewed in full text. After excluding studies without evidence of PAR methodology, or intention to enhance HCW wellbeing, eighteen articles were included. These comprised of 13 core studies and five further studies extending from those core studies. The quality of each study was not systematically assessed as is the case with purely quantitative reviews. Following the

Waterman et al. (2001) review, data related to intervention implementation and evaluation processes were extracted, based on the recognised stages of participatory research methodology. Figure 2.2 represents search activity.

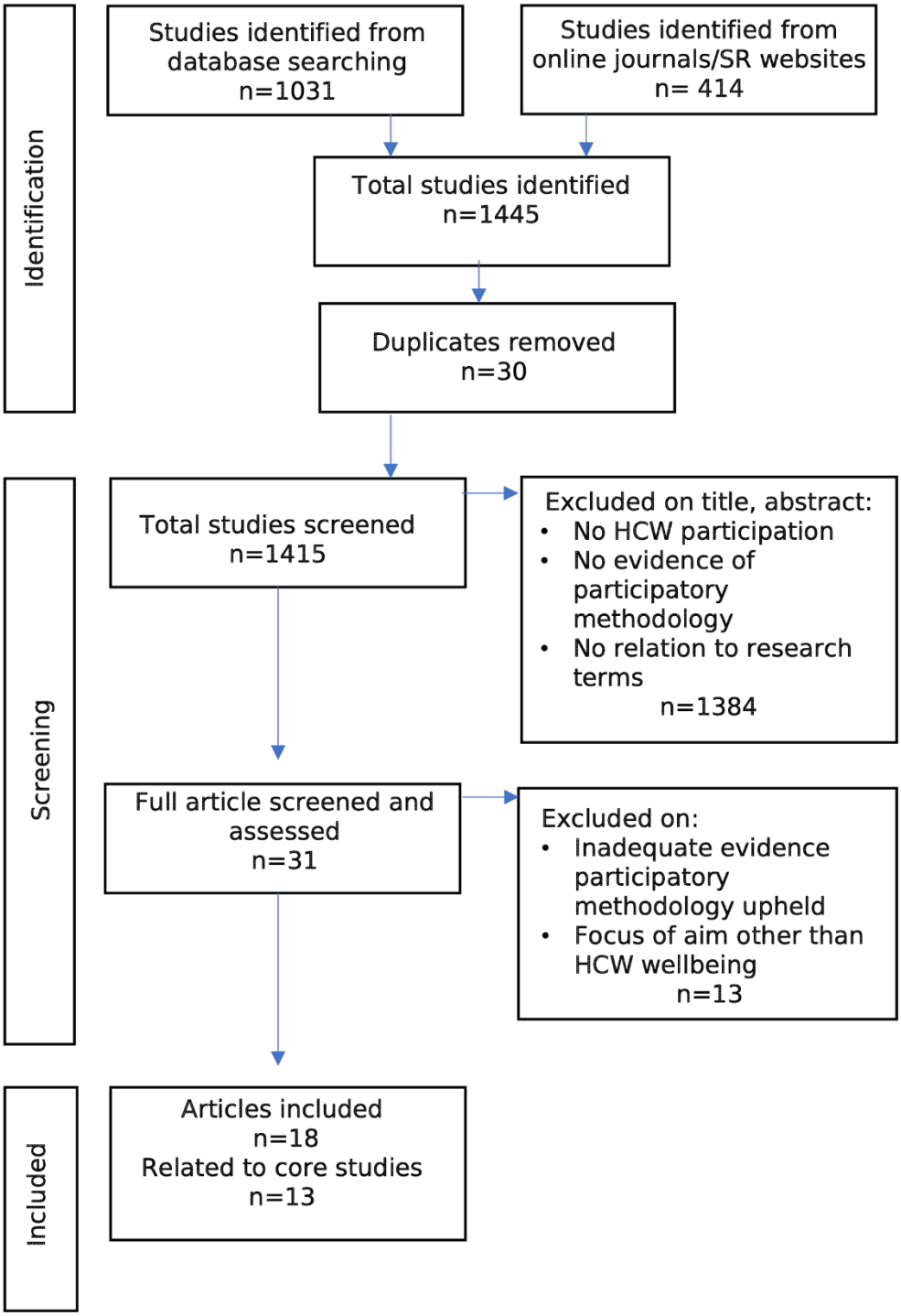

Figure 2.2 Study selection and exclusion

2.4.4 Data extraction

I identified studies for inclusion, and extracted data. To ensure this process had been appropriately undertaken, two supervisors each individually extracted data from two different studies identified for inclusion. Four of the 13 core studies were therefore separately reviewed, discussed and agreed between myself and the Supervisory Team.

2.4.5 Studies' details

An overview includes studies' focus of concern and aim; setting and participants; and design and outcome measures.

2.4.5.1 Focus of concern and aims

Interventions employed markedly distinct strategies. Two studies' focus of concern and aim included only promotion of health. This was to be progressed through organisational learning and improvement. The remaining studies aimed to identify stressful issues and provide remedial action.

2.4.5.2 Setting and participants

Only four studies were sited outside Europe. Eight were hospital-based and five community-based. Hospitals included various specialties ranging from children's to adults' care and, apart from one midwifery study, community studies were undertaken in elderly persons' facilities. Participant numbers varied from eight to 1108. It was not possible to ascertain occupational groups from studies referring to the participation of all hospital staff. Nevertheless, excluding the singular midwifery study, nurses were included in every intervention, with nurse support workers additionally identified in nine.

2.4.5.3 Design and outcome measures

Interventions were initiated and led by academics. Five studies described their design as quasi-experimental with controls, four as a cohort study, two as an organisational case study, and two as exploratory qualitative design. Most studies completed at approximately 12 months, with only four documenting activities beyond this period. Ten of the 13 studies evaluated outcomes using pre- and post-intervention quantitative surveys, including 17 to 131 items. Although elements from two recognised questionnaires (Siegrist, 2017; Karasek et al., 1998) were common to six studies, measures of subjective psychosocial effect otherwise differed. Five of the 10 studies using quantitative surveys additionally used qualitative evaluations. Three studies exclusively used qualitative evaluations, including individual interviews, group feedback, and intervention process analysis.

Interventions overwhelmingly employed problem identification and solution seeking strategies, with distinctly diverse action planned in response. Bourbonnais et al. (2006a, p327), for example, described intervention activity in broad terms as *changes undertaken by the hospital to reduce adverse psychosocial work factors* wherein affected HCWs devised the interventions, whereas Le Blanc et al. (2007) delivered a pre-planned programme of serial presentations, followed by participatory discussions. Intervention teams were routinely established to mobilise frontline HCW activity, with the minority recruiting this group of HCWs onto steering groups.

2.4.6 Study outcomes

Table 2.4 presents studies' details and outcomes. Evidence overall indicated that HCWs benefitted from interventions. Advantageous effects were identified in all studies, and many listed practical workplace changes which had been implemented during study processes. Direct comparison of effects was precluded by the extensive variety of outcome measures used. Psychological status and social support measures were generally reported as improved or unchanged, as were those of effort-reward balance, decision-making, burnout, job satisfaction, and absenteeism. Of the five quasi-experimental studies, three found the majority of psychosocial measures significantly favoured the experimental group (Bourbonnais et al., 2011; Innstrand et al., 2004; Mikkelsen et al., 2000) and two the minority (Uchiyama et al., 2013; Le Blanc et al., 2007). Statistically significant differential effects predominantly derived from sustaining intervention group conditions during periods when control group conditions worsened. Only three of the total studies found deteriorations in experimental group outcome measures (Nielsen and Randall, 2012; Bourbonnais et al., 2011; Lavoie-Tremblay et al., 2005).

2.4.6.1 Impact of context on studies' process

Study authors reported the negative effects of organisational context on processes. These included ongoing major restructuring difficulties, financial constraints, staff shortages, and recruitment/retention problems. Although some HCWs embraced interventions, others' resistance to decision-making and change could not be surmounted. Ineffective teamworking was frequently cited as having hindered intervention implementation, as was generally unsupportive or obstructive management, specifically in failing to release HCWs for participation. Insufficient HCW protected time was frequently regarded as detrimental to implementation. Furthermore, PAR reportedly initially disrupted working routines. A period of orientation and negotiation with HCWs delayed intervention activities.

Table 2.4 Studies' details and outcomes

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Bourbonnais et al, 2006 a/b, 2011 **Focus of concern:** Increasing mental health problems with associated absenteeism **Aim:** To prevent psychosocial work factors adversely affecting mental health **Country:** Canada **Setting:** Experimental and control - Acute care hospitals	**Study design:** Quasi-experimental **Intervention:** Identification of adverse psychosocial conditions and proposed solutions Intervention team of researchers and HCWs Report to management provided **HCW:** Nurses, auxiliary nurses, orderlies, assistant chief nurses **Participants and response rates:** Participant numbers (% response of eligible participants) *Experimental* (3 units) Pre-intervention 492 (73%) of 674 12 months post-intervention 302 (77%) of 391 3 years post-intervention 247 (65%) of 382 *Control* (1 unit) Pre-intervention 618 (69%) of 894 12 months post-intervention 311 (62%) of 502 3 years post-intervention 220 (56%) of 466 **Duration:** Approximately 3 years	**12 months post-intervention in 2002:** 56 intervention targets and recommended solutions composed. Management report given. Themes - teamwork/spirit, staffing, work organisation, training, communication, ergonomy Inter-hospital differences in means of scores pre- and at 12 months: 4 of 11 psychosocial/health indicators statistically significantly improved in the experimental hospital compared to 0 of 11 in control 2 of 11 psychosocial/health indicators statistically significantly deteriorated in both experimental and control hospitals **3 years post-intervention in 2004:** Changes implemented hospital-wide (experimental) represent 80% of suggested solutions to initial 56 intervention targets Inter-hospital differences in means of scores pre- and at 3 years: 7 of 14 psychosocial/health indicators statistically significantly improved in experimental hospital and none significantly deteriorated 3 of 14 statistically significantly improved in control hospital and 1 significantly deteriorated Ruotsalainen, JH et al (2015) (Cochrane Collaboration Review) Analysis 5.3 Any stress-related follow-up over 6 months: Standard mean deviation -0.38

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Deery, 2005 **Focus of concern:** Support for competing client/ organisational demands during organisational change. **Aim:** To explore practice support needs, devise/mobilise support **Country:** England **Setting:** Large maternity unit	**Study design:** Exploratory qualitative **Intervention:** Focus group determined intervention to be implementation of clinical supervision sessions **HCW:** Community midwife team **Participants and responses:** 8 participants (of one team) reduced to 5 by study end **Duration:** Approximately 3 years	Community midwives found exchanging opinions as positive in clinical supervision. Attendance inhibited by lack of protected time Community midwife work seen to arouse anxiety. Government policies, altering practice norms, found overwhelming. Practice emotion-work not understood or acknowledged by midwives, managers, or wider organisation. Community midwives not educationally prepared for group functioning. Existing sub-optimal teamworking behaviours mirrored in clinical supervision sessions, subverting intervention and potential to improve wellbeing through support
Ericson-Lidman and Ahlin, 2017 **Focus of concern:** Stress of troubled conscience on worker/patient wellbeing **Aim:** To compare assessments of stress of conscience, burnout, social support… to deal with troubled conscience **Country:** Sweden **Setting:** 4 older adult units in residential care facility	**Study design:** Intervention study with before and after assessments. Work units randomly selected **Intervention:** Identification of situations causing troubled conscience Problem-based learning within PAR **HCW** Nurses and nurse assistants, including managers **Participants and response rates:** 29 (62%) of 47 completed both questionnaires **Duration:** Approximately 1 year	Pre- and post-intervention differences in most items over the 4 questionnaires were small Two items identified statistically significant differences post-intervention: Perceptions of conscience statement, 'Our conscience warns us against hurting others' received less agreement than pre-intervention, indicating participant learning that conscience may be fallible, and may engender feelings of troubled conscience despite participants working to the best of their ability in clinical situations. Social support question, 'Are your work achievements appreciated by your immediate supervisor?' had higher scores post-intervention, suggesting cooperation, communication, and collaborative learning between staff and managers had been augmented

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Griffin et al, 2000 **Focus of concern:** Organisational health in a changing internal and external context **Aim:** To develop a climate of continued learning and improvement **Country:** Australia **Setting:** Urban women's hospital	**Study design:** Organisational case study with before and after assessments **Intervention:** HCW survey of organisational health Workplace, professional group, organisation, planned strategies responding to findings **HCW:** All hospital staff **Participants and response rates:** Group numbers (% response of eligible participants) 'An overall response rate of 56% was achieved' from 'approximately 1000 staff' **Duration:** Approximately 1 year	**Organisation** Strategies developed around communication, team identification and recognition, management forums, professional development. Leaders more visible and involved staff in work decision-making **Workgroups** Developed multi-disciplinary meetings, communication, staff support, education and training, learning needs, patient-care processes, achievement recognition, collaborative goal-setting, role clarity, and open-door management Statistically significant changes in mean scores in 10 of 12 climate dimensions, excepting role clarity and individual distress Workgroup rated intervention 3.6, expert panel 2.7 (of 5).
Griffiths et al, 2003 **Focus of concern:** Stress at work **Aim:** To reduce stress using a risk management approach **Country:** United Kingdom **Setting:** 15 Children's wards	**Study design:** Risk management intervention with before and after assessments **Intervention:** HCW survey of wellbeing, job satisfaction, absence. Nurses planned stress reduction strategies **Participants and responses:** Group numbers (% response of eligible participants)(Total populations not provided) Pre-intervention 58 (72%) 1 year post-intervention 51 (64%) **HCW:** F, G, and H grade senior nurses **Duration:** Approximately 1 year	Quantitative outcomes measured in % terms. No statistical analyses Overall worn-out scores decreased 'marginally' High pre-intervention job satisfaction increased slightly Slight decrease in G/H grades intending leaving, slight increase for F Absence rates unchanged, increased musculo-skeletal pain Intervention largely well-received Five interventions: Allocation of specific office hours: both improvements and problems Computer installation: improved worn-out score, time for administration and clinical work, and communication Appointment of housekeepers: beneficial, continuing ward problems Improved study leave and training access: direct/indirect benefits Staff open forums: involved staff reported positive views/effects, but not all staff could attend and some actions' impact was modest

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Innstrand et al, 2004 **Focus of concern:** Effect of organisational reforms on stress, burnout, job satisfaction for staff working with people with intellectual disabilities **Aim:** To evaluate changes in stress, burnout and job satisfaction following individual and organisational interventions **Country:** Norway **Setting:** 2 Community residential care units	**Study design:** Longitudinal quasi-experimental **Intervention:** Survey identified stressors HCWs organised intervention programme in response **HCW:** Staff working with residents **Participation:** *Experimental* Pre-intervention 43 responses Post-intervention 36 responses Of these, 22 completed both stages *Control* Pre-intervention 22 responses Post-intervention 11 responses Of these, 9 completed both stages Population totals unclear. Insufficient data to confirm response rates. Participant numbers included those completing only one questionnaire **Duration:** 10 months	Priorities identified: meeting politicians, number of hours worked per week, performance appraisal, training, and exercise opportunities Pre- and post-test scores: Stress - significant reduction in experimental group Burnout - significant reduction in experimental group to exhaustion but no significant effect to cynicism or professional self-efficacy Job satisfaction - significant increase in experimental group

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Lavoie-Tremblay et al, 2005 **Lavoie-Tremblay, 2004** **Focus of concern:** Burnout/absenteeism in changed work environment **Aim:** To evaluate intervention's psychosocial effect **Country:** Canada **Setting:** One long-term hospital unit	**Study design:** Pilot organisational intervention with before and after assessments **Intervention:** Work-team of researchers and HCWs Identification of stressors Action plans implemented by HCWs **Participants and responses:** Group numbers (% response of eligible participants) Pre-intervention 59 (98%) of 60 1 year post-intervention 41 (80%) of 51 **HCW:** Nurses (14), nursing assistants (25), support staff (12), multidisciplinary team reps (9) **Duration:** Approximately 18 months	Most often reported constraints (of total 351): psychological demand (workload), social support (communication/support lacking between shifts and colleagues). Active decision-making seen in choice to prioritise means of increasing team social support over reorganisation of teams. Simple action plans addressed as first step while team trust was re-establishing **Quantitative** Statistically significant improved reward, effort/reward imbalance. Statistically significant decrease in supervisor social support. Unit absenteeism fell from 8.26% to 1.86%; Institutional absenteeism fell from 4.69% to 4.37% **Qualitative** Interview data identified 3 methodological challenges: mobilising teams to create trusting relationships; creating a healthy organisation with other professions; implementing proposed changes

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Le Blanc et al, 2007 **Focus of concern:** Higher levels of the burnout dimensions of emotional exhaustion and depersonalisation in oncology care providers **Aim:** Not stated **Country:** Netherlands **Setting:** 29 Oncology wards in 18 general hospitals	**Study design:** Quasi-experimental. Intervention sites randomly selected, remainder controls **Intervention:** Pre-designed educational programme sessions delivered by counsellors Action plans developed in post-session group work **HCW:** Physicians, nurses, radiotherapy assistants **Participants and responses:** Group numbers (% response of eligible participants). Cohort numbers unstated *Experimental* (9 wards) Pre-intervention 260 (T1) Stated 80 -100% participation Immediately post-intervention 231 (T2) 6 months post T2 208 (T3) *Control* (20 wards) Pre-intervention 404 (T1) Immediately post-intervention 145 (T2) 6 months post T2 96 (T3) **Duration:** Approximately 1 year	Practical outcomes included changes in ward procedures, 'guardian angels' to monitor staff wellbeing, and enabling more staff voice in weekly ward meetings At T2 statistically significantly less emotional exhaustion and depersonalisation in experimental group. At T3, still applied to emotional exhaustion Participants (100% of those completing the programme at T2) rated the intervention programme between 3.5 and 4.5 out of 5 Routsalainen, JH et al (2015) (Cochrane Collaboration Review) Analysis 5.2 Organisational intervention versus no intervention (Follow-up 1-6 months) Any stress-related outcome: Standard mean deviation - 0.13 Analysis 11.2 Organisational intervention versus no intervention (Maslach Burnout Inventory Follow-up 1-6 months) Standard mean deviation- Emotional exhaustion - 0.13, Depersonalisation - 0.08

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Mikkelsen et al, 2000 **Focus of concern:** Following restructuring of public sector, stressful conditions in social and/or technical environment **Aim:** To identify and solve work problems in order to improve workplace health and organisational performance continuously on a long-term basis **Country:** Norway **Setting:** 2 Community healthcare institutions	**Study design:** Quasi-experimental cluster RCT Interventions selected, controls random **Intervention:** Steering group without HCWs Conference exploring good work environments Workgroups planned actions on identified key stressors **HCW:** All supervisors/workers **Participants and response rates** (% response of eligible participants) *Experimental* Pre-intervention 47 (73%) of 64 1 week post-intervention 45 (96%) of 47 1 year post-intervention 20% of 45 *Control* Pre-intervention 35 (49%) of 71 1 week post-intervention 14 (40%) of 35 1 year post-intervention 79% of 14 (Published data used as numbers of participants difficult to confirm) **Duration:** Approximately 1 year	Due to low response rate and small control sample at 1 year post-intervention, analysis was limited to the 1 week post-intervention data. Participatory activity ceased after the initial implementation stage Intervention group showed statistically significant improvement in main effects of role harmony, and one dimension of learning climate (satisfaction), which was not seen in control group Statistically significant differences in changes over time of dependent measures between the intervention and control group in work-related stress, job demands, social support, role harmony, and three of learning climate scale (7 of 15 dependent measures), favouring intervention Both sites identified problems for actioning Qualitative assessments from written records of supervisors, union reps and Organisational Development facilitator were positive about the intervention effectiveness. Participants reported appreciation in involvement in problem identification process

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Munn-Giddings et al, 2005 **Ramon and Morris, 2005** **Ramon and Hart, 2003** **Focus of concern:** Mental health in the workplace **Aim:** To collaboratively develop a strategy promoting wellbeing in the workplace - context specific and sensitive to workforce needs **Country:** England, UK **Setting:** Healthcare Trust (HT) Social Services Dept. (SSD)	**Study design:** Organisational case study **Intervention:** Project management group without HCWs Pre-designed workshops around stress/management HCWs suggested for core stressors **HCW:** HT- practitioners, managers, support staff, administrators SSD- middle and senior managers **Participants:** HT - 42 mixed personnel, all chosen by senior management SSD - 17 middle and senior managers, all chosen by senior management **Duration:** Approximately 6-12 months	Main stressors - organisational culture and senior management communication style. Core role sustained workers in adverse conditions. Support obtained outside work. Culture viewed stress as individuals' responsibility. Reluctance for HCWs to discuss mental health. Autonomous decisions only within imposed NHS bureaucracy limits SSD - high stress levels from high workload/feeling undervalued; poor physical environment; poor relationship with managers HT - mental distress from professional and personal boundary tensions; organisation's failure to confirm role stressors; role clarity issues; powerlessness against government/organisation expectations Primary stressors and proposed solutions reported to managers. Solutions stated little about how HCWs could improve affairs, or own wellbeing. Returnees Support Group and Self-management Pack piloted (managers subsequently unsupported former), plus proposals for sick leave/mental health management. Clarity on organisational change requested. Process reported as enjoyable and useful [12% of 1500 HT, 23.6% of 700 SSD staff responded to baseline work stress questionnaire. Data not included as low response rate and no follow-up questionnaire used]

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Nielsen and Randall, 2012 **Focus of concern:** Maintaining and recruiting HCWs and high absenteeism **Aim:** To implement teams … to create a climate that fostered open discussions and joint decision-making that would improve employee well-being and job satisfaction **Country:** Denmark **Setting:** 2 Eldercare residential/homecare centres	**Study design:** Prospective intervention with before and after assessments **Intervention:** Large teams replaced by smaller groups. Some managerial responsibilities taken by group to support autonomous decision-making in forward-planning client care **HCW:** Team managers and team members **Participants and responses:** Participant numbers (% of total group) Pre-intervention 447 (81%) of 551 18 months later 274 (54%) of 521 **Duration:** Approximately 18 months	**Quantitative** Autonomy and affective wellbeing statistically significantly increased Job satisfaction statistically significantly decreased Social support unchanged **Process evaluation** Pre-intervention (PreI) autonomy and job satisfaction predicted participation levels (active involvement in planning and participation). PreI wellbeing predicted increased degree of reported changes (measure of intervention effectiveness). PreI social support linked to decreased reported changes Participation was statistically significantly related to reported changes. Reported changes statistically significantly related to post-intervention autonomy, job satisfaction, and wellbeing, but participation in isolation did not effect these outcomes. Post-intervention autonomy significantly associated with wellbeing and job satisfaction. Social support post-intervention significantly associated with job satisfaction. Participation regarded as crucial in association with degree of reported changes, and consequently, in intervention outcomes
Shaha and Rabenschlag, 2007 **Focus of concern:** Burdensome physical and psychosocial workload **Aim:** To (a) explore views of burden (b) discern improvement areas (c) develop tailored interventions (d) evaluate intervention **Country:** Switzerland **Setting:** Small county hospital	**Study design:** Qualitative exploratory study **Intervention:** Actions based on identified stressors Problem-based learning techniques used **HCW:** Registered nurses/managers, and nurse assistants **Participants:** 36 in focus groups (surgical and medical) 20 (from medical ward only) continued **Duration** Not stated	Particularly during lower-staffed shifts, documentation and physician rounds were postponed to prioritise good quality nursing care. Ward routine changed to include a break for discussion on tasks to be undertaken Interventions perceived to 'alleviate situations of overtaxation'. Opportunity to discuss themes allowed for transparency among team members and for discussions on 'how to bear differing viewpoints in order to achieve high-quality bedside care'

Study details	Study design, Intervention, Participants, Response Rates, Duration	Outcomes/Findings
Uchiyama et al, 2013 **Focus of concern:** Psychosocial work environment of healthcare workers **Aim:** To investigate the effects on mental health among nurses of a participatory intervention aimed at improving the psychosocial work environment in hospital settings **Country:** Japan **Setting:** 24 Units in 2 private hospitals	**Study design:** Cluster randomised controlled trial **HCW:** Nurses **Intervention:** Researchers worked with workplace key workers, planning strategies in response to initial survey of HCWs Key workers tasked with local implementation **Participants and response rates:** Group numbers (% response of eligible participants) Pre-randomisation - 401 (92%) of 434 completed pre-intervention survey and agreed to participate *Experimental* (11 units) Pre-intervention 183 6 month post-intervention 168 (92%) of 183 Analysed 149 (81%) of 168 as remainder moved to other units *Control* (13 units) Pre-intervention 218 6 month post-intervention 193 (89%) of 218 Analysed 170 (78%) of 193 as remainder moved to other units **Duration:** Approximately 6 months	**Quantitative** No significant effect on mental health *Experimental group* Statistically significant increase in 4 of 13 psychosocial measures of participatory management, job control, co-worker support, and effort *Control group* Statistically significant decrease in goals Statistically significant increase in effort Between-group differences statistically significantly favoured intervention in goals, efficiency, job control, co-worker support Ruotsalainen, JH et al (2015) (Cochrane Collaboration Review) Analysis 5.2 Organisational intervention versus no intervention (Follow-up 1-6 months) Any stress-related outcome: Standard mean deviation - 0.11 **Qualitative** Ward meetings requested for discussion, information-sharing, and communication, and better study opportunities, goal clarification, work organisation. Group meetings exchanging views/good practice key to action facilitation. Reasons for environment improvement - adopting goal-setting ideas, participatory framework Units varied in improved psychosocial environment and participation. Reasons for lack of change - insufficient time for planning; low HCW understanding through insufficient key person communication; three experimental units more interested in improving conditions (salary, schedule, staffing) than psychosocial environment.

2.5 Findings related to review objectives

Findings are reviewed in relation to the two review objectives.

2.5.1 Objective 1: To analyse methodological elements related to effect

In order to methodically evaluate intervention impact, the Nielsen and Abildgaard (2013) framework relating to organisational interventions was applied. Established intervention impact evaluation tools were reportedly scarce (Moore et al., 2015), and this newly developed framework appeared to offer two advantages.

1. It provided specific criteria and guidance for systematic evaluation of a potentially considerable body of data
2. Data could be clearly presented within a recognised academic structure for wider evaluation by other researchers

Seven components of outcomes from which to measure positive impact included: attitudes and values; individual resources; procedures; job characteristics; health and wellbeing; organisational quality and performance; and occupational health services management (Nielsen and Abildgaard, 2013). For the purposes of this review, the level of effect was assessed by the following. Studies providing evidence of having fulfilled four or more components were categorised as positive effect (Pos-E), those with two or three as promising effect (Prom-E), and those with one as unconfirmed effect (Unconf-E). Table 2.5 presents a summary of levels of effect, with five studies categorised as Pos-E, six Prom-E, and two Unconf-E.

Depth of HCW decision-making showed the most marked difference between studies. Participants in every Pos-E study collectively agreed issues, chose strategies, and acted to improve working situations. Exemplified in Lavoie-Tremblay et al.'s (2005) Pos-E study, HCWs autonomously voted down the major proposed change and opted for a slower, stepwise action to first establish inter-HCW trust, before embarking on more marked change. By contrast, Prom-E studies tended toward participant inclusion only after primary, fundamental decisions had been made in, for example, design of intervention programmes (Le Blanc et al., 2007; Munn-Giddings et al., 2005), or in determination of solution strategy (Nielsen and Randall, 2012).

Table 2.5 Study level of effect

Study	No. of components	Level of effect
Bourbonnais et al., 2011, 2006a/b	5	Pos-E
Griffin et al., 2000	5	Pos-E
Griffiths et al., 2003	4	Pos-E
Lavoie-Tremblay, 2004; Lavoie-Tremblay et al., 2005	4	Pos-E
Uchiyama et al., 2013	4	Pos-E
Innstrand et al., 2004	2	Prom-E
Le Blanc et al., 2007	3	Prom-E
Mikkelsen et al., 2000	3	Prom-E
Munn-Giddings et al., 2005; Ramon and Morris, 2005; Ramon and Hart, 2003	2	Prom-E
Nielsen and Randall, 2012	2	Prom-E
Shaha and Ravenschlag, 2007	2	Prom-E
Deery, 2005	1	Unconf-E
Ericson-Lidman and Ahlin, 2017	1	Unconf-E

The general orientation of Pos-E studies towards deeper participant decision-making was also evident in steering group composition and evaluation methods. The two studies with approximately 50% clinical HCW representation on steering groups were both Pos-E studies, whereas the two with no, or limited HCW representation were both Prom-E studies. Furthermore, Pos-E studies' evaluation methods more frequently applied qualitative evaluations, encouraging greater scope for HCW self-expression. Four of the five Pos-E studies invited deeper participation through interviews, focus groups, comment boxes, and peer discussions, and three of four studies using individual evaluation interviews were classified Pos-E.

Beneficial effect was not found to be associated with other study characteristics such as study design, survey timing, or number of survey items. No conclusions can be drawn regarding HCW remuneration as no related information was provided by six studies.

2.5.2 Objective 2: To consider processes modifiable to increase effect

Elements with the capacity to potentially increase effect included study design and evaluation methods; initiator; participant occupational group; and orientation toward stress or wellbeing.

2.5.2.1 Study design and evaluation methods

No specific study design was associated with greater intervention effect. Purely experimental design, nevertheless, appeared to lack advantage. Montano et al. (2014) reported tension between the optimum evidence levels which RCTs were perceived to offer, and the practical difficulties of enacting this approach in organisational settings. In a systematic review of 39 organisational interventions for employee health, Montano et al. (2014) confirmed that RCT designs produced the highest quality data, but found positive effect was produced in only a minimum of studies. Bourbonnais et al. (2006b, p340), having used a quasi-experimental design, noted that workplaces were *not research laboratories.* This view supported Schon's (1995) contention that to meet less defined real-life issues, research designs needed to adapt beyond traditional experimental methodology. Cox et al. (2007) considered the linear progression of RCTs to be rendered unrealistic by the continual change and inability to control events in organisations. These elements likewise challenged the value of control group data emerging from questionable matching of employee conditions, and inter-organisational crossover effect (McVicar et al., 2013). Furthermore, the PAR systematised review found control group participation to be limited. Of the five studies using controls (Uchiyama et al., 2013; Bourbonnais et al., 2011; Le Blanc et al., 2007; Innstrand et al., 2004; Mikkelsen et al., 2000), two control groups yielded questionnaire response rates of less than 25% (Le Blanc et al., 2007; Mikkelsen et al., 2000) and one retained only 9 of 22 participants (Innstrand et al., 2004). Montano et al. (2014) concluded that greater employee participation and diversity of initiatives would more effectively address individual workplaces complexities. Rather than discrete training programmes, the more comprehensive the interventions - including material, time-related, and psychosocial and process elements - the greater the anticipated health impact.

Issues of quantitative and qualitative evaluation methods also warranted consideration. Process data informs understanding of how any impact may have been achieved, yet is seldom generated (Nielsen, 2013). Qualitative participant accounts, using diverse qualitative data generation methods, offer greater insight into effectiveness. Participant views of altered personal workplace experiences enable comprehension of intervention effectiveness and modification of study processes. Quantitative surveys, generally considered as effective process evaluation tools (Nielsen and Randall, 2013), were used in

10 of the 13 studies, including within all quasi-experimental designs. Nonetheless, few of the multiple elements measured found significant differences in effect. Although arguably pointing to overall lack of effect, an alternative interpretation would suggest that quantitative evaluation measures were unaligned to participant experience. The complex and diversely influenced elements of social change are likely to have been inadequately captured (Hughes, 2008). Mikkelsen et al. (2000) and Lavoie-Tremblay et al. (2005) noted that levels of trust were not assessed, despite trust being considered vital in PAR collaboration and foundational to relationships leading to collaborative data generation (Bradbury, 2019). Survey data may also underrepresent how workplace contexts influence outcomes (Cox et al., 2007). Le Blanc et al.'s (2007) survey findings revealed significantly reduced emotional exhaustion, but as contextual organisational factors were not monitored, identifying the mechanism of change was not possible. By contrast, Griffiths et al.'s (2003) qualitative interviewing found explanations for puzzling quantitative results. Participants' prior experience of lack of action consequent to survey completion may also produce low response rates (Coffey et al., 2009). This phenomenon is at risk of emerging if dispirited HCWs tire of successive surveys in organisational and societal demand for services' feedback.

Qualitative evaluation of study processes may additionally be more fully informed by increased reflexivity in data generation choices. Reflexivity encourages researchers to critically reflect on how their personal values, beliefs, and behaviours influence research processes and thus outcomes (Davis, 2020). Although Munn-Giddings et al. (2005) reflected on how disparate roles within their large research team led to lost ownership of the project, such reflection was rarely presented. Furthermore, Munn-Giddings et al.'s (2005) reflection occurred post-intervention, losing the potential to reflexively modify processes, and consequently wellbeing outcomes.

2.5.2.2 Study initiator

Although PAR supports bottom-up wellbeing interventions (Panagopoulou et al., 2015), no interventions had been initiated by a HCW. Stakeholders are generally viewed as prominent senior personnel, yet it is arguable that frontline HCWs are equally crucial key stakeholders. A swell of bottom-up HCW commitment may encourage middle and senior management engagement, as opposed to the more conventional opposite direction of influence. This perspective is supported by the Boorman (2009) review recommendations, which required organisations to make wellbeing services relevant by being designed by local HCWs. Wellbeing initiatives by frontline HCWs are very limited (Dixon-Woods et al., 2014), despite evidence of individual work-units' capability, through HCW engagement, to create high

quality working environments irrespective of wider unfavourable organisational culture (Maben et al., 2012). Frontline HCWs may engender colleague engagement and reduced cynicism by adding assurance that workplace demands are understood. Prior local knowledge and relationships may additionally avoid factors which this systematised review identified as inhibiting progress. These included broken management/HCW relationships - unknown to external researchers (Munn-Giddings et al., 2005); ongoing interdisciplinary disputes (Mikkelsen et al., 2000); and intermediary liaison personnel disrupting communication between researchers and HCWs (Uchiyama et al., 2013).

2.5.2.3 Participant occupational groups

The overwhelming number of study participants in this review comprised of nurses or nurse support workers, a finding echoed in a SR of hospital PAR interventions, which specifically found physician involvement lacking (Montgomery et al., 2015a). Acute wards' functioning depends on close cooperation of different HCW groupings in fast-changing situations, akin to the description of the LW setting in Chapter 1. As each group's ways of working impact on every other group's experience and wellbeing, all HCWs' participation is required. More extensive research has been proposed by Egan (2013) into how psychosocial interventions differently affect employee groups, yet included studies presented little detail as to how diverse HCW groups experienced interventions.

2.5.2.4 Stress versus wellbeing orientation

A minority of this reviews' included studies aimed to focus on advancing wellbeing, as opposed to reducing stress. Bauer and Jenny (2013, p3) suggest organisational and employee health are interdependent and grow forwards through continual interaction:

> *Making the case for a working environment full of enjoyment, resource, and positive health.*

Healthcare workers historically view health through pathogenic perspectives (Montgomery et al., 2013). Conversely, salutogenic approaches - those working towards health enhancement rather than illness reduction - facilitate HCWs building on experiences known to increase wellbeing (Montgomery et al., 2013). Appreciative Inquiry, conceptualised by its founders as *a generative approach to research into organizational life* (Zandee and Cooperrider, 2008, p190), allows creative planning of different organisational futures by use of participant storytelling. Significant positive workplace narratives are shared, generating positivity and new self-organised ways of working (Bushe and Marshak, 2009). Reliving and discussing elements associated with success energises employees, rather than being discouraged by the magnitude of failures emphasised in the more prevalent practice of

problem identification (Ludema and Fry, 2008). Positive psychology approaches similarly move away from individually experienced pathology-related orientations to discover conditions which lead to thriving and worldly wellbeing, including in workplaces (Seligman and Csikszentmihalyi, 2000). Within positive psychology approaches, *what makes life worth living* is identified and amplified, and has shown potential to optimise psychological health (Gable and Haidt, 2005, p104). In contrast to identifying deficiencies, building on what is working well may increase intervention effectiveness.

2.6 Literature review summary

This chapter's literature review supported combining organisational and individual interventions for employee wellbeing. A systematised review was undertaken, aiming to assess the evidence related to the utility of PAR in HCW wellbeing interventions. The review question asked if sufficient evidence of PAR's utility warranted planning a wellbeing initiative on LW. Although challenging to systematically categorise due to heterogeneity in implementation and evaluation methods, analysis of included studies supported overall benefit from PAR. Since the Boorman (2009) review, national guidance has specifically stated that HCWs should co-create wellbeing initiatives and be empowered to control their working conditions. Participatory action research reportedly offers this engagement, yet evidence related to the two review objectives suggested its full potential was unrealised. The capacity of HCWs to self-organise wellbeing strategies remained largely untested. Modifications to future study designs were likely to benefit from inclusion of the following:

- Frontline HCWs initiating interventions in a bottom-up dynamic
- Extending the depth of frontline HCW decision-making in all PAR processes
- Including all HCW groups from the setting
- Generating participant process and evaluation data through qualitative methods, to concurrently reflexively mould study activity
- Adopting a positive orientation to enhancing wellbeing

It was anticipated that implementing the above modifications would optimise effect. The apparent lack of depth of HCW decision-making could be counteracted, and HCWs be instrumental in developing their own wellbeing. Within organisational settings, and as related the planned research study, this approach would constitute *insider* PAR (IPAR). Within IPAR, an employee facilitates an initiative within their personal workplace, is a full member of the organisation, and intends to remain so beyond the research (Coghlan and Brannick, 2014). Rather than an external observer gleaning what can be objectively viewed of the organisation's inner workings, the IPAR researcher (IPARr) would be deeply

entrenched in workplace systems and offer alternative insights (Coghlan and Brannick, 2014). Although an IPAR approach towards LW HCW wellbeing enhancement showed promise, comparison to other potentially appropriate methodologies was indicated, as included in Chapter 3, *Methodology*.

Chapter 3 Methodology

3.1 Introduction

The literature review of Chapter 2 indicated the potential utility of IPAR for a wellbeing intervention study. This chapter includes an exploration of philosophical assumptions which led to the chosen methodology, study objectives, and data generation methods. It is discussed how the research design, by flexibly accommodating working conditions, was developed to encourage HCW participation. The chapter concludes with details of ethical considerations in relation to WbP research activity.

3.2 Framing the research design

Once the study aim and research question had been defined, the research design required construction. Creswell (2014) and Crotty (1998) suggest researchers make their views on reality explicit by embedding the methodology, and harmonious methods, in philosophical perspectives. Although IPAR had been identified as a potential approach, the rationale for whichever methodology was chosen needed to be clearly articulated. I considered myself a pragmatist and would adopt whatever study design was most likely to generate data which addressed the research question (Cox et al., 2007). This did not absolve me from making philosophical decisions consistent with methodology and methods (Mesel, 2013) and I sought a social research framework to guide the process. I acknowledged the impact of my personal values on subsequent design choices and, following McNiff (2016), chose to make these explicit. I valued:

1. Practical HCW benefit being realised through the research effort
2. Including colleagues' perspectives and contributions from every occupational group
3. Partnership with colleagues towards a shared research endeavour
4. Personal connection to colleagues.

My values were influenced by respect for my colleagues' daily giving of their best efforts towards enabling women's optimum birth experiences. In witnessing this, I recognised and acknowledged decisions towards the study design would be influenced by the relationship and compassion I felt towards them.

Supported by the work of Carter and Little (2007), the research design was developed within a framework by Burns Cunningham (2014). This framework derived from a combination of two factors - philosophical assumptions and practical considerations (Burns Cunningham, 2014). Basing methodology in philosophical assumptions intends to explore the deeper

roots of what constitutes knowledge, rather than simply narrowing options to qualitative/quantitative positioning (Mesel, 2013; Crotty, 1998). Mesel (2013) suggests that most enquiries evolve from the practical considerations of how the study purpose and research question(s) should be addressed. As the research question had already been constructed, this matched my experience. Additionally, examining the nature of the question had been proposed as a means of surfacing personal implicit philosophical assumptions (Burns Cunningham, 2014). This necessitated clarifying the constituent elements of ontology, epistemology, and theoretical perspectives.

3.2.1 Ontology

Ontology relates to the study of *being*, of what reality *is* (Crotty, 1998), and is often categorised as realist or relativist. Levers (2013) respectively indicates these as reality existing unallied to the human mind, or in contrast totally subjective wherein *reality is human experience and human experience is reality* (Levers, 2013, p2). Established researchers commonly omit references to ontology (Creswell, 2014; Silverman, 2013) as ontological matters become apparent within epistemological positioning (Crotty, 1998) (see Section 3.2.2) and researchers generally proceed as if both physical and social aspects in the world are real (Carter and Little, 2007).

3.2.2 Epistemologies

An account of epistemological perspectives, how *we come to know what we know* (Crotty, 1998, p8), is considered foundational to validation of any knowledge claim (McNiff, 2016). Epistemological perspectives determine methodological approach and methods. In relation to the WbP research question, the three major epistemologies of objectivism, subjectivism, and constructionism (Crotty, 1998) were explored.

3.2.2.1 Objectivism

Objectivism suggests that reality exists separate to any human consciousness, so that an object in the world contains its essence of meaning regardless of whether it is observed. Consequently, its meaning can only be discovered, whereupon its reality is exposed for all time. This orientation links to the theoretical perspective of positivism wherein researchers posit hypotheses to support cause and effect, seeking patterns and ir/regularities from quantitative data to discover a predictable objective truth (Creswell, 2014; Crotty, 1998). Ideally the methodology is enacted through *gold standard* experimental RCTs (WHO, 2010, p41), which remove any potentially contaminating elements from the discovery of universal truth.

The WbP study question implied a group of people striving towards a communal goal:

> *How can we as maternity healthcare workers enhance our individual and collective wellbeing?*

In terms of positivism, it felt incongruous that individual researchers' hypotheses could reveal universal truths applicable to colleagues' wellbeing. I perceived reality emanating from individuals' interpretations of wellbeing, rather being an objective truth. Being committed to retaining participants' agency in a collective research effort, I felt uncomfortable anticipating collating data and formulating personal conclusions about others' experiences. The richness of colleagues' views would risk being lost if confined to the categorisation required of quantitative data analyses. Furthermore, the *how* within the research question suggested a multifaceted creative process, rather than confinement to one or a small number of hypotheses. In summary, positivism appeared to hold limited opportunity to fully explore the research question.

3.2.2.2 Subjectivism

In contrast to objectivism, subjectivist epistemology proposes an entirely relativist position (Levers, 2013), claiming individuals confer meaning onto objects, such that every individual's reality is uniquely experienced. Objective reality is thereby disallowed (Crotty, 1998). I found this concept challenging in that it was difficult to refute that every individual applied their own meaning onto all they observed in their world. I was uncertain how subjectivism could be assimilated into the research question, except personally to tentatively acknowledge each person's reality as unique and therefore open to exploration. As the study question depended on a group response, a purely individual subjectivist enquiry might not be anticipated to meet the collaborative dynamic the question implied. Nevertheless, alternative opinions had purported that most meaning must originate from individual subjectivist experience:

> *We do import meanings to objects, after all. We import them from our culture.* (Crotty, 1998, p218)

I therefore continued to explore subjectivism in relation to the two associated theoretical perspectives, namely post-structuralism and interpretivism (Crotty, 1998). Diametrically opposing universal truths, post-structuralism espouses language to have infinite and interrelated social meanings (Grant and Giddings, 2002). These meanings are explored through textual deconstruction and reinterpretation, challenging stereotypical social assumptions and discourses. Applied to LW wellbeing, this may promote HCW appreciation or understanding of personal and/or colleagues' views. The active aspect of developing

wellbeing within the research question would, however, be delayed until findings were reviewed and subsequently acted upon.

Crotty (1998) considers the key factors of interpretivism as identifying deeply with participants' personal narratives and taking cultural context into account. Interpretivist theoretical perspectives include the symbolic interactionist methodologies of phenomenology, hermeneutics, and ethnography. Symbolic interactionism proposes human behaviours stem from individuals' interpretations of symbols produced in community with others; phenomenology records individuals' lived experiences as directly expressed; hermeneutics explores the meanings of text and speech; and ethnography studies culture by researcher integration into the group in question (Crotty, 1998). Applied to the study question, individual HCWs in phenomenological or hermeneutic enquiry could express how wellbeing may be developed and similarly, in an ethnographic study, a researcher could integrate within the LW setting and identify aspects of the culture affecting wellbeing. In all cases, data would be analysed by the researcher and presented for further future appraisal. Again, however, translating data into practical benefit, if successfully undertaken, would be delayed until research enquiries completed. Thus, enquiries focussing on individuals' experiences appeared less effective strategies for operationalising the *how* of the WbP study question and for provoking change within the study period.

3.2.2.3 Constructionism

Constructionism posits that reality is created by individuals' conscious minds interplaying with objects in the world, thereby straddling the objectivist and subjectivist stances (Crotty, 1998). These individual minds function in particular social and historical contexts related to a group. The reality so produced is contingent on those specific individuals and those particular contexts. Reality is thereby interpretable in multiple ways, rather than constituting an eternal, objective, predictable truth. Crotty (1998) assimilates subjectivism into social constructionism by adopting a continuum from a strictly relativist to a more nuanced realist position. Subjective reality may be experienced, for example, by a person being coached into a culture, but objective reality is acknowledged in that the culture existed as an entity prior to it being unconsciously adopted by the individual (Andrews, 2012). In this interpretation, all phenomena can be viewed as individually experienced and therefore relativist (tending towards subjectivism), but the culture nevertheless as real (tending towards objectivism). Thus, my cautious understanding viewed LW culture as an objective reality but one which, once embodied by individuals, was not subjectively consciously recognised by HCWs.

3.2.3 Social constructionism, pragmatism, and participatory approaches

I felt social constructionism attuned to my interpretations of reality, particularly after Burns Cunningham (2014, p36) referred to the ontology of subtle realism and I investigated its meaning. Subtle realism denotes acceptance of an *independent knowable reality* (Blaikie, 2010, p94) - a positivist-orientated perspective, but access to which is prevented by culture - a constructionist perspective which considers individuals' realities can only be seen through the prism of the established culture. My feelings aligned with Blaikie's (2010) assertion that this ontology was compatible with social constructionism, and returned to the research question:

> *How can we as maternity healthcare workers enhance our individual and collective wellbeing?*

In terms of ontology and epistemology, I concluded respectively that subtle realism and social constructionism could combine within the research design. My interpretation acknowledged that, within subtle realism, a reality of wellbeing existed for individuals. Considering the influence of culture was irremovable from individuals' perceptions of reality, the group culture encompassing multiple views would act as the conduit towards constructing a different reality. In relation to the research question, the *how* would be open to the vocalisation of all HCW views but only the group's collective imagining of building a different reality could realise movement towards that end. The above deliberations allowed me to adopt social constructionism as the study's foundational epistemology. Any knowledge claims would emanate from the multiple and collective perspectives of LW HCWs as expressed through cultural behaviour.

In terms of practical implications, social constructionism and pragmatism hold common views of knowledge (Gergen and Gergen, 2008). Pragmatists are less interested in theoretical objective truth finding, and more with the utility of research outputs for the world's benefit (Cornish and Gillespie, 2009). Social constructionism likewise focusses on research's impact, but as related to culture. If cultures construct particular knowledge as valuable, the credibility of that knowledge is amplified and maintained, regardless of its foundations and whatever consequences follow (Gergen and Gergen, 2008). Furthermore, Gergen and Gergen (2008, p160) see *kinship* between social constructionism and action research methodology as both are grounded in similar beliefs - knowledge being socially rather than individually constructed; community being formed through language; value of knowledge residing in mobilisation for social benefit; and our *being* in the world depending entirely on relationship with others. These elements all appealed significantly to the community of effort held within the proposed study's research question. As stated in

Chapter 2, workplace-based PAR celebrates and marshals what is considered as the expert knowledge of those in the setting to effect real-life situation changes (Abma et al., 2017; Greenwood, 2007). Rather than representing a prescribed methodology, PAR's wider aspiration focusses on doing good for the world (Gergen and Gergen, 2008). Action researchers purposefully choose ways of living out their values by working with others towards sustainable, democratic, and fair human life conditions (McNiff, 2016; Greenwood, 2007; Winter and Munn-Giddings, 2001). This view is supported in the orientation of enquiry to PAR, expressed as:

> *We are not bounded individuals experiencing the world in isolation. We are already participants, part-of rather than apart-from.*
> (Reason and Bradbury, 2008, p8)

Related to these perspectives, critical theory often accompanies PAR, particularly in relation to perceived disadvantaged communities (Smith and Romero, 2010). Stemming from Marxist philosophies (of culture oppressing citizens), such research intends to liberate participants' agency in effecting personal life changes (Kidd and Kral, 2005). Although sympathetic to such discourses, and it being arguable that HCWs are oppressed, this philosophy was not the driving force related to the study aim.

Having considered the above connections between social constructionism, pragmatism, and PAR, I felt PAR was the most appropriate methodology in answering the *how* of the study question. The nature of pragmatism attuned to my first value of being practically useful (Cornish and Gillespie, 2009). My other values too could find a place as HCW-generated data would be core to action and originate from partnership and relationship with colleagues, and I would not be the sole arbiter of strategies for colleagues' wellbeing. I confidently settled on IPAR as the methodology of choice for the research question.

3.3 Readiness of the setting

For optimum intervention effect, a certain level of *readiness* is required Zhang et al. (2015). This refers to organisational culture and structure supporting such aspects as open respectful manager and employee interaction, and good communication enabling envisioning a mutually desired future. In relation to the specific LW, conditions appeared favourable. The setting's readiness was supported by good interdisciplinary collaboration (including joint training sessions) and the maternity unit had publicly committed to wellbeing action by signing the RCM Charter for healthy workplaces (Astrup, 2016). While future dynamics could not be predicted, senior and unit-level management, the Medical Director, the Trust Organisational Development team, and numerous HCW groups had professed

willingness to actively participate in a wellbeing initiative. As a practising HCW with established interdisciplinary relationships, I was well-positioned to initiate the project and act as an IPARr. The role was congruent with my values, and I welcomed the IPARr positioning, but equally needed to clarify considerations related to the role.

3.4 Acting as an IPAR researcher

A spectrum of factors was found to be related to the role of IPARr. Advantages were proposed as having access to blend into settings, and prior knowledge enabling pertinent questions to be posed (Greene, 2014). Responses, in turn, could more accurately be interpreted due to familiarity with cultures (Greene, 2014). Holian and Coghlan (2013) nevertheless cite differing experiences of the role. These range from perceived coercive IPARr directives securing colleagues' compliant participation, to enhanced, enduring colleague cooperation and relationship. Research processes may also be manipulated by both the IPARr and participants. The IPARr may favour who is approached to generate data, and to whom and how data are fedback, analysed and actioned. Colleagues may likewise, according to relationships with the IPARr and to the research's perceived worth, offer or withhold consent, and give or omit information. Issues of protection of individuals' confidentiality and organisational reputation may also arise (Abma et al., 2019). The above myriad factors indicated that IPAR researchers needed to be prepared for the role being an active element of IPAR research, and not one of a detached data recorder. A further finding from the literature review of Chapter 2 is now explored - that of positively-orientated research enquiries potentially offering greater effect than problem-based approaches.

3.5 Appreciative Inquiry and positive psychology

The strength-based approach of Appreciative Inquiry involves organisational members mentally stepping away from workplace realities and imagining new possibilities in ways of working, often to significant scale (Zandee and Cooperrider, 2008; Ludema and Fry, 2008). In common with PAR, Appreciative Inquiry values employee expertise in envisioning a different future, and in being capable of influence at all stages of change processes. Although appealing for those reasons, it appeared impractical for Appreciative Inquiry to be operationalised within LW. The required steps demanded numerous colleagues regularly leave the workplace to access an environment in which to creatively think through options. Such protected time would not be feasible within LW staffing constraints. Several facilitators would be needed, possibly including external experienced specialists, and I had no related expertise. I was nevertheless keen to adopt the *tone* of Appreciative Inquiry, which I perceived as corresponding to positive psychology. Both Appreciative Inquiry and positive

psychology recognise the beneficial prospects of initiating creative discourses towards enhancing life experience (Ludema and Fry, 2008; Seligman and Csikszentmihalyi, 2000). Positive psychology has been defined as:

> *The study of the conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions.*
> (Gable and Haidt, 2005, p104)

Using positive psychology to identify the factors which sustained HCWs could support the LW study enquiry. Chapter 1 described emotionally draining and inhospitable working conditions. Healthcare workers, nevertheless, persisted in returning to those environments. Self-evidently, attendance must be rooted in strong and diverse drivers. Rather than risking depleting whatever reserves/resilience these drivers provided, a focus on replenishing positive factors appeared inspirational and gainful. I intended to encapsulate this positively orientated school of thought within data generation methods, but first the objectives of the study were defined.

3.6 Study objectives

Organisational action research starts with ascertaining current conditions and working towards a desired future state (Coghlan and Brannick, 2014). Firstly, this would involve using a positive psychology orientation to LW enquiry to determine the aspects of working which supported wellbeing. Secondly, the data generated would serve to inform actions towards future changes. Following these considerations, the first two objectives were proposed as:

1. To collate factors identified as encouraging wellbeing.
2. To collectively design future ways of working

In addition, as stated in Chapter 2, no evidence of a previous IPAR enquiry into HCW wellbeing on a LW had been identified. The third and final objective was thus intended to capture the role of IPAR in the *how* of the study question, as associated with the use of the methodology:

3. To evaluate the role of IPAR in study impact and process.

To fulfil these objectives, the study period was planned as 18 months of study activity followed by a further three months of data analysis. It was not possible to identify an optimum study duration from the literature review of Chapter 2, but four authors had reported six months' duration as inadequate (Uchiyama et al., 2013; Innstrand et al., 2004; Griffiths et al., 2003; Mikkelsen et al., 2000). The proposed total of 21 months was reached by

estimating the maximum time allowable for research activities within the limits of the PhD study period. Data generation methods are described below.

3.7 Data generation

In addition to philosophical assumptions, Burns Cunningham (2014) referred to practical considerations in study design. These were to be addressed through developing data generation methods suitable to the setting. Data generation in participatory research differs from other methodologies in that activities unfold as studies progress. Study designs are not pre-ordained but evolve as events occur (Abma et al., 2019; Smith and Romero, 2010). Rather than linear plans coming to fruition, multiple accounts of participatory studies refer to processes being accompanied by messiness (Abma et al., 2019; Coghlan and Brannick, 2014; Winter and Munn-Giddings, 2001). In the absence of certainty around actual future events in the LW study, data generation methods, although anticipated as appropriate, may not necessarily be employed.

In addition, data generation in participatory studies derives from the relational element between the initiating researcher and those in the setting (Abma et al., 2019). The researcher objectively collecting data from an *other* is replaced by the engagement of two or more parties connecting over a mutually relevant topic (Winter and Munn-Giddings, 2001), ultimately in an effort towards social change (Abma et al., 2019). The term data *generation* therefore more accurately than *collection* represents co-construction of new learning and knowledge within communicative spaces (Abma et al., 2019). Although IPAR could include many creative data generating methods (Winter and Munn-Giddings, 2001), those chosen must fit workplace conditions (Coghlan and Brannick, 2014) in terms of financial resources, duration of study, participant availability, and literacy skills (Vallianatos et al., 2015). There was no capacity within the study term, and no funding, to take HCWs away from LW. Activities were required to be accommodated within the setting's activity, so the principal need was flexibility. Firstly, research processes would need to be tailored around HCWs' clinical priorities. Secondly, to meet diverse HCW needs, a variety of easily accessible methods for participation would be required. These are described as associated with the three study objectives.

3.7.1 Objective 1: To collate factors identified as encouraging wellbeing

As collaboration and relationships would be considered key to data generation, the primary aim would be related to inviting opportunities for verbal exchanges. These were anticipated to take place in individual and group interview scenarios, and in online forums, with most

data being generated during HCWs' duty time. This would adopt the equivalent position of *kneeling in the mud*, as had been successful in a study involving gardening with potential participants (Abma et al., 2019, p127). The metaphor arose from the realisation that natural conversations, of value towards data generation, were established by working alongside others during their daily activities. For LW, this translated into being visible in the setting for several hours each week. Being physically obvious, colleagues would be able to engage at their convenience, and data could opportunistically be generated.

3.7.1.1 Participatory data generation methods

The following data generation methods were anticipated to be congruent with participatory principles.

3.7.1.1.1 Individual interviews

Qualitative semi-structured interviews were intended to both explore individual HCWs' personal perceptions of workplace wellbeing (Mason, 2002) and to form a landscape of determinants of collective LW wellbeing. Questions would not be hypothesis driven, but open and exploratory (Coghlan and Brannick, 2014) (see Appendix 2 for Interview Prompt Guide). Individual interviews were anticipated to be both planned ahead, at times away from the setting (for example in local cafes), and to occur spontaneously. The latter were expected to arise from conversations related to wellbeing and would be considered informal interviews in not being scheduled ahead (Green and Thorogood, 2014), but taking place when clinical activity allowed.

3.7.1.1.2 Group interviews

Groups' data are frequently generated through facilitated focus groups, within which participant views on a specific topic are recorded. These are, however, considered limited in relation to IPAR's determination for dialogue to move beyond collecting views to more creatively bringing action on social change (Coghlan and Brannick, 2014). Consultation groups are a preferred alternative term, wherein interaction and dialogue between all group members, including the IPARr, would work towards this end (Coghlan and Brannick, 2014). I foresaw, however, the difficulties of pre-planning consultation groups given limited HCW availability. I pragmatically accepted that a series of planned groups was unrealistic, but was nevertheless optimistic that informal group interviews, akin to individual interviews unpredictably occurring, would yield stimulating data. This method would offer an alternative for those more comfortable expressing views in group situations (Green and Thorogood, 2014). Digital audio-recording during face-to-face individual and group interviews was intended to add accuracy and allow concurrent notes to be made (Simons, 2009). If consent

for audio-recording were withheld, consent for notes to capture relevant data would be requested. Although I considered face to face exchanges as the most promising method to promote dialogue, to meet diverse HCW preferences (Abma et al., 2019), other methods were designed, including online consultation groups, paper and online questionnaires, and data display areas, as described below.

3.7.1.1.3 Online consultation group

It was not known whether HCWs would prefer face to face or online dialogue. Documentation for a closed online asynchronous (not real-time) group was therefore prepared for the latter eventuality, following a study using this method for exploring midwife resilience (Hunter and Warren, 2013). It was planned that the social networking site Facebook would host interactions if a new group were subsequently to form for data generation. Facebook was chosen as many HCWs already discussed maternity matters in a closed forum on this platform and were familiar with its use.

3.7.1.1.4 Questionnaires

I was reluctant to use quantitative surveys for several reasons. The large number of different measures used to assess psychological effect in the literature review of Chapter 2 had indicated that comparisons to other study evaluations were unlikely to be meaningful. My reticence was also due to questions being prescribed, thus limiting colleagues' self-expression, and to HCWs' cynicism regarding questionnaires' usefulness in effecting change (Coffey et al., 2009). I instinctively felt that, given the extra HCW effort it would demand, promoting a multi-item questionnaire would close colleagues' minds to the study. The literature review of Chapter 2 had suggested use of qualitative methods to determine study impact and process, yet established action researchers advised considerable caution, even regarding qualitative questionnaire use (Coghlan and Brannick, 2014; McNiff, 2013). Practical reservations in terms of historically low response rates and uncertainty in accurately interpreting respondents' messages were cited as issues, but also the ethical dimension of this method's inability in upholding AR dialogic principles (Winter and Munn-Giddings, 2001). Questionnaires were deemed problematic in denying collaboration, closing avenues to new knowledge by prescribing subject matter, and describing static conditions rather than inspiring dynamic forward action. By contrast, providing a range of methods, particularly methods more familiar to the setting's workers were, nevertheless, recognised as potentially useful (Abma et al., 2019). If only a small number of HCWs preferred qualitative questionnaires over interviews, their views could still be included, and particularly so if questionnaires allowed more deviant views to be anonymously expressed. According to McNiff's (2013) guidance to make enquiries short and open-ended, a questionnaire was

developed - before the study start, and conferring with colleagues regarding wording and design - comprising of only two questions (Appendix 3). Wellbeing comment boxes were to be provided for paper questionnaires. For those preferring it, the same questionnaire was to be made available online, the link to which would be included in the Cover Email Study Start (Appendix 4).

3.7.1.1.5 Data display areas

To provide HCWs access to data excerpts once these were generated, data displays were planned for LW areas. I was unsure of the volume of data which may be contributed, and consequently what form displays would take, but expected to visually present data on large posters wherever space allowed. Adhesive notes and pens were to be accessible, so that HCWs could add comments on displays in response to what they read, thus generating further data.

3.7.2 Objective 2: To collectively construct future ways of working

Participatory action research is based on actions developing in multiple paths from the data generated. Those affected by the research may be involved in processes more usually associated with the researcher role (McNiff, 2013). These may include reviewing data, prioritising topics for action, planning and implementing strategies, and evaluating outcomes, before deciding the next step (Vallianatos et al., 2015). The precise model of the group depends on the nature of individual enquiry (Winter and Munn-Giddings, 2001) but, for LW, *Action Groups* (AGs) were anticipated to provide the forum for those processes to be undertaken in an open, democratic manner.

3.7.2.1 Action Groups

It was anticipated that data would be brought to AGs, having been generated from the above methods. Possibly due to the diversity of AR projects, very little direction was available in the literature to guide construction of such groups (McArdle, 2008). I considered that AGs would be organised around topics which were dominant in the data and which showed promise of being developed for HCW wellbeing benefit. Participation in AGs would be welcomed from a cross-section of representatives from occupational groups affected by the topic of interest. Participation levels could not be known in advance as, in association with PAR practice, participation would be voluntary. Interest was anticipated by those who could identify with the sentiments of the data in their own work situations. As large numbers of participants were not expected to be relieved of clinical work in order to attend AGs, it was anticipated that those showing interest could be accommodated. In addition to reviewing data, the groups themselves were also expected to generate data, related not only to the

objective actions taken, but in the associated dialogue. Although such groups may initially be formed for research purposes, they may self-organise by the study endpoint (McArdle, 2008). Should AGs be formed, it was envisaged that they could function within the 18-month study period and then continue beyond that time according to members' preferences.

3.7.3 Objective 3: To evaluate the role of IPAR in study impact and process

The literature review of Chapter 2 identified a lack of contextual qualitative process data in intervention evaluation. An absence of such data disallows study impacts to be situated in real-life conditions, and thus for wider consideration and application in alternative settings (Nielsen and Abildgaard, 2013). It was therefore planned that a full account of the WbP study impact and process data would be presented.

3.7.3.1 Impact and process evaluation

The framework of Nielsen and Abildgaard (2013) was to be used for impact evaluation. Included would be changes in participant attitudes, values, and personal resources; working procedures; working conditions; worker wellbeing; indicators of organisational health; and organisational health and safety routines. Process evaluation was to use the Nielsen and Randall (2013) framework, assessing intervention implementation, context, and participant mental models. (Both papers of Nielsen and Abildgaard [2013] and Nielsen and Randall [2013] include guidance on process evaluation, with the former also focussing on impact evaluation). Mental models describe thought processes which make sense of worldly situations (Nielsen and Randall, 2013). Judgements of a topic's personal relevance regulate employee responses to workplace interventions. Argyris (1995) presents theories-in-use as the thought processes provoking human beings' actual, as opposed to intended, actions. If actions change post intervention, this implies that shifts in mental models have derived from individuals' learning from exposure to the intervention. Process and effect evaluation were informed through the same data generation approaches as for the first two study objectives. An alternative prompt guide was, however, produced to capture the altered focus of enquiry for interview scenarios (Prompt guide - Implementation process and effect, Appendix 5). A specific questionnaire for participant evaluation was not prepared pre-study, which is further discussed in Chapter 4, *Analysis and Findings*.

The above data generation methods were considered fundamental to an IPAR enquiry seeking to enact the principle of participation and to respect diversity in potential participants' preferred approaches to engagement. In addition, reflexivity, another principle of participatory approaches, required consideration (Winter and Munn-Giddings, 2001).

3.7.3.2 Reflexivity and journalling

Reflexivity invites researchers to understand how personal assumptions and beliefs which have assimilated through life's social experiences may influence approaches to research enquiries (Marshall et al., 2010; Winter and Munn-Giddings, 2001). This is more fully explored in Chapter 6, *Reflexivity*. As applied to study processes, my understanding was to hold what I considered knowledge lightly. This was in awareness that my interpretations could be influenced by preconceptions and biases that I may barely discern, but which would nonetheless need to be critically reflected upon. To support this, I intended to maintain a journal recording new thoughts and perspectives prompted during research activities. These were expected to arise from general conversations on LW, in interviews, in data analysis, from engagement with literatures, in personal feelings related to the role of IPARr, and from my perceptions of study progress (Abma et al., 2019; Mc Niff, 2016). I understood this documentation as data to be further analysed as part of the reflexive process (Winter and Munn-Giddings, 2001) and to be revisited in continuing re-evaluation of my engagement with colleagues and with research processes.

In terms of data generation, reflexivity had been applied even before the study started, as related to observation methods. Observations could have described the LW situation in, for example, how kindness would be expressed (McNiff, 2013), but this was anticipated to be counterproductive. I could not ethically proceed without informing colleagues of observational methods (Robson and McCartan, 2016). This was likely to disturb and distort natural activity and delineate the *researcher* from the *researched,* undermining the value of the initiative as collective (Abma et al., 2019). My choice was also influenced by my imagining myself feeling uncomfortable if I, as a colleague, were one of the *researched*. In summary, the study design is presented in Figure 3.1, including the various elements documented to this point. Processes for review of data are now considered.

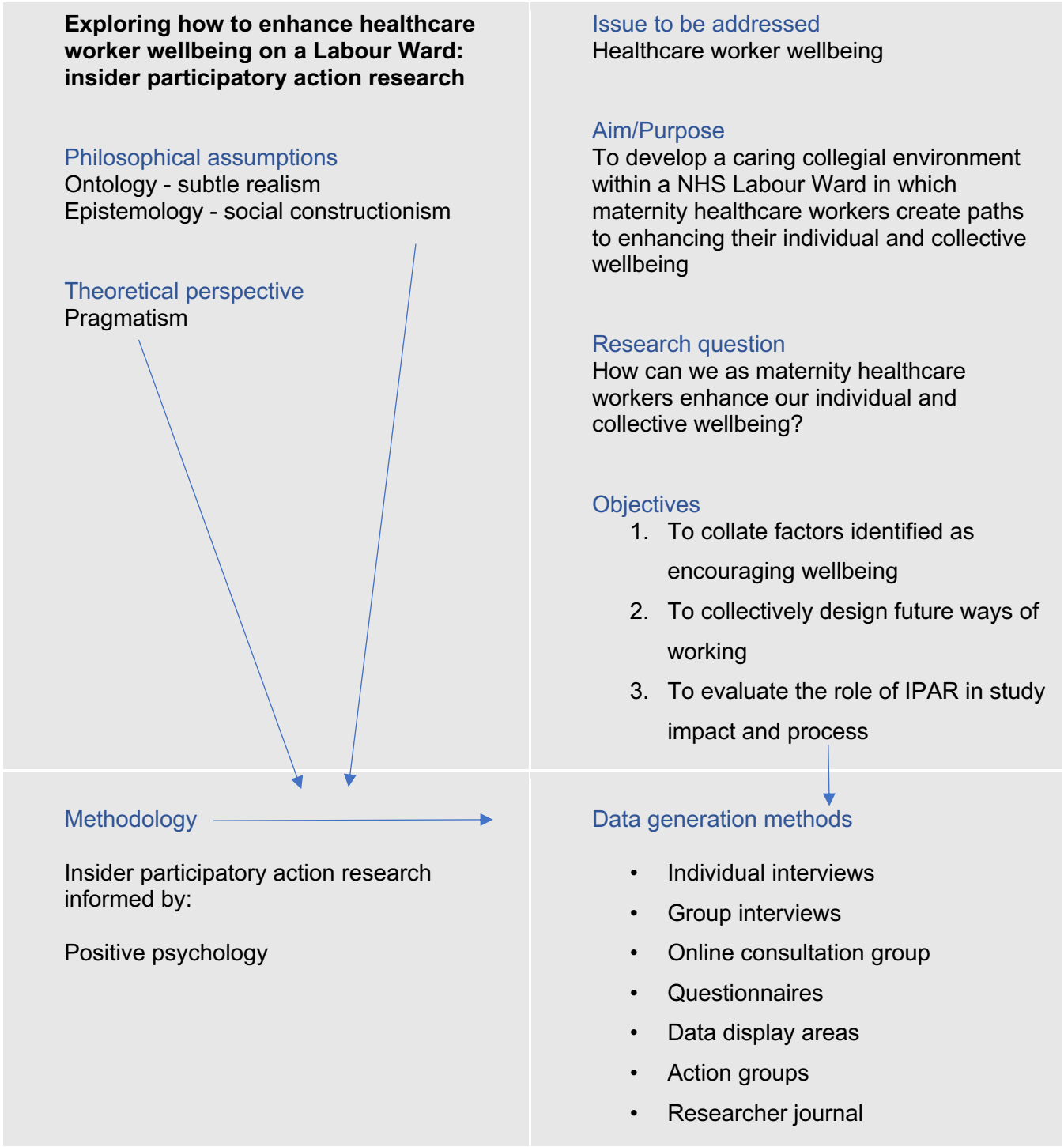

Figure 3.1 Study design

3.8 Data analysis

Data analysis in participatory research is often referred to as sense-making, in that its goal is perceived as finding meaning, or making sense, for those involved in activity (Abma et al. 2019). This leads to learning and instigating change, rather than more typically closing with interpretation of findings (Winter and Munn-Giddings, 2001). To achieve progress towards that end, data analysis is integral to study activities and is ongoing throughout, with new

insights being fed back to participants to inform that learning and change. Abma et al. (2019) suggest that, ideally, a group constituted from those affected by study activities would review all data generated. Each member would increase the opportunity for alternative perspectives to create meaningful understandings, and hence actions. Not all those contributing to enquiries would be obliged to engage, but rather those interested in learning how to do so, those already skilled, and those with sufficient time. To increase diversity of interpretations, HCWs from all occupational groups were to be invited by poster adverts to participate. Actual numbers engaging from each group could not be known in advance.

Both Abma et al. (2019) and Winter and Munn-Giddings (2001) suggest elaborate processes may deter inclusion of diverse members, and therefore meaningfulness for those unused to academic activity, and be overly time-consuming in terms of prompting action. Instead, a flexible approach dependent on the capabilities of interested parties may be more productive. Before starting the study, I envisaged time commitments would challenge engagement of peer participant reviewers. To facilitate this eventuality, however, and to make engagement as straight-forward as possible, I anticipated using thematic analysis (TA), particularly in relation to Objective 1 and Objective 2, as discussed below. It was planned that Computer Assisted Qualitative Data Analysis Software (CAQDAS) would be used to store data and support analyses if volumes of data proved unmanageable manually.

3.8.1 Thematic analysis

I understood TA to be appropriate for both inexperienced and experienced researchers, and to allow data to be examined to varying depths (Braun and Clarke, 2006). This would offer advantages for participatory approaches which could involve diverse participants in data review (Robson and McCartan, 2016). The process would be inductive, including data being repeatedly read, collated into initial codes (noteworthy elements), categorised from codes into overarching themes, and finally integrated into a narrative synthesis (Braun and Clarke, 2006). I planned to start this process by reviewing all data as they became available and manually highlighting transcripts with preliminary codes and themes. In order to increase engagement and inclusivity for inexperienced participants, I intended to use the methods of McMenamin et al. (2015a/b). These would include verbally introducing participants to the TA processes of categorising data into codes and themes. Activities/actions would afterwards be manually timetabled using charts and Post-it notes. Peer participant reviewers would be provided with data to develop and make note of their individual perspectives. Thereafter, it was planned that peer participant reviewers would meet with

myself and other participants to discuss data interpretations to date. After iterations of this process, the group interpretations would be agreed.

Other techniques for data analysis were considered but these were not found to fit action research's dimension of prioritising collective learning and action over in-depth analysis (Winter and Munn-Giddings, 2001). In reference, for example, to Robson and McCartan's (2016) descriptions of discourse/conversational analysis and grounded theory analysis, the first two respectively concentrate on deep analysis of language, and the third on theory generation through detailed data scrutiny. Additionally, framework analysis uses pre-determined themes in a deductive process, often towards later policy development (Green and Thorogood, 2014), rather than towards action being incited within the study period. In contrast, I anticipated that TA would allow the factors encouraging HCW wellbeing to be represented (Objective 1) and to additionally provide a basis for future actions in AGs (Objective 2). Analysis in relation to Objective 3 was expected to follow a different process, as described earlier. The above data generation methods were subjected to ethical consideration.

3.9 Ethical considerations

Ethical study practices were to be based on the Framework for Research Ethics set out by the UK Economic and Social Research Council (ESRC), as formulated on the World Medical Association Declaration of Helsinki (ESRC, 2017). Six principles constituted the ESRC's ethical research guidance:

- Ensuring quality and integrity in research
- Seeking informed consent
- Respecting confidentiality and anonymity of participant data
- Ensuring voluntary participation
- Avoiding harm
- Illustrating independence and impartiality

After outlining study activity within which to contextualise ethical practice, there follows a description of how these key ESRC (2017) principles would be applied.

3.9.1 Planning study commencement

Once study ethical approval had been granted from the Health Research Authority (Appendix 6) and NHS permissions received (Appendix 7), I would email the senior designated HCW for each of the occupational groups that I anticipated approaching for

participation. This would include the LW manager, Medical Director, Theatre Manager, and Domestic Services Manager. I would introduce myself and the study, attach the Participant Information Sheet (PIS) (Appendix 8), and request each group's participation. This would include colleagues from midwifery, obstetric, anaesthetic, HCA, receptionist, housekeeping, domestic, and operating theatre groups. Two weeks before the study start date, posters giving notice of the forthcoming research activity were to be displayed in LW HCW areas, and in the theatre area (on a separate hospital level where theatre HCWs are based) (Appendix 9). The intention would be to make colleagues aware of the email which they would shortly receive. At the study start, administrators serving the different groups would be requested to send HCWs the PIS and Questionnaire as attachments within the Cover Email Study Start. Also included would be the link to the online questionnaire and related Cover Email and Online Questionnaire (Appendix 10). For easy access, multiple paper PIS and questionnaire copies would additionally be placed in HCW areas. To provide further study context for HCWs beyond that included in the PIS, I would give details/presentations at shift changeovers, within management and research meetings, including theatre bases, and during personal exchanges on LW if HCWs raised queries. My contact details would also be included on the posters and PIS. The following describes how ESRC (2017) principles were to be applied.

3.9.2 Ensuring quality and integrity

The quality of qualitative studies is frequently evaluated by the qualitative equivalent of quantitative terms. *Trustworthiness* in qualitative studies thus incorporates *dependability, credibility*, and *transferability* of findings, respectively providing alternatives for the quantitative terminologies of reliability, validity, and generalisability (Robinson, 2006). While not referring specifically to IPAR, I found these broad terms useful in structuring support for the study's quality.

3.9.2.1 Dependability

I understood dependability to reflect the consistency of research methods (Mason, 2002). This would be upheld by routinely generating data in the manner articulated in the PIS, and as described in initial discussions/presentations. While a completely uniform approach would be inconsistent with the evolutionary nature of IPAR data generation, I anticipated detailed descriptions of research processes and the associated contexts would illustrate coherence with knowledge claims.

3.9.2.2 Credibility

Credibility stems from demonstration that data interpretations have been soundly reached through thorough methodological practices (Mason, 2002), and may therefore be deemed *meaningful, credible, and true* (Abma et al., 2019, p178). In relation specifically to participatory research credibility, Abma et al. (2019) refer to six criteria from the International Collaboration for Participatory Health Research (ICPHR)(2017). These frame quality in terms of participatory, intersubjective, contextual, catalytic, ethical, and empathetic validity. Application of these criteria would confirm local HCWs as having engaged actively in processes which they regarded as meaningful and ethical within LW (including raised understanding of others' situations), resulting in potential for social change.

3.9.2.3 Transferability

Unlike generalisability in quantitative research referring to drawing conclusions from statistical analyses applying across broader populations, I situated the transferability of study findings in a similar mode to that of qualitative research. Green and Thorogood (2014) locate the relevance of qualitative findings in the notion that it is in concepts that findings are generalisable. A study, for example, may expose certain individuals' or groups' previously unknown beliefs, or may make evident the mechanism for particular observed behaviours, thus offering sensitising concepts for practitioners in other settings (Green and Thorogood, 2014). Being aware of such constructs being related to transferability would prompt me to be constantly reflexively alert to such developments. To support others' independent assessment as to the extent to which study dependability, credibility, and transferability had been achieved, I also intended to provide a full and detailed account of study processes (Green and Thorogood, 2014).

3.9.3 Seeking informed consent

As all participants were to be HCWs, capacity to consent was assumed. The ESRC (2017) suggested that informed consent may be achieved by including the purpose, methods, intended uses, and risks of the research as well as the individual impact of participation. The design of the PIS was intended to make this information explicit. Written consent for participation was to be requested for interviews and AGs, using either Consent Form 1 (Anonymous) (Appendix 11) or Consent Form 2 (Identifiable) (Appendix 12). Since some HCWs would have no experience of research forms, I anticipated there may be occasions when I would explain the different forms' terminology.

In addition to planned interviews, I expected informal individual and group interviews would occur spontaneously on LW. Following conversations regarding wellbeing, I planned to ask

colleagues if they were comfortable with different quotes being used as data. If agreed, the PIS and consent forms would be discussed, and I would prepare an account of the data. If, in a few days' time, the contents and participation were accepted, relevant consent forms would be signed. The intervening period would be intended to provide time for reconsideration, recognising that HCWs may accidentally rather than purposefully enter research activity (Franklin et al., 2012). A different approach would apply to the Online Consultation Group. Following a poster display (Appendix 13) and subsequent email communication (Appendix 14), those expressing interest would be sent the group's Ground Rules (Appendix 15). The latter, based on a previous online investigation of midwives' resilience (Hunter and Warren, 2013), would state that consent would be considered as having been given if the HCW requested inclusion after reading the PIS and Ground Rules. Regarding questionnaires, submission would be considered as constituting consent, as stated within those forms.

Withdrawal from the study without need for explanation would be advised as standard to all participants (ESRC, 2017) but also their degree of involvement, and potential withdrawal/suspension of such, would be emphasised as entirely under their control. Similarly, it would be communicated that it was under participants' power to decline audio-recording; their data being shared within AGs; and their role/identity entering the public domain on LW displays and in publications, as included in consent forms. Additionally, I would inform all potential participants that the completed thesis was required to be uploaded onto the internet, meaning it would be globally accessible for an unstipulated length of time. I intended to particularly emphasise this for participants who chose to self-identify.

3.9.4 Respecting participant confidentiality and anonymity

University policies would be followed to comply with the General Data Protection Regulation (GDPR) of the Data Protection Act (2018) on collection, storage, processing, and disclosure of personal information. University policy dictates that research data be stored for 10 years, before being destroyed by shredding paper data and deleting electronic material. As participatory methodology unusually enables participants other than the researcher to access data, unless self-identification were chosen, all identification features would be removed. After entering a confidentiality agreement, data to a private transcription company would first be transferred from a digital recorder to a password-protected computer. Once transcriptions were returned, the original digital audio record would be deleted from the digital device, completed transcriptions stored on password-protected computer files, and data stored in the online repository subscribed to by the university. As the setting is not in the vicinity of the university, Consent Forms would be stored in a locked LW cupboard in a

locked office, which only I would have access to. At the first opportunity these would be transferred to the first supervisor's university office and stored under the same conditions. Wellbeing LW comment boxes with questionnaires would be locked, and only I would hold keys.

Tolich (2016) suggests that as interviewers know interviewees' identity, *anonymity* be substituted by *de-identification*. Although offered as standard, de-identification may be undesirable, and participation declined unless identity is acknowledged (Silverman, 2013). Particularly within research promoting participant agency, it may be considered unethical to fail to enable choice for public recognition of personal contributions (Abma et al., 2019; McNiff, 2016; McNiff, 2013). Two different consent forms were therefore designed. In addition to both enabling entry of role descriptors (chosen by participants), Consent Form 1 would confirm de-identification, and Consent Form 2 would allow self-identification.

3.9.5 Ensuring voluntary participation

As I had worked long-term in the study setting, it was conceivable that colleagues would participate out of friendship or perceived obligation (McNeill and Nolan, 2011). While acknowledging this could not entirely be prevented, attempts would be made to reduce the possibility. It would be emphasised in discussions/presentations throughout the project that participatory approaches respected individuals' agency and, particularly as the study aimed to enhance wellbeing, involuntary participation would undermine this. Additionally, I intended to underline that I would not pursue colleagues' involvement but, if HCWs wished to approach me, I would be regularly available on LW to engage in informal interviews, or to arrange a pre-planned session. Due to the longitudinal nature of the study, for those participating in AG/data review activities, I would also repeatedly verify willingness to continue. Practice would entail adopting consent as a process rather than as an isolated event, allowing HCWs opportunities to re-evaluate consent (Franklin et al., 2012; Sin, 2005).

3.9.6 Avoiding harm

As interviews may cause participants emotional harm (Mitchell, 2011), Reid and Frisby (2008) suggest consequences be anticipated. As the study focussed on wellbeing, it was possible that informal discussions/interviews would trigger unacknowledged or unresolved personal issues. The PIS referred to being able to stop/pause if participants became upset, yet Sin (2005) refers to the difficulty of abandoning participants after evoking such emotions. Although IPAR intends to go beyond data generation to instigate wellbeing enhancement, and thereby potentially reduce abandonment, the immediate distress may not be avoided,

nor it guaranteed that issues would be resolved. To allow HCWs to personally assess risks of participation, attempts would be made to make the research aims and consent processes transparent, and to provide a variety of options for participation methods and in non-/disclosure of identification. Furthermore, HCWs apprehensive about participation would be able to discuss queries while I was present on LW. Should study processes prompt HCWs to personally pursue health concerns, posters and the PIS would include Trust wellbeing resources. The LW manager had also agreed that senior colleagues would meet any participants distressed by processes.

3.9.7 Illustrating independence and impartiality

My independence as a researcher could readily be confirmed since I individually chose to register at the awarding university following concern for HCW wellbeing. I had no prior links to academic institutions and received no funding before registration. Claiming impartiality may, however, be more problematic given my lengthy experience in the setting having influenced my relationships with colleagues, and my beliefs and values as related to HCW wellbeing. I was aware also that role-duality in IPAR - being simultaneously positioned as an employee and a researcher - yielded mixed benefits and drawbacks, as above. I was aware that my assumptions of local knowledge may blind me to new insights in colleagues' accounts, which researchers outside of the organisation may more readily identify (Coghlan and Brannick, 2014). I did, however, feel comfortable in the perspective that:

> *The old core assumption of what it means to do research - be distantly objective - would be turned on its head within the IPAR approach.*
> (Bradbury, 2019, pxii)

It was acknowledged that researchers brought only one of many perspectives to the multiple ways of knowing, not only within review of others' data, but also within reflexive self-generation of data. For the real-world context of interrelation and interdependency, aspiring to be totally unbiased or impartial would be seen as an untenable position for an IPARr (Abma et al., 2019). I nevertheless aimed to tread a path between being reassured that constructionism supported multiple perspectives of knowledge (including my own), and being guided by reflexivity to a respectful collegial, yet still analytical, stance (Burns et al., 2012). I would seek to usefully apply my local perspectives to data, without indulging this to the extent that potential for new learning would go unrecognised. Also, as a practitioner in the setting, I would need to be cognisant of over-identification with my own occupational group and with general HCW experience. Regarding these considerations I did, however, feel very open, curious, and enthusiastic to engage with all groups of colleagues, feeling there was much capacity to generate novel data. Firstly, my LW experience indicated that

midwives' opinions varied on many clinical and non-clinical topics. Accounts of wellbeing were consequently expected to be diverse. Secondly, although I had worked with colleagues from other occupational groups for long periods, I nevertheless had minimal prior knowledge of factors supporting their workplace wellbeing.

3.10 Theory generation

Theory in participatory research is regarded as developing continually and carried within the practitioner, and is never complete or static (McNiff, 2016; Winter and Munn-Giddings, 2001). Data generation methods as described above do not concur with those of positivist methodologies. Thus, theory derives not from analysis of dependent and independent variables to form an objective truth, but from relationship with others (McNiff, 2016). In response to reflection on others' views, new practices and behaviours are inclined to become integrated into one's personal way of living, which in turn impacts on others' ways of living (McNiff, 2016; Winter and Munn-Giddings, 2001). Descriptions and explanations of the intricacies of the study process would be offered to inform comparable situations and development of further theories.

3.11 Chapter summary

This chapter discussed the process leading to adoption of IPAR as the methodology of choice, and how the research design was developed to align with LW HCWs' workplace needs. Methods anticipated to be effective in data generation, and related ethical considerations, were presented, while acknowledging that study events could not be predicted. Chapter 4, *Analysis and Findings*, discusses the events which took place how the study objectives were advanced.

Chapter 4 Analysis and findings

4.1 Introduction

Chapter 3 described the data generation methods designed for the WbP. Since the nature of participatory approaches does not allow research activity to be prescribed, it was not known which methods would be responded to, or to what extent. This chapter gives details of how the study ultimately took form, including the sources of data and the analysis process. According to IPAR methodology, data were analysed from the outset and findings integrated into study activities. As analysis and findings merged during this process, the remaining chapter is framed around the three study objectives, rather than discrete analysis and findings sections. Analysis of the three objectives encompasses the factors supporting HCW wellbeing; actions taken in response to findings; and, finally, how IPAR influenced study impacts and processes. For ease of reference, the study research question, aim and objectives are reintroduced in Figure 4.1.

Research question

How can we as maternity healthcare workers enhance our individual and collective wellbeing?

Study aim

To develop a caring collegial environment within a NHS Labour Ward in which maternity healthcare workers create paths to enhancing their individual and collective wellbeing.

Study objectives

Objective 1:

To collate factors identified as encouraging wellbeing.

Objective 2:

To collectively construct future ways of working.

Objective 3:

To evaluate the role of IPAR in study impact and process.

Figure 4.1 Study research question, aim and objectives

4.2 Study commencement

Following posters advertising the start of the study, all HCW groups agreed to participate. Whenever opportunities arose in the first weeks of study activity, the WbP approach was introduced to individual colleagues and groups. A moveable noticeboard was used to discuss how stages of the WbP had been planned, and the ways in which colleagues could participate. The same material was presented at obstetric and anaesthetic meetings, and at Preceptorship Midwife (PMW) induction sessions. This detailed introduction was repeated for new-starter HCWs and those rotating into LW. I attended two to four times per week to an approximate total of 900 hours. From the outset, HCWs showed interest in the WbP and contributed through a variety of methods, with data generated throughout the entire study period. Within a few weeks, planned and unplanned individual and group interviews took place, questionnaires were completed, and data quotes were displayed - with comments added - on a large wall in LW Training Room.

4.3 The analysis process

As IPAR fundamentally aspires to activate change in response to the needs of those in a setting, implementing actions took priority over in-depth analysis (Winter and Munn-Giddings, 2001). Action was informed by critically analysing HCW data and determining new insights. By the end of data generation in July 2020, 59 individual/group interviews had been contributed and 96 questionnaires. Four HCWs had sent emails evaluating study activities, 16 Post-it notes had been added to the display wall, and data had been generated in AGs and peer participant review sessions (see below). Interview content varied from my documenting HCWs' comments as they hurried between clinical tasks to digitally audio-recording one-hour private exchanges. In relation to interviews, in the first third of the study period these described positive experiences, in contrast to the remaining interviews which largely comprised of evaluation data. Of those interview or email contributions, 37 HCWs chose to self-identify, and 30 to remain anonymous. Regarding questionnaires, content varied from including one short statement to an A4 page packed with content. The degree of anonymity in questionnaire responses could not be ascertained (see detail after Table 4.2). In relation to content, responses in the first period of the WbP again related to positive work experiences and the majority in the latter period to study evaluations.

As soon as initial data were generated, I began manually highlighting transcripts with preliminary codes and themes. To support overall analysis and according to the IPAR principle of introducing multiple perspectives, all LW HCWs were invited to participate in reviewing data. Advertisement posters were used from September 2019 to July 2020. Six

HCWs came forward, all of whom were midwives. Most data review sessions involved a single participant and myself and required two to three hours for two to three interviews. As most midwives rarely left labouring women's rooms during 12-hour shifts, sessions regularly occurred outside participants' working hours. Peer participant reviewers were provided with verbal information regarding TA and, prior to each session, the most recent analysis findings.

Table 4.1 presents estimated numbers of potential participants from the different occupational groups, and the numbers of those who contributed by interview. Participation rates varied between occupational groups, ranging from 8% to 50%.

Table 4.1 Number and proportion of interviews offered according to occupational group

Occupational group	Number of practitioners in group (estimate)	Number of individuals interviewed
Midwifery	150	32 (21%)
Obstetric doctor	60	5 (8%)
Theatre practitioner	45	5 (11%)
Anaesthetic	21	4 (19%)
Healthcare assistant (HCA)	20	10 (50%)
Housekeeping, domestic, receptionist	13	5 (38%)
Totals	319	64 (19%)

These figures must be regarded with considerable caution for two reasons. Firstly, rates apply only to interview activity and HCWs from different occupational groups may have preferred to engage by other methods. Secondly, estimated practitioner figures present a maximum possible number. Registered colleagues, such as doctors, worked in other maternity areas and rotated through LW sometimes for only short periods, in contrast to, for example, support colleagues (comprising HCA, housekeeping, domestic, reception roles) whose activity was confined to LW. Hence, different groups' exposure to study activity and

ease of participation varied considerably. Overall, approximately 19% of all HCWs participated in interviews.

Table 4.2 presents data according to self-disclosure of identity on questionnaire forms. Numbers of individuals completing multiple copies cannot be known as the majority were anonymous.

Table 4.2 Number of participants disclosing identity data on questionnaires

Participant identity details	Paper questionnaire	Duplicate printout	Online questionnaire	Total
Anonymous	42	21	5	68
Name only	6	1	0	7
Role only	7	0	5	12
Name and role	6	0	3	9
Total	61	22	13	96

It can be seen in Table 4.2 that paper questionnaires more often included identification details than forms described as *duplicate printouts*. During the last period of study activity, I had used posters on a large Handover noticeboard to seek evaluation data (see Figure 4.2). While I was absent, a group of midwives exactly duplicated the poster questions on the noticeboard onto paper printouts, and subsequently distributed these at shift changes. The two documents differed in that the section including HCW identification details, in the paper questionnaire, was omitted from the duplicate printouts. Hence, calculation of return rates by occupational group was not possible. These events are further discussed in Section 4.6.2.2.4 and in Chapter 6, *Reflexivity.*

Data analysis according to Braun and Clarke (2006) was guided by the research question and objectives and undertaken in three stages according to the three study objectives, as described below.

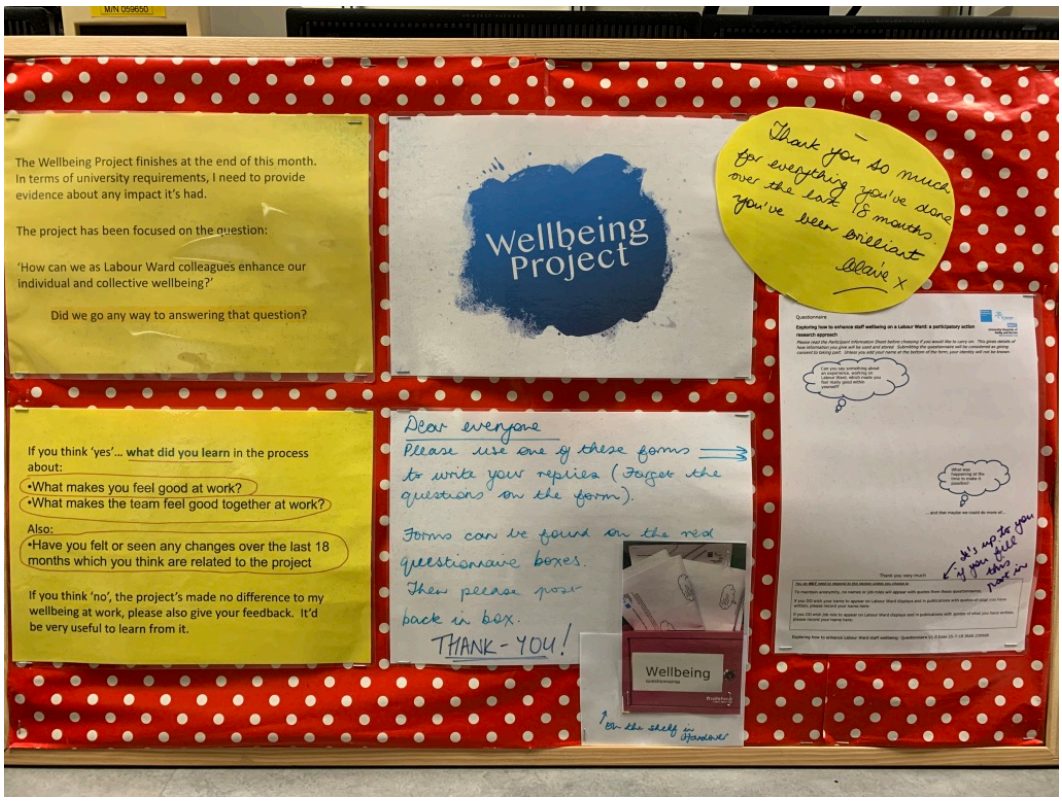

Figure 4.2 Board requesting final evaluations

4.4 Objective 1: To collate factors identified as encouraging wellbeing

From six weeks after the study commenced, data were displayed on a large wall in LW Training Room, accessible to all HCWs. (Figures 4.3 shows the entire wall and Figure 4.4 the enlarged central message). Initial data excerpts were grouped under the headings below and further data added as these were generated.

- Teamworking
- Achieving good care
- Theatre
- Tea-trolley
- Giving each other support
- Giving and receiving - Feedback and gratitude.

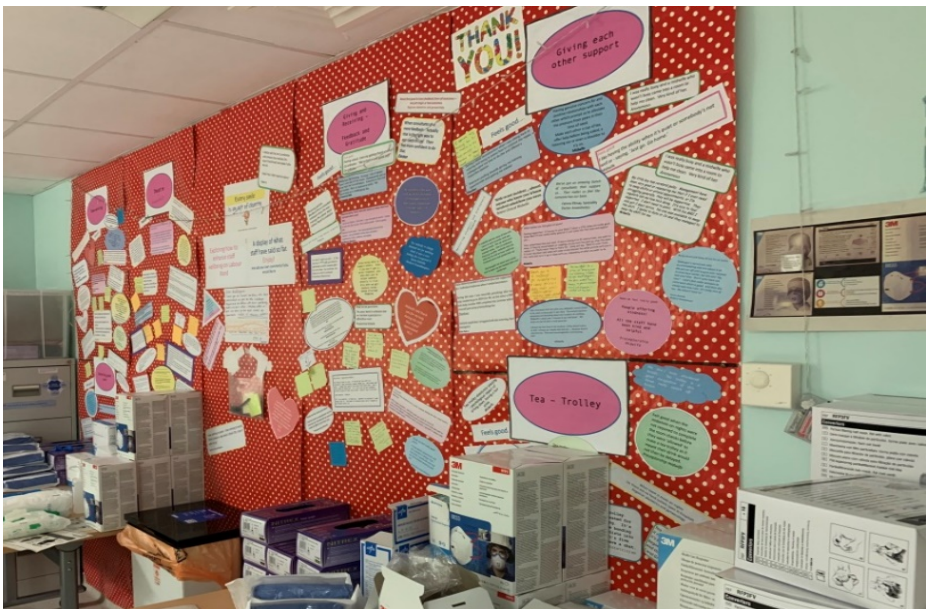

Figure 4.3 Data display wall

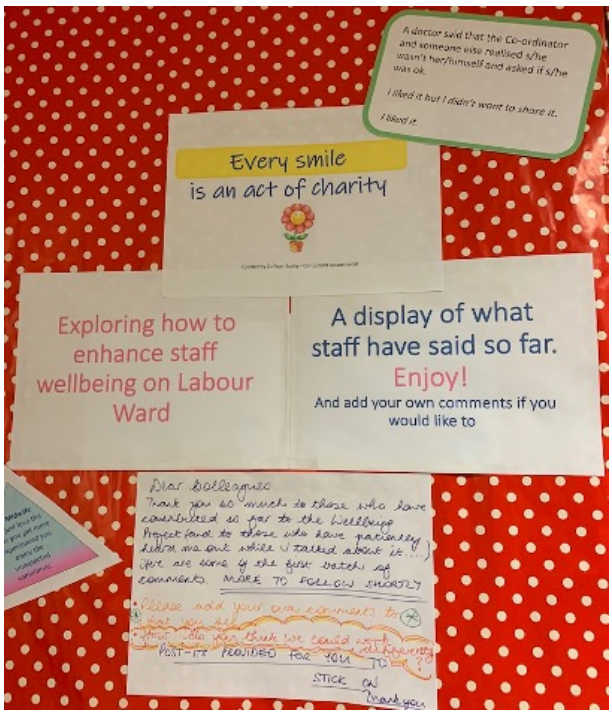

Figure 4.4 Central message of data display wall

The display wall headings had been in place for several months prior to peer participant review, as I had initially rapidly grouped data to orientate HCWs to the main topic areas. The peer participant reviewers were, nevertheless, to consider data afresh. Data were discussed line by line, screening for elements positively influencing wellbeing at work. When relevant data were identified, excerpts were grouped together under preliminary code names, and further excerpts added, with new codes created as necessary. Reviewing data in this detail regularly stimulated reflection, promoted discussion, and introduced new

perspectives into subsequent analyses. For example, as later presented under Section 4.4.1.6 *Belonging or effective teamworking?* a single reflection could alter the collective approach to subsequent analyses. Data were at times examined and logged under more than one code, going back and forward from one code to another.

As data were reviewed, it became evident that the factors encouraging wellbeing effectively provided HCW nourishment. The peer participant reviewers and myself started grouping codes under the three themes of *Emotional, Professional,* and *Physical nourishment*, with these themes separated into sub-themes when codes suggested different sources of the various facets of wellbeing. Figure 4.5 summarises the themes and sub-themes derived from codes. Although the relative importance of the *Emotional nourishment* theme may be appreciated from Figure 4.5, a numerical description of data emphasises how many more comments related to this theme:

- 286 comments from 98 individuals were categorised as *Emotional nourishment*
- 81 comments from 69 individuals were categorised as *Professional nourishment*
- 47 comments from 47 individuals were categorised as *Physical nourishment.*

The next section provides details of each of the three main themes. Interview data quotes are followed by participant details, including or excluding name and/or role according to a participant's consent. Questionnaire/printout data are presented verbatim according to participants' original documentation. Thus:

- Quotes include a variety of grammar and spellings
- Names may be abbreviated
- Roles may be omitted or be inconsistent with conventional role descriptors.

4.4.1 Emotional nourishment

More individuals' data could be attributed to this theme than any other. Six sub-themes were identified as in Figure 4.5: *Joy in work; Appreciative communication; Welcoming behaviours; Positive environment; Colleagues caring;* and *Belonging*. Each is presented in turn.

4.4.1.1 Joy in work

Participants from many occupational groups expressed joy connected to elements of their role, and to being in colleagues' company.

> *I appreciate my role as an anaesthetist. I am one of the few people in the world who can provide pain relief for one of the worst pains people can have.*
> (Anon, Doctor Int37)

> *I love coming to work on labour ward because I love all the people I work with.*
> (Anon, Midwife OQ10)

The above accounts demonstrate how wellbeing was sustained both from the intrinsic nature of the role requirements and from colleague relationships.

4.4.1.2 Appreciative communication

This sub-theme related to giving and receiving positive feedback and offering and being offered gratitude. The majority of feedback making HCWs feel good focused not on clinical proficiency but on how their work exertions had been noticed. Although contemporaneous verbal feedback was most common, emails, texts, cards, social media, pre-printed 'You are appreciated' cards (feedback cards provided by the Trust), and even sensing the influence of one's efforts reportedly impacted on HCW wellbeing. Participants referred to encouraging feedback from parents, family and society, but the great majority emphasised how colleagues' feedback fortified them, making them feel happier, more confident, and reassured that their efforts were worthwhile. Length of service appeared unrelated to pleasure in receiving feedback, with a newly registered midwife and an experienced anaesthetist both commenting on its significance:

> [Manager] *She'll say…you're really coming into your own...it's just a passing comment on the corridor, but she puts a little spring in your step… that's important…our own perception of ourself is we're rubbish.*
> (Sophie Nabbs, Registered [PMW] Band 5 Int39)

> [Feedback] *is necessary in everybody's life.*
> (Dr Gauri Sankhe, Anaesthetist Int52)

References to gratitude related to recognition of work endeavours and to feeling valued, inspiring further energy and effort.

> [Co-ordinator] *personally always thanks you...a bit of mini-feedback. You feel valued for what you've done.*
> (Alice Ware, Registered Midwife Int17)

> *Thank you makes a massive difference. You'll...quite happily do other stuff and more.*
> (Rebecca Buxton [No role entered] Int9)

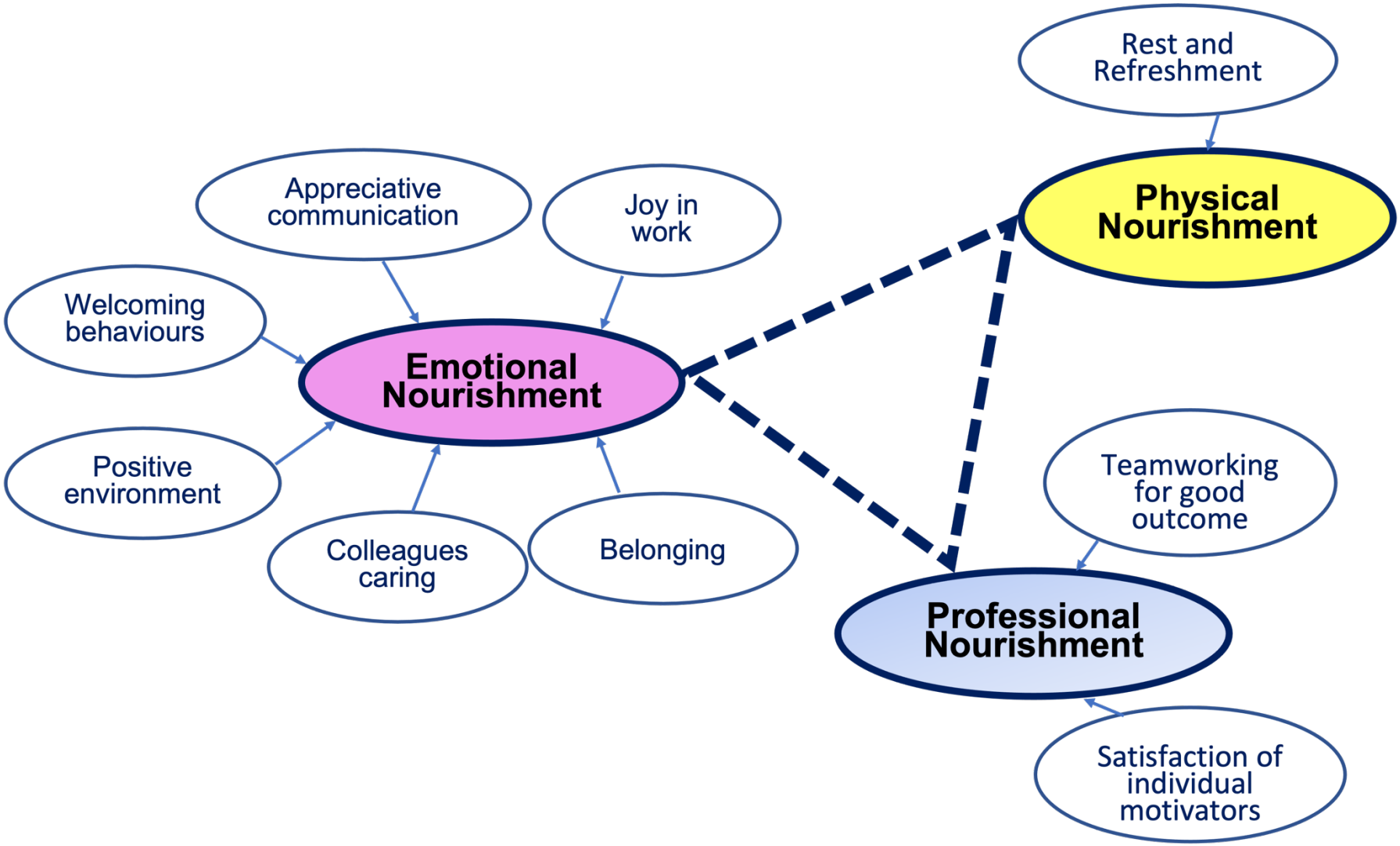

Figure 4.5 Wellbeing themes

4.4.1.3 Welcoming behaviours

Healthcare workers reported feeling encouraged by several elements of being welcomed to LW. These included being acknowledged, shown respect, and addressed by name. This extract summarises sentiments from many participant narratives:

> *Midwives…theatre staff…HCAs…the ladies who...clean...all play a part and I am very respectful of each and every one… respect…that's the common string and from that stems everything.*
> (Fatima Eltinay, Specialty Doctor Anaesthetics Int28)

Respectful behaviours were described in patiently sharing knowledge; having one's opinion heard; politely approaching others; appreciating others' role responsibilities; and non-judgemental interactions:

> *I can ask for help without feeling sense of worthlessness*
> (Anon Q35)

The importance of respectfulness was manifested in fearing to appear disrespectful when not knowing colleagues' roles/names:

> *I'd feel bad if I was to say something wrong. I'd be like, oh, that's the wrong name.*
> (Anon Int40)

Smiling and greeting were reportedly appreciated, as was use of names:

> *People have started saying "Morning Amy". They actually talk to me. It's nice. You feel part of the team.*
> (Amy Rich, Registered Midwife Int19)

> [Felt good] *being known by my name not just my job title.*
> (Anon Q69)

Thus, welcoming behaviours were noticed by HCWs and connected to recognition of individuality.

4.4.1.4 Positive environment

Healthcare worker data linked a positive environment to experiencing camaraderie, banter, and humour, providing a workplace described as having:

> *Good vibes and friendly atmosphere*
> (Anon Q64)

This atmosphere supported uplifting experiences as this conversation depicts:

> [Coordinator] *What makes me feel good at work? - A positive team environment - supporting each other. Bit of banter. Smiles.*
>
> [Steph] - *Happy faces…It's infectious.* [During divorce] *I just wanted to be at work …Doesn't always mean you're happier at home… We are each other's pick me ups.*
> (Anon, Coordinator and Steph Longson, Senior Clinical Midwife, both Int7)

These last quotes imply colleagues reaching out to others, as elaborated upon in the following sub-theme.

4.4.1.5 Colleagues caring

This sub-theme had the largest number of individual contributors. Healthcare workers reported giving and receiving support; positive role-modelling by senior colleagues; and witnessing helpful behaviours, as beneficial to wellbeing. A small proportion of HCWs appreciated being cared for following significant work or homelife events/illnesses. Many colleagues reported feeling good when their workload was noticed, and consequently alleviated by others. As related to this, senior practitioners enjoyed being in a position to oversee such situations, offer assistance, and raise spirits. An explanation was suggested for coordinators' pleasure in such positive interventions:

> *I have looked after you and that's made you feel a bit better…We enjoy caring for the women so it's logical that coordinators enjoy looking after us.*
> (Rosie, Core Midwife Birth Centre - Peer participant review session 18-6-20)

Many individuals also described how senior colleagues - specifically coordinators/LW manager/consultants - established the prevailing atmosphere:

> *Even though this is a really busy shift, I personally don't feel everyone's stressed. On the outside* [Coordinator's] *still smiling, still chatty…not imposing it on us if she is stressed.*
> (Anon, Midwife Int31)

Coordinators acknowledged this dynamic and its effect on HCW wellbeing:

> *When the midwives have been able to give good care, it reflects back in the unit...If someone's a bit down, the next person might feel down...If things are going well, it infects the whole team too…Sometimes I pretend...If I'm the leader and the role model, if I sit there with a face like thunder, how are they going to keep going?*
> (Steph Longson, Senior Clinical Midwife Int7)

Other less senior HCWs also enjoyed caring for colleagues. Many accounts described offering assistance both within and between occupational groups, including receptionists, obstetric doctors, domestics, anaesthetists, midwives, housekeepers, HCAs and theatre practitioners. Healthcare workers appreciated colleagues' willingness to volunteer for tasks which could justifiably be judged as outside their job role. One respondent connected enjoying work on LW to the context of colleagues' caring:

> *Having genuine concern for and positive relationships with each other which prompt us to alleviate the pressure from peers in their time of need. Make each other a cup of tea, offer help before being asked, a listening ear or even a shoulder to cry on.*
> (Anon, Midwife OQ10)

While feeling cared for and being able to care for colleagues apparently increased wellbeing, so too did witnessing positive behaviours. This included witnessing individual/team competence

effecting reassuringly high practice standards in women's care, and kindness between HCWs or towards women. An experienced anaesthetist reportedly slowly guided a colleague through a new procedure:

> *She let him take his time. It was nice to see their teamwork and rapport.*
> (Becky, Midwife - Peer participant review session 29-6-20)

4.4.1.6 Belonging or effective teamworking?

During the process of peer participant review, the initial sub-theme of teamworking was debated, and the sub-theme of *Belonging* subsequently developed. Rosie (Core Midwife, Birth Centre) in January 2020 compared one participant's feeling of enjoying shared work experiences to effective teamworking, stating:

> *Shared experience is more than just teamwork. It's bonding. The tea-trolley bonds. We are held together. Teamwork is just working together for an effective outcome.*

These comments firmly separated teamworking as exclusively professional, and the tea-trolley as simply physical food/drink, to both creating emotional bonding through shared experience. I realised this perspective's relevance in relation to an episode with a new-starter colleague. An apparently agitated doctor suddenly left Handover to seek company on another ward. They later reported feeling uncomfortable with unfamiliar HCWs and with their new role (personal communication). Shared experiences were subsequently considered as the separate concept of *Belonging* and previous quotes reviewed and re-categorised. *Belonging* implied being accepted and valued, and thereby being easeful at work, as evoked by this account:

> *I really enjoyed working…the last three years. Slowly…I have developed a fantastic rapport with midwives and they're amazing.* [Describes resolving clinical situations together]...*makes us feel good in this unit…you have to develop that bond and rapport...to come to this point.*

The same participant, after being sought out to join a takeaway order, stated:

> *They know in one corner, in one room, there's an anaesthetist...they thought about us…They consider you, also, as a part of the team and they do remember… That little thing really touched me.*
> (Dr Gauri Sankhe, Anaesthetist Int52)

Belonging appeared to develop over time, as stated by another participant who initially felt lonely:

> *Come to work and go home. No-one to talk to.*

After approximately one year:

> *I have good feedback…"we can't have any domestic like you"... housekeepers, HCAs, midwives, everybody. I feel I'm one of the team…I don't feel odd here.*
> (Anon Int12)

Feeling comfortable in the workplace, described by many, was summarised by one midwife:

> *You feel...a sense of belonging...you feel safer at work...You can feel a bit vulnerable and you know that people will look after you…that has a massive effect on people's...mental wellbeing…and whether they enjoy work...you become part of a team…like a little mini home.*
> (Catherine Cartwright, Core Midwife LW Int38)

Others referenced family-like connections:

> *I've got my blood family and I've got my work family. I think we're one big happy family.*
> (Anon, Senior Clinical Midwife Int27)

Barriers to belonging, however, also existed. Working with many different colleagues made it difficult for new-starter HCWs to make friends. Low confidence prevented associations with perceived unyielding established friendship groups. Being the post-holder of a single-person role, or being the only one of an occupational group working at any one time, also isolated HCWs from the main hub of ward activity. Physically distanced roles (for example, reception), and being in a senior position were reportedly similarly disconnecting. One HCW commented:

> *Everyone goes, "we're all in it together", but we're also not, we're just there on our own.*
> (Tim Gray, Clerical Legend Int34)

4.4.2 Physical nourishment

This theme comprised of references to food, drink, and rest. Provision of a tea-trolley allowed HCWs to easily access refreshments during short periods away from clinical care, and to socialise with other occupational groups:

> *Whole gathering of everybody, the laughing...when everyone can come.*
> (Anon Int40)

Colleagues being together reportedly provided respite for comfort, connection, rest, informal and unthreatening learning discussions, and a means of refuelling to keep going. Specifically, the tea-trolley was identified by one participant as:

> *The superglue bonding the anaesthetists into the fold.*
> (Anon, Consultant Obstetrician Int4)

Individuals also reported appreciation of rest:

> *Absolutely amazing…Psychological impact of sitting down, having a hot drink.*
> (Anon, Midwife Int15)

Although many accounts were notably brief, physical nourishment was a strong theme in terms of number of individual comments. The psychological benefit of social contact appeared interwoven with physical resting and refuelling, positively influencing wellbeing. Finally, the *Professional nourishment* theme is presented.

4.4.3 Professional nourishment

This theme encompassed two sub-themes which heightened wellbeing. The first related to HCWs' *Satisfaction of individual motivators*, and the second to the ability to contribute to *Teamworking for good outcome. Satisfaction of individual motivators* was exemplified by the following quotes:

> *Being wholeheartedly with woman, treating her at all times with kindness, dignity and compassion.*
> (Anon, Preceptorship Midwife Q12)

And:

> [Seeing] *…a woman on a continuing basis…emotional satisfaction.*
> (Anon, Registrar Obstetrics and Gynaecology Int1)

Regardless of occupational role, HCWs reported perceiving worth in their work. Motivators related to varied experiences ranging from practising high quality care, facilitating saving a life, learning, teaching, acting autonomously, and to preparing a birthing room:

> *I take pride in cleaning a room. I find it a privilege…it's the first place the baby will be.*
> (Jodie Allsop, HCA Int59)

Data related to teamworking were less easily categorised as HCWs commented on multiple positive diverse aspects. Many briefly stated that teamworking was good, others that teamworking increased communication and learning. Teamworking also reportedly raised wellbeing by encouraging social interaction or *professional bonding* (Midwife, Anon Int55). The two largest groups of data were, however, focussed on teamworking being evident through offers of mutual practical support, and this mutual support leading to effective clinical functioning. As these two elements were related, they were difficult to separate. Hierarchy was reported as a hindrance, whereas willingness to offer assistance, whatever one's role, was viewed as conducive to facilitating quality care. Good outcomes built further confidence and respect for teams. These teams could then consequently be relied upon to recognise clinical need and to competently respond:

> [Teamworking] *a failsafe mechanism…a critical situation...a good outcome, it makes you feel good to think that you have made a difference as a team.*
> (Anon OQ13)

> [Teamworking] *amazing…Just come along and you're there for the patient. Give me a job - I'll do it.*
> (Lucille Griffiths, Senior Operating Department Practitioner Int42)

Social interaction with time to reflect, debrief, and share knowledge was also celebrated as a positive means of deepening team relationships and enhancing communication.

4.4.4 Wellbeing concept model

During data analysis, I increasingly questioned presenting the themes relating to nourishment as three discrete elements. In respect of Robson and McCartan's (2016) suggestion to take data beyond description and increase relevance to practice and theory, a concept model for LW HCW wellbeing was developed. Figure 4.6 intends to transfer the components of sub-/themes, and the interaction between them, into an image more aligned to everyday workplace situations.

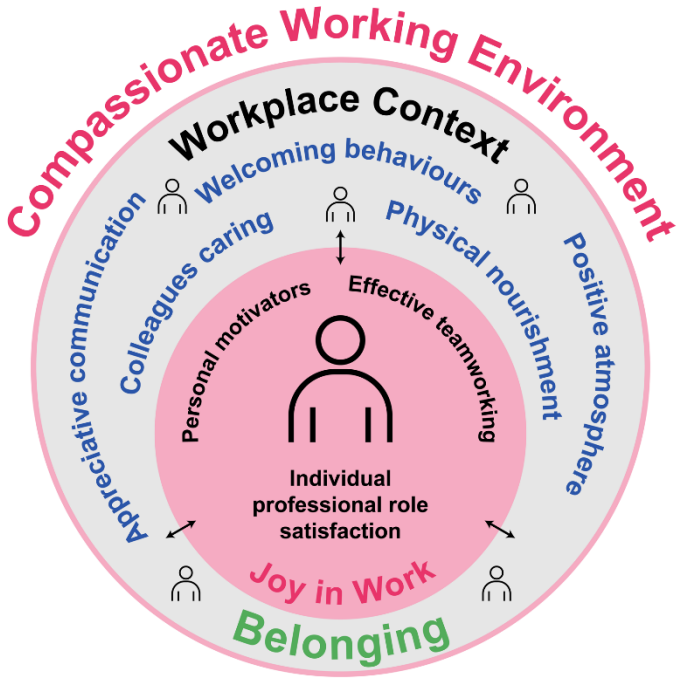

Figure 4.6 Labour Ward healthcare worker wellbeing concept model

The HCW is nested as an individual element (pink circle) within the larger workplace context (pale blue-grey circle). The individual gains professional nourishment/role satisfaction from the combination of being personally motivated by the role, and by contributing to effective teamworking. This brings *Joy in Work*. As they cannot be separated, the emotional and physical nourishment sub-/themes are encapsulated together within the workplace context. Both interact and augment each other. For example, being provided with *Physical Nourishment* simultaneously supports *Emotional Nourishment* as related to feeling cared for by colleagues. The emotional and physical nourishment sub-/themes of the workplace context are also brought together to act as foundations to Belonging. This model, referred to henceforth as the WbP-Mod, underlines the interdependent relationship between the individual and the context. Neither of the two elements is itself sufficient to provide HCW wellbeing. The context alone is inadequate for wellbeing if the individual does not feel professionally satisfied - the *Joy in Work*. Likewise, *Individual professional*

role satisfaction cannot be anticipated to sustain wellbeing in the absence of the emotional and physical nourishment supporting an individual's sense of social Belonging.

The WbP-Mod encompasses components of the real world LW setting which at a fundamental level fulfil the three human needs of autonomy, competence/contribution, and relatedness/belonging (West et al., 2020; Ryan and Deci, 2000). Autonomy and competence/contribution are achieved through the individual's role, and relatedness/belonging through the workplace context. Having addressed Objective 1 by collating the factors which HCWs identified as fuelling wellbeing, Objective 2 is now considered.

4.5 Objective 2: To collectively construct future ways of working

Data related to Objective 1 informed planning towards Objective 2, the construction of future ways of working. The rationale for forming the three AGs - the Theatre AG, Healthcare assistant AG, and Coordinator AG - is described. Each AG's outcomes are included, before an overall account of AG activity is provided.

4.5.1 Theatre Action Group

Initial data referring to experiences benefitting HCW wellbeing most frequently related to the general LW. The only data pointing to a more specific environment included scenarios in theatre, indicating the need to establish a related AG. Labour Ward HCWs reported particular appreciation of support in theatre, where workload was perceived to be regularly challenging. The six Theatre Action Group meetings included a LW senior clinical midwife, a Senior Operating Department Practitioner, and myself, and were intermittently informed by one other Operating Department Practitioner and a LW theatre Maternity Support Worker. Data underlined the positive effect of inter-occupational teamworking on wellbeing, reporting how small helpful acts made a noteworthy difference. Such gestures may have been particularly appreciated given, as later expressed, tension was not historically unusual:

> *The relationship between theatre staff and midwifery staff isn't always the best.*
> (Lucille Griffiths, Senior Operating Department Practitioner Int42)

Informal conversations concerning differences of approach in clinical scenarios regularly revealed misunderstandings of the requirements of others' occupational roles. Theatre AG provided a forum for exchange of such information and potential adaptation of behaviours.

4.5.1.1 Theatre Action Group activities and outcomes

The Theatre AG meetings led to a number of developments. As an example, HCWs had reported feeling uncomfortable not knowing theatre co-workers' roles and names. Initial investigations by

the LW Manager into cloth hats, which displayed name and role, had not progressed. Theatre AG pursued enquiries and after months of discussions between LW management, senior theatre management, and Infection Control services, use of such hats was approved. In absence of funding, 52 obstetric, anaesthetic, HCA, and midwifery colleagues purchased individual hats. Theatre colleagues reported the cost as prohibitive. Impact was immediate:

> *I wore my hat for the first time...and someone called me* [Name] *which wouldn't have happened.*
> (Anon, Senior Clinical Midwife during AG meeting 17-1-20)

Using data quotes, Theatre AG organised poster displays of behaviours which different occupational groups appreciated from the other. Dialogue and liaison between LW and theatre HCWs reportedly improved, enabling progress to be made on: management of sensitive cases; placement of monitoring leads facilitating skin-to-skin contact between mother and baby; partners' attendance; supporting birth plans; tissue disposal processes; and documentation. Labour Ward HCWs also more frequently offered refreshments to theatre colleagues and, for the first time, social media posts (on a pre-existing LW forum) thanked theatre practitioners for assistance. While AG activities made positive impacts, one participant noted:

> *Communication and teamwork between obs* [Obstetric] *theatre and labour ward staff has improved a lot...all staff members do need to understand each others roles... in order to improve this further.*
> (Anon Q70)

A member of the AG summarised ongoing aspirations as:

> *Trying to become one team, not them and us.*
> (Louise Humphries, Senior Operating Department Practitioner during AG meeting 17-1-20)

4.5.2 Healthcare assistant Action Group

As HCA and housekeeping colleagues had from the outset engaged with me in long conversations regarding the WbP aims, and informally discussed their wellbeing, the LW manager invited me to a HCA meeting within the first month of study activity. A HCA AG was established at that meeting, to be attached to regular HCA meetings and to include housekeeping colleagues when they intermittently attended. A further four two-hour meetings took place with one or more senior midwives, six to nine HCA/housekeeping colleagues, and myself. Colleagues discussed factors affecting wellbeing and how/whether any positive impact had been felt. This was the only group to express interest in an online consultation group. One HCA set up and acted as an administrator to a closed Facebook group for that purpose. Participants, however, used the group largely to arrange meetings and discuss ongoing actions, continuing to discuss their wellbeing in face to face meetings.

4.5.2.1 Healthcare assistant Action Group activities and outcomes

Dominant threads in wellbeing, and in encouraging motivation, reportedly related to occasions when HCAs worked more closely with others, and were shown gratitude for their work. One expressed a midwife being:

> *So appreciative of my help...it just made me feel better for the rest of the shift.*
> (Anon, HCA Int9)

The group were enthusiastic to extend their role beyond cleaning and preparing LW rooms, and to be useful to the wider LW and theatre teams:

> *It's not that we want to do their job. It's just that we want to help them.*
> (Andreia Gomes, HCA Int9)

Discussions during meetings regularly focussed on how HCAs could develop their role, but there was uncertainty as to how this may be achieved. Although HCAs wished to work in theatre for example, some voiced apprehension about scribing. The LW theatre Maternity Support Worker worked with the Practice Development Team and myself to create a HCA Scribing Framework. This form listed routine episodes of activity and required only the addition of time, date, and HCA signature to individual entries. Forms were subsequently formally approved by the Trust Risk Team and reported by HCAs to be used to good effect.

Other role developments evolved, with HCAs recounting regular experience in theatre work, births, and admission procedures. These were achieved by both HCAs offering their skills to coordinators, and raised awareness prompting coordinators to suggest such opportunities. In addition, a number of actions both towards women/families' and colleagues' welfare were initiated. Fundraising resulted in the refurbishment of women/families' and colleagues' sitting rooms, and soft lighting in birthing rooms and the bathroom. A HCA started a Communication Book, individual HCA skills' lists were displayed for midwives' reference, and HCAs explained their role during a new-starter HCA induction day. Lastly, HCAs reported more frequently assisting each other and housekeeping colleagues, and midwives more frequently assisting HCAs. It was reported that:

> *Being here is a nicer place to be than it used to be.*
> (Jodie Allsop, Healthcare assistant Int61)

A senior midwife agreed to continue organising HCA meetings to include a wellbeing focus.

4.5.3 Coordinator Action Group

Twenty-two senior midwives held coordinator posts during the WbP. Initial data, as earlier stated, suggested coordinators were core to setting LW atmosphere. Housekeeping and HCA colleagues - in general and in the HCA AG - reported wellbeing as often dependent on coordinator behaviours. One participant classified coordinators as the *cornerstone* of LW activities (Fatima

Eltinay, Specialty Doctor Anaesthetics Int23). Early data from a coordinator, nevertheless, suggested the role held its challenges:

> *We support all levels of staff with stress. This is so rarely considered towards the Co-ordinators. It can be a lonely place to be.*
> (Anon, Labour Ward Co-ordinator Q9)

Cognisant of this, when the LW Manager invited me to a coordinator meeting to discuss preliminary WbP data, I felt it an opportunity to discuss wellbeing actions to support both coordinators and others. Three meetings took place, with 7- 8 attendees excluding the manager and myself.

4.5.3.1 Coordinator Action Group activities and outcomes

Prior to the first meeting, I provided coordinators with two data sets. The first comprised of HCW quotes related to coordinators' actions, and the second to comments coordinators had themselves made regarding workplace wellbeing. One coordinator designed and displayed a poster acknowledging the comments related to coordinator actions, and presenting proposals as to how all groups could constructively work together. The second meeting entailed a three-hour *Feeling All-together Better - FAB* - programme which was co-presented by a midwife interested in employee wellbeing, and myself. The programme updated coordinators on WbP data including, for example, new-starters' attempts to fit into LW teams, and to manage work/homelife balance. Refreshments and therapy treatments (aromatherapy hand massages and reiki arm/shoulder massages) were provided, and several attendees subsequently reported personal benefit to wellbeing. The third meeting involved my communicating different Theatre AG data, which resulted in two coordinators planning to meet theatre practitioners to discuss certain theatre procedures.

The following statements exemplify coordinators' responses to data:

> *Made me think about how I can support* [PMWs] *and how imperative it is to "feel welcome" and included in just the smallest of things.*
> (Siân, Midwife Int49)

> *Big responsibility...because you've got the whole team that you're able to influence…It's thanking people for what they've done and...give them feedback… implement it… starts to become a bit more instinctive…the more you do it, the more you just do it without really thinking.*
> (Anon, Senior Clinical Midwife Int43)

Although meetings progressed to more discussion group than action-planning, the coordinators supported the overall WbP. Messages from display boards were communicated when I was absent and, furthermore, the improved working experiences reported by HCAs and housekeeping

colleagues required coordinator facilitation. Coordinators apparently responded to data by, for example, enabling HCA role development.

4.5.4 Overall account of Action Group activity

By using WbP data, AGs planned and delivered action towards progressing Objective 2. The three AGs allowed topics to be tackled which previously would have constituted more undercurrent peer to peer discussions. The Theatre AG grew from a position of uneasy relationships to improving LW and theatre HCW rapport, and facilitating practical outcomes for women/families' and practitioners' benefit. The HCA AG provided a forums for HCAs to express a desire to extend their roles, instigated initiatives for women's/families' and colleagues' advantage, and increased inter-disciplinary teamworking. The Coordinator AG served to assist the WbP process by communicating related information, enabling HCAs' roles to develop, and improving members' personal wellbeing. Although strict AR process was not adhered to in a formal step-wise structure, outcomes supported AGs having positively influenced individual and collective wellbeing.

4.6 Objective 3: To evaluate IPAR methodology in study impact and process

This section presents study impact and, thereafter, how process elements may have influenced any effect. Evaluation data were used to question whether the WbP met the aim of the study and, if so, by which means. As discussed in earlier chapters, impact evaluation and process evaluation are naturally interwoven through a project's progress, yet it is important to consider both separately as process elements may significantly influence impact (Dixon-Woods, 2014).

As anticipated in Chapter 3, *Methodology, a* formal intervention evaluation framework (Nielsen and Randall, 2013; Nielsen and Abildgaard, 2013) was used to structure evaluation data. Additionally, an Action Research Journal editorial with broader *quality choicepoints,* specifically for action research, was also utilised (Bradbury et. al., 2020, p3). This had been published since the initial plans for data evaluation had been made and referred to broader transformation within social systems. I felt that, particularly as a novice researcher, combining the sources would offer means to a thorough and comprehensive evaluation.

4.6.1 Study impact evaluation

Evaluation data are presented in four sections. Firstly, major impacts are categorised according to the numbers of associated HCW comments. Secondly, data are presented according to the multiple criteria within the structured evaluation framework (Nielsen and Randall, 2013; Nielsen

and Abildgaard, 2013), including a sub-section of the impact of the researcher. Thirdly, the impact as related to the LW manager is documented and, fourthly, impact related to social systems.

4.6.1.1 Overview of major impacts

Evaluation data were generated from interviews, questionnaires, Post-it notes, and during AG and peer participant review sessions. The seven major impacts in Figure 4.7 represent factors which HCWs most frequently evaluated as having enhanced wellbeing. Impacts were difficult to separate as most interrelated and potentially enhanced each other. Participants' evaluations indicated that raised sensitivity to the significance of wellbeing increased behaviours towards that end, and fuelled a more positive cultural tone. The IPARr presence also reportedly increased HCW wellbeing (see Section 4.6.1.2.1).

1. **Improved culture, morale, positivity, atmosphere** - 38 individuals commented on improved environmental mood and atmosphere.

2. **Perceived benefit from the IPARr role** - 30 individuals commented on feeling personally valued and cared for or on the IPARr role being generally advantageous.

3. **Increased caring behaviours** towards colleagues, and in initiatives for women/families - 25 individuals raised greater conscious awareness of others' clinical situations prompting: proactive offers of support; increased breaktimes and manageable caseloads; going beyond the standard enquiry into colleagues' welfare; making introductions to new starters; and more frequently bringing in food to share.

4. **Raised awareness regarding the impact of behaviours/actions on wellbeing** - 12 individuals reported appreciating the difference that small compassionate gestures made to wellbeing.

5. **Increased expressions of gratitude and positive feedback** - 12 individuals reported this effect, often between different occupational groups.

6. **Improved teamworking** -12 individuals reported this, nine within interdisciplinary teamworking, and three within general teamworking.

7. **Anticipated benefit to women/family experience subsequent to HCWs' wellbeing improvement** - 9 individuals linked HCW wellbeing with quality in women's care episodes.

Figure 4.7 Evaluation data - major impacts of study activity

4.6.1.2 Impact evaluation using structured framework

Impact evaluation using a structured framework (Nielsen and Abildgaard, 2013) is summarised in Table 4.3. Impact claims are to the left, and illustrative accounts to the right. Evaluation criteria exactly reproduce those of the framework. Data supported claims that changes occurred in attitudes, values, knowledge; development of individual resources; working procedures; working conditions; employee health and wellbeing; and occupational safety and health management. To avoid HCWs linking WbP intentions to organisational performance targets, absenteeism and retention data were not sought. Impact on occupational safety and health management was achieved at the time of analysis through several avenues listed in Table 4.3 and changes continue to develop. Having provided overall outcomes, further detail is added in relation to regards my presence as IPARr to *Changes in employee health and wellbeing*.

Table 4.3 Impact evaluation

Evaluation criteria	Participant accounts *(Participant quotes in italics)*
Changes in attitudes, values, knowledge HCWs reportedly altered behaviours in response to heightened awareness of the impact of behaviours on others' wellbeing. Increases were reported in caring actions towards colleagues and women/families; teamworking; and wellbeing-related learning.	*More people ask...if you're ok...recognise beforehand that you might need help. It's easier to ask for help.* (Charlotte, Midwife Int45) *I've had greater awareness that the medical staff also feel vulnerable.* (Kate, Senior Midwife Int62)
Development of individual resources HCWs independently fund-raised for: • women/families - improving the sitting room and bathroom decor, reorganising dining experiences • colleagues - refurbishing sitting room, HCA Communication Book, HCW photo display. Other maternity ward replicated fund-raising.	[After introducing soft bathroom lighting] *If I was lying in that bath and staring at these lights, I wouldn't like it...couldn't relax...Right, we'll do something about it.* (Pat Notley, HCA Int50) *I'm relating it to the fact people are feeling better about the ward and want it to change* [and] *Haven't known the enthusiasm. We're just as tired now, just as busy, but we're putting in the extra mile now for the patients.* (Karen Battelle, Housekeeper Int 35 [and] Int44)
Changes in working procedures Wellbeing-orientated behaviours became more prevalent; Multidisciplinary team relationships improved.	[WbP] *is now fully integrated to our daily routine…Teamwork has always been fantastic, but...has got a whole lot better. The biggest achievement...all levels of staff have been included - which is paramount if we are all working together. From receptionists and HCA's - to co-ordinating band 7's. We are all just a little bit kinder.* (Anon Q30) *Communication of feelings, needs & appreciation between the MDTs* [Multidisciplinary Teams] *is improved. Instead of people moaning...concerns are being shared.* (Anon Q68)
Changes in working conditions Reports indicated that the LW atmosphere had become more buoyant, and the culture more positive.	[WbP] *Has improved the "vibe" at work, lifted moral and made people more positive.* (Anon Q56) *There has definitely been a warming in the culture of mutual support.* (Janet A. Q29)
Changes in employee health and wellbeing Expressions of feedback and gratitude and the IPARr presence reportedly augmented wellbeing.	*A big difference…before…you'd just go home, and you'd worked really hard and no thanks, no appreciation. Yes, it's helped a lot.* (Chloe Goodwin, HCA Int36)

Evaluation criteria	Participant accounts *(Participant quotes in italics)*
	People acknowledge when a good deed has been done which makes coming to work more enjoyable. (Anon Q69) *Having someone to freely talk to* [IPARr]*...The input from an external source not involved in the situation also allows to regain focus and rationality.* (Anon, HCA Q33)
Changes in organisational health	Organisational performance, absenteeism and retention were not measured.
Changes in occupational safety and health management Routines in support of wellbeing were initiated, remain in progress, and continue to develop.	• Colleague Support Worker role began to be developed through Human Resources department • WbP scheduled into Preceptorship Midwife Programme • WbP discussed during induction for new starter midwives and support workers • Interdisciplinary Wellbeing Group formed and meeting regularly • First Schwartz round organised in maternity location • HCWs nominated to continue theatre, HCA, coordinator AG activities • WbP findings being integrated into Organisational Development toolkit

4.6.1.2.1 The impact of the insider-researcher presence

The quote included in Table 4.3 - *Changes in employee health and wellbeing* Anon, HCA Q33 - was offered by one of 30 individuals who referred to the IPARr presence as beneficial. This is further explored as the level of impact was unexpected and some colleagues expressed deep emotions:

> [Support from IPARr was] *essential...as I found myself feeling very overwhelmed, under pressure + alone. I want to take this opportunity to THANK YOU from the bottom of my heart* [Heart shape drawn]*!*
> (Anon, HCA Q33)

> *I felt broken… your study really helped because I felt somebody was saying we were important, because I didn't feel important, loved, or needed...It's not just the new people…different stresses...affect the most senior midwives.*
> (Anon, Senior Clinical Midwife Int48)

Thirty participants made 39 comments regarding the effect of the IPARr presence. Twenty-one comments referred to feeling cared for, seven to feeling valued, seven to observing related beneficial changes within LW, and four to my visibility acting as a prompt for wellbeing awareness. Table 4.4 includes participant accounts demonstrating findings.

Table 4.4 Impact of insider-researcher presence

Impact of insider-researcher presence	**Participant accounts** *(Participant quotes in italics)*
Feeling cared for 21 comments	*We have been cared for and people are aware of how much an impact having a tea trolley or a 10 minute break on a busy shift makes on your day.* (Anon Q46)
Feeling valued 7 comments	*It has made me feel valued and highlighted the importance of caring for carers.* (Anon Q22)
Beneficial changes witnessed within setting 7 comments	*Improvement in staff mental wellbeing by having Clare available for chat and debrief.* (Anon Q43)
As prompting wellbeing 4 comments	*Seeing you on a shift in civies makes me think about well being and reminds me it's important to be kind.* (Anon Q35)

As discussed in Chapter 3, *Methodology*, I positioned myself in LW to enable data generation. Unexpectedly, individuals from every occupational group and every level of seniority approached me to share their life experiences. Most colleagues recounted home-life situations, often of a personal nature, related to marriages and relationships, family

tensions, addictions, individual and family health concerns, child-care, and many other issues. Others, especially those new to roles, discussed clinical events and uncertainties. These exchanges usually communicated past or present HCW anxiety and often took over 30 minutes to share, but not infrequently much longer. It was usual for between one and three of these interactions to occur during any half-day session. Two participants offered a rationale for this, perceiving me to have:

> *No other role at that moment.*
> (Anon, Midwife Int55)

> *No Allies or responsibilities. Who is present non clinically + Available for chats about anything that may be concerning/upsetting you.*
> (Anon, HCA Q33)

Another participant commented on the necessity of trust:

> *I can only talk to people I can trust...It's really good for me.*
> (Anon Q82)

Being cared for was most often reported to be related to me supplying refreshments, but often also to asking about how colleagues were finding work that day. Others reported feeling valued simply by my having initiated the WbP and seeing me regularly on LW, illustrating my ongoing interest in their wellbeing. Having an opportunity to express feelings was welcomed both in research activity and in spontaneous conversations. Three respondents suggested the role become permanent and be available on each shift. Another suggested a rationale for this:

> *It's no-one's but everyone's role, isn't it?*
> (Anon, Midwife Int55)

Overall, being present in LW to facilitate data generation developed into an entirely separate phenomenon towards enhancing HCW wellbeing. Provision of refreshments was appreciated, in addition to being perceived as a listening-ear. In terms of study impact, this unplanned activity apparently evolved into being perceived as effectual as the activity planned in the original study design.

4.6.1.3 Impact on manager

As managers' responses to IPAR may lead to research activity being progressed or alternatively confounded (Nielsen and Abildgaard, 2013), excerpts of the manager's overall evaluation feedback are included:

> *You're helping me...You have these conversations. It's incredibly positive and worth doing.*
> (Kate, Senior Midwife Int8)

Staff actively seek out Claire for discussion...[WbP] *has improved the morale and pastoral side...done what all ward managers would want to achieve if they had more time.*
(Kate, Senior Midwife Int62)

The above two comments communicate general satisfaction that the WbP imparted benefit to those HCWs for whom the manager had responsibility. In addition, more personal changes were noted:

I've had more cards to say thank you for things...was blown away at Christmas-time...that was quite remarkable.
(Kate, Senior Midwife Int62)

These responses suggest the manager perceived advantages both in the wider LW sphere and in personal wellbeing.

4.6.1.4 Impact on social systems

Having evaluated data related to the local setting, the following refers to a more holistic evaluation of the WbP impact. Bradbury et al. (2020, p4) refer to seeking confirmation that knowledge generated provokes transformation of social systems through:

Meaning and relevance beyond the immediate context in support of the flourishing of persons, communities, and the wider ecology.

Participant quotes suggested the WbP's influence had travelled outside LW, and had influenced people and communities to flourish:

[WbP] *has made a HUGE difference. Not only on Labour ward...Staff have rotated into different areas and carried on your work.*
(Anon Q30)

Another HCW reported:

When the Preceptorship Midwives were feeding back on 'Things To Celebrate'...the following verbal comments were made:

"I haven't even worked on Labour Ward yet, however I already know about the work Claire is doing and I feel it is having a positive impact on the whole service, not just Labour Ward"
(Neesha Rawal, Midwife email 2-4-19 following peer review session)

In reference to Bradbury et al.'s (2020) quality choicepoints, HCWs reported changed individual, group, and organisational behaviours (Table 4.3), supporting the community of HCWs having been energised into more purposefully pursuing LW wellbeing. These aspects could be termed a social transformation in that a flourishing of persons and community was reported. Data related to process are now considered.

4.6.2 Process evaluation

As IPAR was intrinsic to study design, the role played by this methodology was evaluated in relation to its being interwoven within study process. Nielsen and Randall (2013) apply process evaluation to discrete, pre-designed interventions with specific implementation strategies. Although action research adopts a more generative approach to enquiries, certain criteria shared relevance to both approaches and were thus included. Nielsen and Randall (2013) situate evaluation in factors related to context, the intervention itself, and participant mental model changes. Evaluation closely followed this structure, starting with context.

4.6.2.1 Factors related to context

As a conducive context is vital to intervention impact (Dixon-Woods, 2014), Nielsen and Randall (2013) propose this is closely reviewed in terms of hindering and facilitating factors.

4.6.2.1.1 Hindering factors:

Three factors hindered process - the Covid pandemic (Covid19), time constraints, and LW structure. Firstly, the pandemic curtailed study activity for the last five months of the WbP (March-July 2020). Having given notice of my intention to suspend clinical work during that period - to devote time to the last stages of the WbP activity - pandemic demands resulted in acutely diminished staffing levels and high Covid19-related activity. My clinical hours increased and HCWs were diverted from WbP activity. Several planned WbP activities were cancelled, including the first Schwartz round to be (accessibly) located in the maternity unit, and a multidisciplinary social event.

Secondly, general constraints on HCW time affected availability for interviews. Although many individual HCW accounts were successfully captured in short exchanges between clinical activities, longer interviews could only occur in break times or off-duty periods. Scheduling meetings with obstetric and anaesthetic doctors became particularly difficult. Organising group interviews proved unfeasible in HCWs' short periods of availability. Action Group meetings were frequently postponed or curtailed due to last-minute clinical demands.

Data too were constantly being generated and ideally would have been discussed within various intra- and inter-occupational group meetings, including AGs. Time constraints limited these exchanges. Although HCA and Coordinator AGs were attached to pre-existing meetings, Theatre AG meetings were organised around HCWs' free periods and required many communications to finalise. Work demands resulted in participants arriving and leaving at different times, reducing discussion effectiveness. Time constraints were also

suggested as the reason general LW meetings rarely occurred. During the 18-month study period, one maternity-wide unit meeting took place for midwives, but no LW-specific meetings occurred, reducing the opportunity for more widely discussing WbP data and for participation.

Thirdly, the physical LW structure offered limited space for WbP activity. The Training Room, the largest communal room, was used for many purposes and data displays were frequently partly obscured by furniture and stock, reducing access for weeks at a time. Additionally, minimal room availability resulted in interviews frequently taking place in available birthing rooms.

4.6.2.1.2 Facilitating factors:

Although internal or external challenges such as changes in management or funding could disturb study progress, no major changes occurred in the WbP until Covid19. On the contrary, the WbP's longitudinal nature, the constancy of the LW manager's collaboration, and my presence on LW as IPARr facilitated activities. Firstly, the 18-month study period provided time for individual HCWs' assessment of study relevance and value. Participant comments suggested that this period was needed to construct personal orientations and responses:

> *When I first heard about it... I don't think I appreciated...how it would develop...I would have been aware that it was an action research project but didn't really appreciate what that entailed... it almost puts a smile on my face every time I see you because we know that that's what you're here for.*
> (Anon, Senior Clinical Midwife Int43)

Secondly, the LW Manager committed to our regularly meeting to exchange feedback and perceptions of WbP progress/impact, and additionally organised my access to many individuals and meetings. I was also enabled, without intrusion, to independently develop the WbP. The constancy of this relationship facilitated WbP progress.

4.6.2.2 Intervention factors

Checklist criteria on process implementation related to four questions - who initiated interventions and for what purpose; whether interventions targeted relevant issues; whether information reached target groups; and who drove changes (Nielsen and Randall, 2013). The four questions reflect the framework's terminology and are considered in regard to the influence of IPAR methodology.

4.6.2.2.1 Who implemented the intervention and for what purpose?

Nielsen and Randall (2013) suggest the individual intervention initiator and their intended objectives be examined. Firstly, the initiator's seniority in the workplace hierarchy has the potential to agitate or challenge others' positions of power. Secondly, employees' engagement may be influenced by perception of both the project's prime motive, and anticipated personal benefit. The WbP enquiry had been initiated to explore how HCW wellbeing may be enhanced and was independent of organisational performance-related aspirations. For HCWs to wish to engage, however, they needed to be convinced of my motives.

Evaluation data suggested a variety of aspects of the IPARr role appealed to different HCWs. Some participants made no comment on my motives but reportedly anticipated my having potential to effect a difference by, for example, escalating enquiry findings more quickly:

> *It helps you are someone who's worked on the unit for a long time and therefore has the ability to pass concerns to those who have influence.*
> (Anon, Consultant Obstetrician Int62)

Others stated that my being a familiar figure in the setting, and the knowledge that the WbP was being undertaken as a personal initiative, would influence opinions:

> *People know you and know you are using your own time…That's the difference between this and what other people have done...it's different to the manager saying, "I want to improve this, what suggestions can you make?" via email.*
> (Rosie, Core Midwife [Birth Centre] during peer participant review 6-3-20)

Another potentially influential aspect of being the initiator of a project is the question of trust. This has been labelled as social glue (Bradbury, 2019) between participants and researchers, such that greater data generation may be expected to follow trusting relationships. One WbP participant linked my insider status to enabling deeper participant accounts:

> *I wouldn't feel comfortable with an outsider…I might say "Yes", "No", "Maybe" to questions. Because I feel comfortable with you, I can give more in-depth answers.*
> (Carol Greasley, Housekeeper Int29)

Healthcare worker comments suggested that I was not perceived as a threat to LW functioning or to relationships within it. To the contrary, HCWs indicated support for the IPARr role.

4.6.2.2.2 Did the intervention target the problems of the workplace?

Nielsen and Randall (2013) suggest evaluating the extent to which problematic issues raised by employees receive due attention. As discussed throughout, WbP activity was not problem-based but tailored around HCW experiences of wellbeing. Nevertheless, the WbP focus needed to be relevant to HCWs' stated interests before engagement could be expected (Nielsen et al., 2007). The following quote indicates the study topic of wellbeing as pertinent to colleagues:

> *A few people have said...it made them feel valued that you...somebody's interested in how we feel and that wants to improve things.*
> (Anon, Midwife Int33)

It is not possible to know how LW HCW views were coloured by previous relationships with me, and the views of those who did not participate cannot be gauged. However, 21 participants added gratitude statements to data items such as questionnaires. It is unlikely that these would have been included unless study activity had focussed on a subject significant to HCWs.

4.6.2.2.3 Did the intervention reach the target group?

For an organisational intervention to be effective, it needs to connect with the target group it is designed to influence (Nielsen and Randall, 2013). The WbP intended all those working on LW to be considered within this group. Various participant evaluations confirmed the access which diverse HCW groups had received:

> *Very multi-disciplinary…more about a team and less about midwives and obstetricians...the housekeepers and the support workers and the receptionists are all being encouraged to get involved.*
> (Angela, Midwife Int32)

Connecting with all HCWs in the setting appeared to encourage participation from a range of occupational groups:

> *I am proud you are asking me...It's really good including domestics.*
> (Anon Int12)

Also:

> *Proud...honoured* [to be invited to participate].
> (Fatima Eltinay, Speciality doctor anaesthetics Int23)

Healthcare worker evaluations suggested that tools used to share data (wall/board displays, posters) had further extended contact by prompting communication and awareness around the WbP:

> *I found it very encouraging to read the form in the anaesthetic office summarising all the comments practitioners made...Great to see such positive stories and that we are doing something right!*
> (Anon, Staff Grade Anaesthetist Q16)

> *Good thing...*[display board]...*different staff were able to see it on different shifts...It wasn't forced...It made you think...It got people talking.*
> (Alice Ware, Registered Midwife Int17)

Without actively making contact on LW, a number of respondents underlined that simply seeing me in the setting connected them to the WbP, with some linking this to modifying their behaviours:

> *Your visible presence acts as a reminder to me to be mindful of the wellbeing of staff.*
> (Sarah Smith, Senior Clinical Educator Int 41)

In addition to the participant referring to the WbP being integrated into LW routines (Table 4.3), another suggested the WbP was:

> *Like an aura. It's in the background.*
> (Siân, Midwife Int54)

Penetration of WbP activity to HCWs occurred through data displays and through the IPARr presence, such that the subject of wellbeing permeated the setting.

4.6.2.2.4 Who were the drivers of change?

This question refers to the roles played by management, participant commitment, and participant decision-making, the latter being particularly indicative of deeper participant engagement (Nielsen and Randall, 2013). Senior management were uninvolved after consenting to study activity and middle management played no part. As stated above, the LW manager actively facilitated study progress. Participant commitment and decision-making over the study duration are now considered.

Healthcare worker commitment was demonstrated over the entire WbP period by completion of 59 group/individual interviews and 96 questionnaires, and by ongoing AG activity. Nearly one in five HCWs gave interviews, often in their free time, and many hours were dedicated to peer participant review. The production of the *duplicate printout* (Section 4.3) exemplified independent decision-making. One of the midwives involved explained it as an attempt to draw attention to my request for new information regarding WbP evaluations (as opposed to

the initial enquiry around wellbeing sources). These midwives' actions simultaneously indicated participant commitment, decision-making, and action in driving change, implying they considered themselves less the subjects of a research project and more as active co-participant stakeholders working in tandem with the IPARr. Likewise, observing the impacts of AG meetings, participants from many occupational groups actively became decision-makers, driving change through facilitating practical alterations to their future desired ways of working, with the adoption of theatre hats serving as an example. Outwith AGs, HCWs also demonstrated decision-making in the initiatives witnessed towards making the environment more comfortable for women and for colleagues.

While some changes could objectively be observed, there is evidence that other HCWs were less visibly driving change. Participants had evaluated LW morale and culture as more positive and caring, an outcome reliant on change in group behaviour. While some spoke openly of modifying behaviours, not all acted so overtly. One senior midwife, for example, never publicly engaged with the WbP and yet was frequently named among those who commenced taking refreshments to theatre practitioners (a Theatre AG impact). Such actions indicate that numbers of participants driving change through personal decision-making may be underestimated.

4.6.2.2.5 Participant mental models

As stated earlier, changes in mental models imply an intervention affects how participants view, and consequently act towards, a given subject (Nielsen and Randall, 2013; Argyris, 1995). The precise extent of LW HCW mental model change cannot be known but 12 participants referred to new learning around how personal behaviours positively affected others. Twenty-five HCWs also reported witnessing colleagues' enactment of more caring behaviours, implying employment of theories-in-use (Argyris, 1995). Theories were translating into practice, rather than simply being mentally acknowledged:

> *In the beginning I was unsure...wondered if it was going to be a bit wishy-washy...As I've seen it grow...it's become incredibly important...I think that my behaviour has changed...I'm probably more aware of what I say or the way in which I say it.*
> (Kate, Senior Midwife Int62)

Another example of altered mental models relates to perceived improved teamworking.

> *Nobody has said, "This is how we want to work". It's just it's starting to - people have started to talk about it and now people are starting to do it.*
> (Karen Battelle, Housekeeper Int35)

The finding that one participant even formulated a rationale for changed behaviour further implies change in theories-in-use:

> *There seems to be a more supportive atmosphere since the survey* [WbP] *began. Maybe thinking about how we feel encourages self reflection and makes us behave differently towards our colleagues.*
> (Anon Q44)

There is evidence, however, that mental models did not uniformly modify to enhance wellbeing development as some HCWs perceived no personal advantage. In relation to refurbishing the HCW sitting room for example:

> *It's not addressing...my issues. So if it doesn't do that then...I just go, I can see you've sprinkled sugar on stuff.*
> (Tim Gray, Clerical Legend Int34)

Another participant suggested any changes were only evident when I was present but, as data disclosed few such views, the extent of such opinions is unknown. Mental model changes related to the WbP may moreover need to be considered within the work context of HCWs, that is, one of ongoing emotional demand as discussed in the Chapter 2, *Literature review*. Of 59 interviews, 11 referenced being frightened, anxious, stressed, or apprehensive:

> *Never had anxiety 'til I started this job.*
> (Anon, Midwife Int31)

> *It's a very stressful part of the hospital.*
> (Fatima Eltinay, Specialty Doctor Anaesthetics Int28)

Given the environmental tension, being offered even a short intermission through IPAR activities - such as talking about positive experiences or being part of discussions around the tea-trolley - may have altered mental models and contributed to the accounts of improved morale and positivity. As one participant stated:

> *When you first qualify it's frightening, it's really frightening...If you take away the fear, then all you've got left is to enjoy your job.*
> (Catherine Cartwright, Core midwife - LW Int38)

In support of this perspective, another participant also stated:

> *You're reminding us that we are humans. We're not robots. We do have feelings.*
> (Carol Greasley, Housekeeper Int29)

This was one of nine accounts emphasising HCWs as human beings with personal needs.

Over the course of the WbP, a culture shift towards nurturing wellbeing - as exemplified in more caring colleague behaviours - appeared to be developing. Examining related work

theories could establish to what extent this was a chance fortuitous local development. To support future potential application to other settings, theoretical concepts related to wellbeing were investigated.

4.6.3 Theoretical mechanisms supporting culture shift

The WbP experience indicated that the introduction of wellbeing as a topic of collective interest, in conjunction with positive psychology and IPAR methodology, fostered the culture shift towards nurturing wellbeing. Beginning with the nature of the topic, when interventions are intended to improve employee conditions, rather than organisational financial status, psychosocial and health effects are likely to be greater (Bambra et al., 2007). Furthermore, when participants appraise the intervention content as good quality and likely to sustain change, outcomes are directly positively influenced (Daniels et al., 2017a; Nielsen et al., 2007). The above analysis illustrated that LW HCWs viewed the topic and WbP motive constructively, potentially therefore promising greater effect.

Positive psychology (Seligman and Csikszentmihalyi, 2000) was introduced to the WbP by identification of positive workplace experiences. On reading related data, participants reported uplifted emotions and increased awareness and learning, leading to increased compassionate behaviours. Fredrickson's broaden and build theory (Fredrickson and Joiner, 2018) explains this phenomenon as incremental positive experiences feeding positive affect. Positive emotions prime non-conscious motivation for similarly uplifting experiences. The mind opens to other promising resources and an upward spiral of further positive growth is activated, termed *positive potentiation* (Fredrickson and Joiner, 2018, p4). Applied to LW HCWs, it is conceivable that in initially expressing experiences which nourished wellbeing, personal positive emotions expanded. Thereafter, re-experiencing such emotions in writing, sharing, hearing, and reading other similar affirmative narratives, positive emotions were reignited. These emotions could accrue as resources, magnifying positive affect still further.

In support of increasing positive experiences are theories related to the concepts of *we-narratives* and *emotional contagion*. Firstly, *we-narratives* are presented by Tollefsen and Gallagher (2017) as interpretations and portrayals of past events. These are constructed by a group to bring coherence to *the way things are done around here,* that is, to the culture of a workplace (Braithwaite et al., 2017, p2). Such narratives offer sense-making and emotional meaning to those affected by work events, and establish group norms/rationales for future action in similar scenarios. The magnification of LW colleagues' caring behaviours fits a *we-narrative* construct in that increased displays of compassion could be seen to

represent a gradual integration of such behaviours into cultural norms. Secondly, as previously stated, participants referred to the WbP imparting an ongoing atmosphere of influence, such that its effects were spreading and becoming absorbed into LW ways of working. Thirty-eight participant evaluations referred to heightened positivity, with LW being a happier place where people smiled more. This phenomenon may represent *emotional contagion*, defined as the transfer of moods from one person to another (Barsade et al., 2018). Positive affect intensified within the group through individuals' more joyful dispositions.

A further factor which potentially benefitted LW HCW wellbeing was the IPAR process itself. The Job Demands-Resources model (Bakker and Demerouti, 2007) proposes that wellbeing may be heightened not only by reducing workplace demands but by increasing resources. Major WbP impacts included factors which could be considered resources, namely increased caring, morale, gratitude, positive feedback, and teamworking. Likewise, new interdisciplinary dialogues, AG outputs, and increased decision-making could constitute resources. Demand reduction is likely from increased agency around reflecting on, interpreting, and feeding back on data, and the associated vicarious positive feelings. The IPARr presence also reportedly effected a dual demand reduction in physical and emotional needs. Thus, IPAR processes, in association with compassionate LW leadership, appeared to directly support the positive emotions fuelling culture change. A conceptualisation of the theoretical mechanisms supporting the culture shift towards nurturing wellbeing is presented in Figure 4.8.

Positive psychology allied with IPAR, around a topic of collective interest, could theoretically have brought about the culture shift towards nurturing wellbeing. *Emotional contagion* and *we-narratives* added to this momentum. Leadership and context within every setting is unique, yet a theoretical basis for the WbP dynamics may prove useful for other workplaces. A King's Fund report declared an intention to support HCWs' understanding of how workplaces may influence their wellbeing and practice (West et al., 2020). If HCWs were in a position to rationalise the factors influential towards WbP impact, these could prospectively be role-modelled or used to guide behaviours.

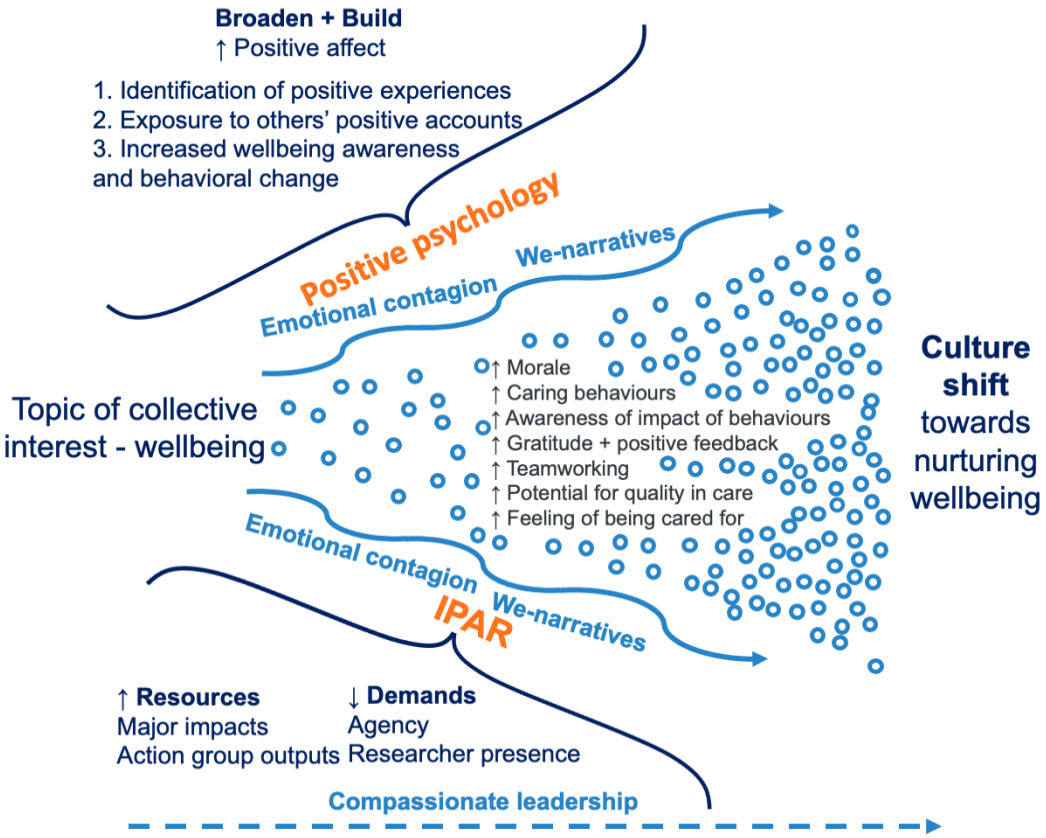

Figure 4.8 Theoretical mechanisms of culture shift

4.7 Chapter summary

This chapter sought to make sense of HCW data in terms of the research question objectives. It was identified that HCWs found joy and belonging through achieving individual professional role satisfaction within a compassionate working environment. Positive WbP impact was evidenced by a culture shift towards nurturing compassionate behaviours; AG group initiatives for improving colleagues' and women's experiences; and recognition of the IPARr non-clinical presence as beneficial to HCW wellbeing. Steps toward the study aim were considered as successfully instigated and, in relation to the research question, process evaluation confirmed IPAR as a productive methodology. Chapter 5, *Discussion*, continues with a consideration of the value of the WbP experiences to local and broader contexts.

Chapter 5 Discussion

5.1 Introduction

Chapter 4 described WbP findings and how they were reached. This chapter discusses how WbP experiences may be practically useful for future wellbeing interventions. The WbP, adopting IPAR for HCW wellbeing enhancement, was the first known of its kind. Its value lies in exploring which processes evolved to support local wellbeing, and in identifying learning which extends its worth more broadly. Learning is initially discussed in regard to how LW HCW engagement and action resulted in local benefit, followed by *Headline learning* points offered for future intervention strategies. After considering related sustainability, dissemination, transferability, strengths, limitations, and future research, the chapter summary is presented.

5.2 The local value of the Wellbeing Project

The WbP was the first known research study aiming to enhance HCW wellbeing through IPAR. The literature review of Chapter 2 identified that a combination of individual and organisational interventions was most likely to effect the greatest benefit to HCW wellbeing. Furthermore, studies with the most positive outcomes were associated with increased HCW decision-making. These factors were integrated into WbP study design, with an IPAR approach used to facilitate HCW decision-making opportunities. This methodology constituted an organisational approach but with the option of HCWs pursuing specific individual interventions. Following the literature review findings, other elements anticipated to magnify effect were additionally adopted. These included involving all occupational groups of HCWs, generating qualitative data to reflexively feedback into and modify study processes, and a positive orientation to research enquiries.

Although participatory research outcomes are difficult to quantify and articulate (Abma et al., 2019), the WbP's effectiveness may be investigated through three domains associated with PAR methodology. These comprise of assessing any local benefit, how fully those in the setting engaged with the project's ambition, and the level of democratic action (Abma et al., 2019). After first discussing local benefit, the *how* of the research question is addressed through a critique of the extent of participant engagement and democratic action.

5.2.1 Local benefit

The culture shift towards nurturing wellbeing may be considered as constituting the greatest value of the WbP. A healthy workplace community was fostered through several mechanisms. In addition to accounts directly reporting improved culture, participants referred to enhanced morale, camaraderie, positivity, and atmosphere. Caring behaviours magnified, spread by the dynamics of

we-narratives and *emotional contagion* (Figure 4.8). Increased expressions of gratitude and feedback were accompanied by improved teamworking. An arena was created in which HCWs could exercise greater agency. This was practised individually by role-modelling personally preferred behaviours, in Action Group dialogue, and in individuals/groups initiating environmental changes for colleagues' and women's heightened experiences. Overall, the WbP progressed the study aim of developing a caring collegial environment in which HCWs created paths to enhancing individual and collective wellbeing. The next section discusses *how* this was realised through participant engagement and democratic action. First, the factors supporting LW HCW wellbeing are briefly compared to the wider literature. This is intended to confirm that the initial base of LW HCW wellbeing was not dissimilar to that of other HCWs. This would imply that discussions around process and impact would be applicable beyond the setting.

The WbP-Mod (Figure 4.6) summarised elements fuelling LW HCWs' wellbeing. It is used as the foundation for discussions related to wider HCW wellbeing. As represented in the WbP-Mod, LW HCWs' *Individual professional role satisfaction* stemmed from two closely interwoven elements - satisfaction of *Personal motivators*, and contribution to *Effective teamworking*. Both concepts were located in the broader literature. Firstly, satisfaction of *Personal motivators* was reported by early career UK midwives as a source of pleasure in work (Cull et al., 2020). Examples included facilitating natural births and adopting leadership roles (Cull et al., 2020). Secondly, contribution to *Effective teamworking,* referred to as collective competence, was proposed by Liberati et al. (2019) as instrumental to securing safe maternity practice. *Personal motivators* and contributions to *Effective teamworking* were also considered as wellbeing resources by nurses/nurse assistants in a Swedish emergency ward (Bringsen et al., 2012). The WbP's findings therefore resonate with other narratives reported to support wellbeing.

Regarding the *Workplace context* in the WbP-Mod, many of the factors supporting LW HCW wellbeing, such as *Welcoming behaviours* and *Colleagues caring*, also featured in other studies. Turnover reduced by 44% in an American programme specifically encouraging new-starter nurses to feel welcome (Hinson and Spatz, 2011), and in a narrative literature review of incivility, Schilpzand et al. (2016) underlined the impact on HCW wellbeing of respectful and compassionate behaviours. Furthermore, colleagues' caring behaviours sustained UK and New Zealand midwives (Hunter et al., 2018; Hunter et al., 2016), as illustrated in the *generous spirit* of reciprocal acts of compassion (Hunter et al., 2016, p52).

Social benefits of giving and receiving feedback and gratitude, as expressed in *Appreciative communication* in the WbP-Mod, were demonstrated by two studies. In Grant and Gino (2010), a simple gratitude statement, added to an email acknowledging a helpful act, made the recipient

both twice as likely to assist the same person again, and to assist an unknown person, in comparison to receiving no additional statement. Similarly, Kumar and Epley (2018) revealed how writing letters of gratitude lifted writers' moods, and how consistently writers underestimated the related degree of recipients' pleasure. *Appreciative communication* was thus found to uplift both givers and receivers, accounting for the wellbeing enhancement reported by LW HCWs.

The benefits of *Positive atmospheres* at work, as represented in the WbP-Mod, also found parallels in the literature. Midwives in the UK appreciated camaraderie and laughter during difficult times, including the energy and compassion of colleagues who buoyed morale (Cull et al., 2020), and Swedish HCWs talked similarly of affirming atmospheres upholding wellbeing (Bringsen et al., 2012). *Physical nourishment* references within the WbP largely focussed on the benefits of breaks for food, drink, and rest. The literature concurred that work conditions allowing for physical sustenance were important, yet frequently found provision lacking. Practitioners experienced 13-hour night shifts without food or drink services (Health Education England [HEE], 2019), with the absence of refreshment and toilet breaks apparently normalised (Hunter et al., 2018). These accounts emphasise the significance of *Physical nourishment* to wellbeing. Healthcare workers cannot presume that food and drink will be available, accounting for LW HCW reports so often celebrating refreshment opportunities to physically recharge.

The WbP-Mod additionally conceptualised *Individual professional role satisfaction* as providing *Joy in work*, and contextual elements as supporting a *Compassionate working environment*, both promoting a sense of *Belonging*. Despite doctors' wellbeing literature being more deficit-focussed, most doctors in the 2018 NHS Staff Survey in England reported looking forward to going to, and were enthusiastic about, their work (GMC, 2019). Likewise, in a maternity unit case study, Maben et al. (2012) found midwives expressing great love for their role, using very similar expressions of joy as did WbP HCWs. Workplace *Belonging*, according to WbP participants, was related to feeling a family-like connection with colleagues. A mixed-methods study of all HCW groups' stress in three UK NHS Trusts found the same sentiment expressed, with colleague relationships considered a key theme (Ravalier et al., 2020). As 45% of HCWs recently identified peers as their greatest support to wellbeing (HEE, 2019) and the GMC (2019) consider belonging to be reflected in caring reciprocal peer interactions, there is much evidence supporting *Belonging* being regarded as an important WbP-Mod concept.

Although the majority of factors nourishing WbP participants' wellbeing found parallels in the wellbeing literature, small differences were found. For example, in Bringsen et al. (2012), learning was reported as a resource, whereas WbP HCWs only referred to learning resources in relation to colleagues' generosity in offering teaching. Overall, WbP-Mod components corresponded to other

literature sources and may be considered broadly consistent with wider HCW wellbeing findings. How participant engagement and democratic action effected impact now follows.

5.2.2 Participant engagement and democratic action

Firstly, participant engagement was based on an organisational intervention approach, with HCWs from every occupational group being included. Securing medical colleagues' engagement was particularly unusual, as discussed in Chapter 2, *Literature review*. Using local knowledge of the context, considered vital as *practical wisdom* (Dixon-Woods, 2014, p95), engagement was encouraged by bringing the initiative directly to HCWs. Proactive approaches were applied, such as visiting individuals' offices to share information, and giving presentations during routine medical meetings. Additionally, a variety of methods were employed through which HCWs could engage. Though conventional paper or online questionnaires were available, the more novel display wall proved particularly effective. In accordance with IPAR principles, the wall acted as a means of making data available to all participants. Its existence proved key to engagement. Potential participants are known to not always access study surveys or online information (Ramos et al., 2020; Schneider et al., 2019). By contrast, the display wall's size and colouring made it difficult to overlook, it was readily accessible to HCWs, and adding new participant accounts invited interest. A flexible approach requiring the least effort from those in the setting, and clearly displaying data, proved effective.

Participant engagement was also apparently encouraged by my visibility in the setting for long periods. This allowed regular clarification of WbP intentions, particularly as IPAR was largely unfamiliar to HCWs. Pre-understanding of the ebb and flow of activity, how HCW roles functioned, and HCWs' sporadic availability, allowed opportunistic engagement. The flexibility of informal interviewing made data generation possible in a pressured clinical setting. Although there was no assurance around the effectiveness of including these strategies in study design, retrospectively they are considered to have been instrumental to impact.

Secondly, democratic action followed from colleague engagement. The WbP sought to enhance wellbeing by bringing about practical differences in ways of working, and in how HCWs felt at work, by building on positive experiences. This aspiration, communicated within the PIS, data displays, and in conversations while attending as IPARr, was evidently acted upon in different ways by individual HCWs. For some, contributing a questionnaire or interview could be considered democratic action. Others exhibited agency by fund-raising; improving LW environment individually and in groups; joining AGs; working on AG documents; and reviewing data. As exemplified in Theatre AG, possibly for the first time, HCWs directly communicated with clinical co-workers from different occupational groups (normally a management function).

Democratic action and learning derived from discovering what was practically useful and meaningful to the other. Many of these democratic actions were observable, yet others were less readily witnessed. Proactively caring for colleagues, communicating appreciatively, working differently in teams, self-identifying in data - all these potential ways of behaving differently indicated spontaneous democratic action, providing foundations for WbP impacts. The dominant local benefit, that of the culture shift towards nurturing wellbeing, was underpinned by these numerous expressions of democratic action.

The study posed the research question:

> *How can we as maternity healthcare workers enhance our individual and collective wellbeing?*

The *how* of the question appears rooted in the principles and practice of IPAR. Without adding burden, HCWs' working lives were integrated into the participatory approach. Illuminating data accounts revealed colleagues' lived experiences, providing tools for others to act towards change. An overarching communal venture to make a difference to workplace conditions was catalysed. At the heart of this lay the participatory elements of:

- Exploring experiences with all of those in the setting
- Creatively making data accounts available
- Collectively applying learning through dialogue and action.

The entire process was supported by a positive psychology approach, sustaining the aspects of working which nurtured HCW wellbeing. Learning is intrinsic to what is regarded as impact in participatory research (McNiff, 2016). Contribution to knowledge is viewed as a fluid, ongoing pursuit, as opposed to providing a finite, bounded conclusion. In respect of this orientation to knowledge claims, the *how* of WbP enhancement, as above, is offered for scrutiny. For learning to be taken beyond this local situation, *Headline learning* points were developed for wider review and scholarship, as next discussed.

5.3 Extending the value of the Wellbeing Project

The rationale for commencing the WbP could not be considered unique in healthcare. *Headline learning* points thus invite wider learning regarding application of WbP experiences to diverse settings. These are not considered as solutions to organisational wellbeing, but as the first step in knowledge building, the second step being to explore their meaning *(*Coghlan and Brannick, 2014). By enquiring into and reflecting on meanings, further learning for future practice may be fostered, and the value of the WbP extended.

5.3.1 Headline learning

Headline learning points invite engagement in learning discussions around compassion; positivity; notions of leadership; support worker roles; HCWs' need for care; and usefulness of participatory approaches in intervention research, as presented in Table 5.1.

Table 5.1 Headline learning

The power of compassion	Positivity recharges workplaces	Everyone a leader	Support workers warrant attention	Healthcare workers need doulas	Tailored approaches fit well

5.3.1.1 The power of compassion

Compassion is discussed in terms of its connection to belonging, how belonging is fundamental to wellbeing, and how HCW wellbeing impacts on the quality of care received. Compassion has been defined as:

> *The feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help*
> Goetz (2010, p351)

Participants reported increased caring behaviours as an impact of the WbP, fundamentally representing an upsurge in compassionate actions. The WbP did not seek to teach such means to wellbeing enhancement. To the contrary, these actions appeared to evolve from witnessing such behaviours and learning from colleagues' accounts. The concept of compassion in the workplace is discussed, both in connection with its unique importance, and in its relationship with belonging and patient safety.

Regarding Goetz's (2010) definition, although the WbP did not directly explore suffering, HCWs would have been aware from access to data that *not* meeting stated sources of wellbeing could be detrimental to colleagues. Thus, LW HCWs were positioned to anticipate colleagues' needs and offer practical, meaningful support before it being necessarily requested. Acting compassionately is not passive but is purposefully mindful (Lilius et al., 2011). It may be exercised overtly, as in offering additional personnel to new-starter colleagues in theatre, or may be less obviously exhibited. For example, applying learning of the human need to belong by purposefully smiling at and greeting a new colleague, may be interpreted by the recipient as an equally compassionate act. Human beings notice more the needs of those they know and like (Kanov et al., 2004). Exposure to WbP data confirming the impact of such behaviours on wellbeing may have counteracted this tendency and prompted compassionate behaviours towards less familiar

colleagues.

As described in Chapter 4, *Analysis and Findings*, compassion is considered a contagious phenomenon. Compassionate behaviours escalate further replication of such behaviours (Fredrickson and Joiner, 2018; Lilius et al., 2011). Compassion is a relatively new concept in research (Dutton et al. 2014). Open expression of compassion has, nevertheless, been associated with workers feeling valued (Crowther et al., 2019), and absence of compassion with feelings of invisibility (Rabelo and Mahalingam, 2019). Cleaning workers described being ignored and avoided as not only provoking sadness and shame, but also as dehumanising (Rabelo and Mahalingam, 2019). Role-modelling compassion is considered particularly crucial in leaders' behaviours as this establishes cultural expectations and norms (West et al., 2020). During the WbP, leaders enquired after colleagues' welfare and comforted those in distress. These actions made explicit the acceptable, prevailing behaviours constituting culture, *the way things are done around here* (Braithwaite et al., 2017, p2). Multiple replication of these actions would have been required to effect the culture shift observed on LW. This suggests a critical proportion of HCWs witnessed such behaviours in leaders, and others, and consciously acted compassionately.

Although the growth of compassion within the LW has been established as a major impact, this cannot be viewed as a solitary, isolated phenomenon. Compassion nourishes belonging. Within work groups, compassionate behaviours are known to nourish belonging and belonging to nourish compassionate behaviours (Dutton et al., 2014). Belonging was reportedly significant to WbP participants in terms of feeling good about being a part of LW, and to not being alone. Human beings need to believe others care about them, to the extent that belonging is considered a basic human motivation (Baumeister and Leary, 1995). A sense of belonging may hold particular meaning for HCWs as their capacity to create this sensation at work is limited. Filstad et al. (2019) found that items brought into offices from home, such as photographs and clocks, engendered feelings of belonging, as did taking meal-breaks together. As bringing household items to healthcare areas is not possible, and clinical activity often prevents shared mealtimes, shared social and refreshment opportunities may hold special significance for HCWs. This is important towards wellbeing as social connections reduce loneliness, encourage caring for others, and lift mood (Baumeister and Leary, 1995). Workplace belonging is also likely to reduce HCWs' perceptions of simply being a small cog in a vast wheel (Bradbury, 2019; Ballatt and Campling, 2011), and instead emphasise their personal value within the environment.

A further consideration related to belonging is the sensation of fear in the workplace, as fear escalates the need to belong (Baumeister and Leary, 1995). Heightened belonging in the WbP may thus have served to reduce fear. Several participants spontaneously testified to feeling afraid

and anxious at work, despite this not being included in the WbP enquiry. Fear at work may be lethal to patient safety and practice improvement (Berwick, 2013) yet, as suggested by one of the WbP participants, when fear is removed, the avenue to work enjoyment is opened. Witnessing increased mutual caring and belonging is likely to have reduced HCWs' fears, and increased enjoyment, potentially accounting for LW HCWs' increased positivity and morale. Furthermore, the value of this increased compassion and belonging does not end with HCW wellbeing. The value continues in quality of care provision.

The culture of a healthcare workplace has profound implications for both employees and those they care for (Francis, 2013). Compassionate cultures nourish quality of care as good HCW wellbeing is linked to improved patient experience (Maben et al., 2012). Treating HCWs with compassion - making them feel valued, respected, and supported - cultivates caring cultures towards patients (West et al., 2020; West and Coia, 2019; Dixon-Woods et al., 2014). The production of a toolkit by NHS England (2017) to measure, address, and improve how culture presents itself within 15 steps of a person's arrival to a ward, stresses its palpable nature and the importance attributed to the force it exerts. Assessments of culture include the impression the ward gives of welcoming others, and of being safe, caring, and organised. Interactions between colleagues and patients are appraised, based on the premise that how HCWs feel at work is transmitted through actions, and is consequently important to both individuals and to the organisation. Garcia-Buades et al.'s (2019) SR correlated collective worker wellbeing with improved role performance, and Braithwaite et al.'s (2017) qualitative meta-synthesis, found positive organisational and workplace cultures correlated with improved mortality, hospital-acquired infections, and patient satisfaction. Caring cultures, nevertheless, need time to develop within settings and cannot be implemented on demand (Berwick, 2013). Healthcare workplaces are complex adaptive systems (Braithwaite et al., 2018; Vaandrager and Koelen, 2013) and, to effect culture change, a community of workers needs to interconnect towards the same goals (Vaandrager and Koelen, 2013). The WbP exemplified such a collective effort, with HCWs initiating culture change through increasing compassionate behaviours.

Wellbeing Project participants anticipated that women's experiences would benefit as a consequence of improvement to colleagues' wellbeing. Evidence supports this proposition. When midwives' human needs are unmet, supportive midwife-mother relationships founder and women are rendered vulnerable to psychological trauma (Patterson et al. 2019). Women's security needs have been destabilised by witnessing midwives *stressed, rushed, crying,* and apparently having *no control* (Pezaro et al., 2018, p661). Conversely, Zaki's (2020) account of being emotionally moved by witnessing professionals' compassion towards his newborn child underline how HCWs' performance relates not only to objectively measurable practice-related criteria but also to the

more nuanced way in which their compassion is expressed through behaviour. These studies suggest that maternity HCW welfare will influence the quality of care, substantiating the anticipated benefit of the WbP to women.

In addition to increased compassionate behaviours, LW HCWs reported improved intra- and inter-disciplinary teamworking, a fundamental requirement for maternity service safety (Liberati et al., 2021). Increased compassion in groups encourages wellbeing and consolidates the social connections vital to effective teamworking (Kanov et al, 2004). Being connected socially to colleagues is associated with the notion of psychological safety, an essential component in healthcare health and safety (Edmondson, 2019). Psychological safety refers to a confidence within groups that concerns raised will be respected and reviewed, encouraging a culture of openness to potentially preventable safety issues (Edmondson, 2019). Multiple maternity reports have demonstrated how the primacy of patient safety is lost when interdisciplinary relationships and communication breaks down (Ockenden, 2022/2020; Welsh Government, 2021; Kirkup, 2015). Women and babies die, and morbidities are suffered. Failures in teamworking are illustrated by Ockenden (2022) findings mimicking those of Kirkup (2015) many years before. By contrast, a positive deviance ethnographic study illustrated alternative ways of group interactions (Liberati et al., 2019). When HCWs understood and valued colleagues within compassionate cultures, non-hierarchical decision-making enabled women's and babies' safety to be prioritised (Liberati et al., 2019). Enhancing LW HCW wellbeing by enabling different occupational groups to appreciate their interdependency is therefore likely to diminish women's and babies' exposure to the most severe risks.

5.3.1.2 Positivity recharges workplaces

The WbP adopted a positive lens to enquiry after the literature review of Chapter 2 found wellbeing interventions to be dominated by problem-solving investigations. By utilising the IPAR principle that data is not owned by researchers but by all participants (Brydon-Miller, 2008), positive data accounts themselves became instrumental to wellbeing. The accessibility of WbP data induced vicarious feelings of pleasure, with continually updated displays allowing repeated opportunity for this. As presented in Figure 4.8, a theoretical basis was proposed for the dynamic of positive emotions fuelling further positive emotions. Bono et al. (2013) found greater numbers of positive events correlated with reduced stress, based on HCWs simply recording naturally occurring uplifting events over a three-week period. Labour Ward HCWs expressed their positive experiences and witnessed their accounts being displayed over 18 months, theoretically engendering even greater effect on wellbeing. Many authors consider that adopting positive orientations to what is working well activates creativity and agency (Montgomery et al. 2013; Bushe and Marshak, 2009; Zandee and Cooperrider, 2008). Wellbeing Project experiences lend

support to this view. Examples include the LW environment being improved (new seating, lighting, pictures), and communication being enhanced (Coordinator AG designed poster responding to study data; HCA initiated Communication Book). Being given occasion to make explicit the joy in one's role, and in one's connection with colleagues, was perceived as uplifting. This was evidenced by the many newly instigated posts on the (pre-existing) online maternity forum which expressed enjoyment of practice situations and interactions with colleagues. Joy is important as cultures aspiring to high quality care depend on practitioners' happiness in their roles. Happiness feeds the team's collective effort and further cements colleague connectivity (Maben et al., 2012).

Less constructive outcomes may result from the alternative of problem-solving approaches. An intervention in a German emergency department found favourable outcomes in HCW job control and overtime, yet most measures deteriorated (social support, job satisfaction, depersonalisation, turnover intention) (Schneider et al., 2019). Schneider et al. (2019) indicated that expectations were raised by identifying problems and solutions, but that as solutions were only partially met, further demoralisation ensued. Openly identifying problems may also expose vulnerabilities within workplaces. To reduce burnout, Ramos et al.'s (2020) research team drafted solutions to workplace problems identified by local HCWs. The response of the senior doctor was to withdraw support, leading to termination of the study. Ramos et al. (2020) suggested that, in anticipation of departmental shortcomings being publicised, the individual feared damage to their personal hierarchical status. Had positive aspects of the workplace been emphasised, perceptions of threat may have been averted.

Despite positive orientations to study enquiries appearing productive, a conceivable danger is that critical voices may not feel welcomed and will be unheard. By their very omission, it is difficult to estimate the extent to which this may have occurred in the WbP. What can be confirmed are the numerous avenues in which HCWs could anonymously provide more critical views regarding WbP activities and LW conditions (paper and online questionnaires, additions to display wall/boards). Adopting a positive psychology orientation also allowed less positive accounts to be presented, but in a manner more likely to avoid offence or defence. For example, one participant expressed frustration that evening refreshments were not provided until a particular (routine LW) task had been completed. This was rephrased as it being appreciated when refreshments were provided regardless of whether this task had been completed. The critical voice was not lost but assimilated into the discourse. Issues thereby raised were less liable to negatively affect colleagues, an outcome contrary to the WbP aim, and potentially to maintaining study progress.

5.3.1.3 Everyone a leader

Employees have conventionally been regarded as comprising of leaders and remaining others. This distinction was blurred by using IPAR in the WbP. The most senior LW leader, the manager, adopted the position of learner and purposefully acted on data to promote wellbeing. Neither did other senior leaders attempt to direct processes. Instead, these colleagues joined the collective venture of sharing personal accounts and being made aware of others' working experiences. Vulnerabilities in many occupational groups were laid bare - an anaesthetist was touched by an invitation to a pizza order; domestic and coordinator colleagues both experienced workplace loneliness; another worker felt disconnected from the team. Commonalities between senior HCWs and others were made evident. Data revealed factors nurturing wellbeing as pertinent to many colleagues, simply as human beings.

These WbP findings correspond to more recent challenges to the notion of leaders being something detached or *other* than the main work group. Leadership is currently being located in a wider, collective responsibility. In recognition of all HCWs' ability to modify working environments, informal, as well as formal, leadership is increasingly acknowledged as necessary to grow a culture of individual and collective agency (Eckert et al., 2014). The NHS People Plan tasks *everyone* (NHSE, 2020) with building a compassionate and inclusive culture in which colleagues care for each other. The WbP witnessed this being practically enacted. Those considered as leaders exhibited equivalent human needs to others and engaged in learning around wellbeing. Those not holding senior roles exhibited capacity to instigate independent action in a leader-like manner.

West et al. (2014, p4) state *every interaction by every leader at every level shapes the emerging culture of an organisation*. The People Plan has, however, recently constructed leadership as *distributed* (NHSE, 2020, p28), promoting the notion that every HCW has the capacity to make a difference to another's workday. While HCWs may themselves aspire to be part of such a movement, they may struggle to know in which ways to enact those views (Kline, 2019). The WbP's experience demonstrated how knowledge and understanding of other HCWs' daily realities may be built, providing an initial path for other workplaces to move towards development of such leadership behaviours.

5.3.1.4 Support workers warrant attention

As WbP data were often anonymous, participation rates from different occupational groups could not be ascertained. It was notable, nonetheless, how frequently support colleagues - HCA, housekeeping, domestic, and reception groups - engaged in interview activity and in informal conversation. Specifically in interview rates, the greatest differential was seen between support

colleagues' and other groups' rates, with 45% of support colleagues contributing to individual or group interview. The next highest interview rate was 21%, from midwifery colleagues (see Table 4.1). It must be restated that support colleagues consistently worked within LW, unlike many other WbP participants whose exposure to study activities was more limited. Nevertheless, Bourbonnais et al.'s (2011) organisational intervention also noted a high support worker participation rate of 72.2%, compared to a nurse rate of 46.5%. In that and other studies, support workers reported feeling marginalised by a lack of teamworking and absence of appreciation by nurse co-workers (Ramos et al., 2020; Bourbonnais et al., 2011; Mikkelsen et al., 2000). The literature related to support worker wellbeing was therefore examined to explore the context of support workers' wellbeing needs more extensively.

Between 2010 and 2019, national sickness absence rates for support workers (assisting doctors, nurses, and midwives) were 5.8% of total working days, the second highest by staff group, after ambulance support workers at 6.2% (Jones, 2020). These rates were markedly higher than doctors at approximately 1- 2% and midwives, nurses, and health visitors at 4.5 - 4.8%, and are economically significant in that support colleagues constitute 40% of NHS staff numbers (Anderson et al., 2021). Although explanations for sickness absence are complex, these figures potentially indicate a group of colleagues challenged by workplace demands. LaMontagne et al. (2014) found lower status workers in Australia had the highest mental health problems and highest exposure to job stressors, yet the least access to stress interventions. A Cochrane review of HCW stress interventions supported this conclusion, finding stress intervention participants to almost exclusively be nurses (Ruotsalainen et al., 2015).

This raises the question of the extent to which HCW support worker role demands are understood. Empathy is not an automatic response and those offering it need to be able to share the other's emotions and perspectives to desire to change the other's situation (Fourie et al., 2017). The feeling of invisibility reported by university cleaning workers while carrying out their roles (Rabelo and Mahalingam, 2019) has been replicated in HCWs. During interviews with nurses and doctors, Ramos et al. (2020) noted the non-existence of references to their support worker colleagues. Additionally, both these last two studies' workers complained of never receiving gratitude. Ramos et al. (2020) suggested this lack of recognition stemmed from those most distanced from the work of others failing to appreciate those workers' contributions. During the initial HCA AG meeting, the first topic support colleagues reported was how meaningful receiving gratitude felt. The extent, if any, that this reflected a general lack of gratitude is not known, but the potential for this group to feel undervalued and therefore seek engagement with the WbP cannot be discounted. Many LW support colleagues also expressed a desire to extend their roles, apparently indicating a lack of individual professional role satisfaction (as represented in the WbP-Mod). In response, the HCA

and Theatre AGs developed various strategies. Further opportunities for work experience, with related supporting tools, were designed (exemplified in HCAs' increased presence in theatre, facilitated by the Scribing Framework devised in Theatre AG). Labour Ward support workers may not be alone in their aspirations to extend roles as at least a quarter of NHS support workers in 2015 were academically qualified to work at a higher level (Skills for Health, 2015). Of a variety of HCW groups' reports of control experienced in the workplace, HCAs fell in the 10th lowest percentile (Ravalier et al., 2020). The basic human need of autonomy (within role specifications) may be unsatisfied and frustrated by unfulfilled potential, with wellbeing consequently diminished (Ryan and Deci, 2000).

Despite NHS support colleagues having high sickness absence levels, questionable regard by colleagues, and limited autonomy, this group has not featured highly in wellbeing intervention studies. Egan's (2013) review of organisational interventions identified that the effect of health interventions on different occupational groups of workers was not uniform, and called for more related research. Findings from the WbP indicate that support workers would respond to interventions to improve wellbeing, and would simultaneously contribute to healthcare service provision.

5.3.1.5 Healthcare workers need doulas

Participants reported the IPARr presence as a positive influence towards their wellbeing. Although difficult to measure and compare in the context of the wider study, this impact could retrospectively be viewed as an intervention in itself. Many colleagues reported feeling more personally cared for and valued, while others witnessed general benefit to the LW, or were reminded to consider others' wellbeing. My availability as IPARr was not intentional to increasing wellbeing, but to facilitate ease of engagement to the WbP, yet enacting IPAR's key principle of participation fortuitously highlighted HCWs' need for support during duty time. For some, provision of refreshments, or physical nourishment, may have been sufficient to experience a sense of being valued. For others, being afforded time to be listened to may have offered more the element of emotional nourishment, coupled with my reportedly being perceived as trustworthy and outside LW hierarchies.

The need for strategies to support workplace wellbeing has already been recognised within maternity settings. Locally, the LW manager stated that she herself would like to offer the pastoral care she considered was being provided within the WbP (were it not for time constraints). More broadly, Hunter et al. (2018) recommended interventions be implemented to relieve midwives' high burnout scores. Similar calls for increased doctors' support have also been made (HEE, 2019; West and Coia, 2019; RCOG, 2011). The large number of colleagues who took the opportunity to

talk to me indicated the extent of willingness within LW HCWs to express their feelings. This was at a time when they felt ready to do so and when another person apparently offered the opportunity. Labour Ward activity levels would often preclude two HCWs simultaneously having more than a short exchange. The presence of an IPARr allowed an approach to be made at HCWs' discretion, knowing their personal time limitations, and judging the IPARr as apparently available. Midwives have expressed preference for face-to-face interventions to support their emotional wellbeing (Hunter et al., 2018). While service demands may not allow the protected time those midwives desired, having recourse to a person free of clinical responsibilities apparently appealed to a significant number of WbP participants. It is noteworthy that not only familiar colleagues, but different grades of every occupational group initiated these conversations. The need to be listened to apparently applied across all roles and levels of seniority.

The popularity of creating a stop for tea, cake, and conversation may be viewed as unsurprising, yet this type of simple support met basic human needs and offered elements of physical and emotional nourishment. The creation of a *Colleague Support Worker* (CSW) role could offer flexible, ongoing, informal sustenance to HCWs at a time of their choosing. The activity entailed in the role could be decided within local settings according to individual workplace conditions. Regarding the local LW, the manager anticipated a CSW role as preparing refreshments for HCWs, acting as a listening ear, updating wellbeing notice boards, liaising with others interested in wellbeing, organising social outings, and supporting fundraising. Trusted individuals may fulfil such roles in organisations, potentially as an employee or in a volunteer capacity.

5.3.1.6 Tailored approaches fits well

Integration of IPAR methodology proved successful in enabling experiences to be known from the everyday working lives of HCWs. This is consistent with commentaries which continue to stress the need for processes to be flexibly tailored around specific employee situations (West, 2020; Montgomery et al., 2019). Since wellbeing derives from workplace systems, and each system is individual, local work populations' specific requirements need to be prioritised (Holman et al., 2018; Egan and Bond, 2015). Prescriptive, pre-designed generic programmes are less likely to be impactful (West, 2020). Exemplars include Spence (2015) finding employees more concerned with communications, resources, and social relations than the physical and mental health programmes offered by the employer; midwives lamenting the inappropriateness of lunchtime walking initiatives in the absence of lunchtimes (Cull et al., 2020); and wellbeing resources being inaccessibly situated for HCWs (Ravalier et al., 2020; Quirk et al., 2018).

Insider PAR was also advantageous in that it facilitated engagement with the LW culture in its complex entirety. Open, exploratory enquiry enabled a multitude of factors potentially influential to

wellbeing to materialise. Positivist scientific paradigms, by comparison, conventionally favour a defined component delivering a specific objective (Tetrick and Winslow, 2015; Bambra et al., 2009), yet theory suggests wider dynamics are related to change. Rather than distinct individual elements effecting differences in HCW wellbeing, workplace cultures are constructed from a broad field of individual resources emerging and interplaying (Hobfoll et al., 2018). Proposing RCTs, with discrete, prescribed strategies, as the optimum approach to organisational interventions is difficult to reconcile within the multifaceted nature of culture (Cox et al., 2007).

From a practical perspective, IPAR is appealing in many respects, including ability to be low cost, start rapidly, and avoid the delay inherent in external practitioners being accepted into the setting. Healthcare workers' desires may focus on swift improvements for the disturbing levels of poor wellbeing which they experience and witness. The WbP's use of readily accessible data generation methods were responsive to this need. Time-consuming research tools may add burden, given HCWs' considerable physical and emotional demands (HEE, 2019) and limited time and enthusiasm for extra activity (Quirk et al., 2018). A recent survey of NHS HCWs produced a 14.5% response rate, despite enquiries being related to their personal wellbeing (Ravalier et al., 2020), seemingly indicating a lack of surplus energy or motivation.

Cox et al. (2007) state that the key question surrounding intervention activity is the intended strategic goal, and whether data generated by the methodology provide appropriate evidence to that end. The WbP process and evaluation data indicated that the aim of the WbP, to develop a caring collegial environment on LW, was progressed. Evidence in support of participatory approaches in improving healthcare environments continues to emerge (Paguio et al., 2020). Insider PAR offers creative opportunities to those without a specific hypothesis but seeking to advance wellbeing, and can be considered a credible methodology in wellbeing initiatives. Although the WbP made progress towards HCW wellbeing, sustaining initial aspirations may prove challenging. The culture shift needed to continue while individual HCWs left and joined the environment. Having discussed the *Headline learning* offered as contribution to knowledge, the future of the WbP demands consideration in regard to the question of workplace culture.

5.4 Culture as a sustaining force

Culture is a continually transfiguring phenomenon (Braithwaite et al., 2017) and it cannot be assumed that the culture shift on LW will be maintained. Caring cultures depend on the enduring nature of supportive group behaviours (Edmondson, 2019). Montgomery et al. (2015b, p39) comment on how the dangers of interventions include offering *respite rather than a solution.* While participatory approaches do not subscribe to finite solutions, continuation of the culture shift

nevertheless holds challenges. These include the loss of the formal research framework as, particularly given Covid19 disruptions, without the study driving AGs and stimulating discussions, a focus on wellbeing may wane. Other ongoing challenges include the variety of different occupational groups within teams, and the constantly rotating individual membership within those teams. Consciousness needs to be kept alive as to the value of proactive compassionate behaviours in nurturing relationships within and between teams. In support of this, the longitudinal nature of the WbP - a period of over 18 months - provided a firm basis for a future culture supportive of wellbeing. Healthcare workers independently evolved proactive compassionate behaviours which were reinforced by reciprocal colleague/leader actions. Witnessing the resulting increased positivity and teamworking encouraged other HCWs to role-model similar modes of behaving, further sustaining the culture. Although some HCWs rotate in and out of LW, the core body of LW colleagues is projected to continue this dynamic.

To sustain WbP benefit, the general environment also continues to reflect ongoing interest in wellbeing. Various data displays exemplify this. The first is a WbP poster prompted by a consultant anaesthetist on LW which was presented at the Obstetric Anaesthetists' Association Annual Scientific Meeting (2021) (Appendix 16). After presentation, the consultant suggested copies be displayed in anaesthetic offices and theatre. The second concerns a wall display in the doctors' 'mess', a separate sitting room for medical colleagues. It provides data excerpts underlining how medical colleagues contributed to others' wellbeing and is intended to support positive affect, particularly for those new to the setting. Other smaller displays are intermittently used. One, for example, is sited in theatre and contains excerpts of posts on social media which have expressed gratitude to theatre HCWs. Through these means, colleagues can witness that their wellbeing is still actively being considered.

Beyond the local situation, enduring controversies concern the paradox of failing to address unchanging, unacceptable work conditions while concurrently promoting resilience training for HCWs. This debate is particularly relevant given the more recent preferred strategy of influencing wellbeing through culture change (HCHSCC, 2021b; NHSE, 2020; HEE, 2019; West and Coia, 2019). Crowther et al. (2016) compared the concepts of resilience and sustainability in relation to midwives' capacity to maintain practice. Resilience - the ability to experience adversity and yet find sufficient self-resource to subsequently re-engage in meaningful practice - was proposed as an element of sustainability. Those desirous of and influential in maintaining a vital, purposeful working environment demonstrated the necessary resourcefulness/resilience to repeatedly reconnect and interact with that aspiration. In so doing, positive environmental conditions were sustained (Crowther et al., 2016) This analysis resonates with WbP experience in that HCWs' behaviour nurtured the environment and the LW atmosphere consequently nurtured HCWs'

continued behaviour. The fundamental conditions of LW remained unchanged in terms of HCW numbers, yet positivity and relationship thrived, implying that resilience became embodied in HCWs as their situation improved. Healthcare workers continuing to behave in ways which nourish both individual and collective wellbeing may be expected to sustain improved environmental conditions. Resilient behaviours blending with the culture shift may offer greater influence to the person than resilience programmes alone.

Similarly, the discussion in the literature review of Chapter 2, regarding secondary individual versus primary organisational interventions, has relevance to WbP sustainability. A combination of the two intervention types is more likely to sustain wellbeing into the longer term (PHE, 2016). The secondary individual intervention of the *Feeling All-together Better* (*FAB*) session, for example, increased coordinators' wellbeing. This wellbeing could, nevertheless, not be sustained without the primary preventative LW culture being correspondingly supportive. Going forward, other organisational measures already established are expected to keep the WbP agenda alive. The many changes considered to have impacted occupational health, as developed in new activities and processes (see Table 4.3), are anticipated to continue. Furthermore, HCWs continue to be active in conversations concerning wellbeing, allowing any interest in new secondary interventions to be voiced.

5.5 Dissemination of Wellbeing Project experiences

My primary interest remains with influencing HCW wellbeing, which I have pursued within the hospital Trust and to wider audiences. Locally, I have presented the WbP to senior midwife managers; to a senior nurse Research and Service-Improvement Masterclass; and to Organisational Development practitioners. Plans are being made to demonstrate the WbP process in management leadership programmes, and at a Trust Nurses and Midwives Conference (delayed by Covid 19). A summary report of Wellbeing Project process and impacts will be provided to LW, Women's and Children's Division, and Trust leaders to consider for future action.

National and international conferences provide forums to share the positive, participatory, and practical elements of the WbP. These include not only midwifery, obstetric, anaesthetic, and support worker groups but other disciplines such as Organisational Development, Health Services management, psychology, healthcare education, and research. In addition to formal presentations, workshops within conferences offer ideal interactive spaces for practitioners to exchange views on the intervention and consider how initiatives may be locally applied. The prospect of commencing such an intervention may, in delegates' minds, be taken from the abstract to an achievable proposition. Appendix 17 includes national and international dissemination thus far undertaken. I also intend to share experiences through submissions to journals in the above

fields, emphasising the operationally achievable factors of the WbP. Following participatory principles, colleagues would be anticipated to co-present at conferences and to co-facilitate workshops, as well as contributing as co-authors to submissions for publication. The following section discusses details of how the WbP's experiences may be transferred to other settings both locally and more broadly, in terms of principles and practicalities.

5.6 Transferability

The significance of meeting basic human needs through workplace compassion and belonging is widely relevant. The overarching consideration of transferability relates to the accessibility of IPAR processes, given that the WbP was initiated by a non-managerial frontline clinician. This indicates that although a formal, complex study could be instigated in response to review of the WbP, equally a small-scale enquiry into factors supporting employee wellbeing may be deemed productive for particular workplaces. Equally, communicating WbP findings alone, in absence of any other activities, may be sufficient for some groups to stimulate dialogue. Discussing how people may be welcomed to workplaces by use of names, smiling, and greeting, and how emotions travel, is transferrable information.

5.6.1 Transferability of principles

There is wide concern regarding the lengthy periods of time taken to translate research findings into mainstream practice, such that implementation science developed to address the delay (Dadich et al., 2021). Insider PAR methodology aims to start situating local impact before study processes end and may consequently be viewed as less vulnerable to the boundary between findings being available and transfer into practice. Both implementation science and participatory approaches, nevertheless, promote intervention context and process being made evident. This enables others to situate and evaluate reported impact, or lack thereof (Dadich et al., 2021; Friedman et al., 2018). Hence, the WbP account of IPAR applied in a real-world situation has been made available for interrogation, including the potential theoretical mechanisms instrumental to effect. The transferability of the WbP experiences depends not on indiscriminate imitation of the documented processes (Biron and Karanika-Murray, 2015), but on application of the demonstrated IPAR principles. As all workplaces are unique, applying principles allows interventions to be tailored to workplace conditions. In so doing, the utility of the WbP findings could additionally be broadened beyond healthcare applications.

5.6.2 Transferability of practicalities

Although the WbP was initiated as a formal research study with the attendant academic requirements, processes could be undertaken independent of research enquiry. A volunteer or

mix of employees and volunteers could facilitate collective activities. Despite operating within multiple teams from different occupational groups, the WbP fostered beneficial impact, suggesting at least an equivalent effect could be expected in smaller teams with less instability in team membership. The study design would readily transfer to other workplaces, with descriptions of the practical steps taken within the WbP modified according to workplace needs. Positive work experiences could be displayed, small discussion groups started, and actions planned, evaluated, and modified. Such activity could be formal or informal, following the pace of the environment, and with employees remaining within their workplaces and contributing flexibly around work demands. No additional room space or technological support would be needed, thus providing a cost-effective strategy free from external organisational consultancy fees.

5.7 Strengths

A significant strength of the WbP was its accessibility. For participants, the participatory study design encouraged all those in the setting to contribute their experiences, evaluate the narratives of others, and make decisions based on personal perceptions. For researchers, extensive data were made available on which to base knowledge claims, and processes were made accessible for review. The intervention practicalities were simple and straightforward to set up, and not highly resource dependent. Wellbeing Project messages were simple and held global traction - paying attention to basic human needs enhances employees' wellbeing.

5.8 Limitations

The WbP took place in one English NHS Trust and was context specific in every aspect - the HCWs, the IPARr, leadership, senior management, the culture towards wellbeing, the readiness for an intervention, clinical activity levels, existing teamworking, the setting's structure, to name only some elements. As how a project unfolds cannot be predicted, large-scale replication is not possible (Abma et al., 2019). The IPARr is required to undertake the role as a competent practitioner with sufficient resolve to draw attention and act upon a situation considered in need of change (McNiff, 2016). The authenticity of an IPARr demands behaviour that is consistently attentive, intelligent, reasonable, and responsible (Coghlan and Brannick, 2014). Anticipating colleagues' responses and navigating ever-changing circumstances make these ideal qualities demanding for individual researchers to maintain. Chapter 6, *Reflexivity*, discusses in detail the influence I, as IPARr, exerted on study process. As with every project relying on an IPARr, impact must necessarily be enhanced and/or limited by individuals' personal attributes and/or shortcomings.

Although HCWs contributed rich data to the WbP, different and more data may have been generated had colleagues not been restrained by time, particularly medical colleagues. As a significant proportion of data were anonymous, it is not possible to deduce the extent to which different HCW groups participated. It is nevertheless reasonable to consider study findings most reflected the experiences of those HCWs who were regularly scheduled to spend long periods in the setting. Greater diversity of data may have been generated had HCWs been offered more protected time for dialogue within their own occupational groups and within interdisciplinary group meetings. In addition, participatory approaches aspire to include participants in every stage of research. This was not the case in the design of the WbP question or implementation. Although six participants acted as peer participant reviewers, these were limited to midwife perspectives only. A greater range of data interpretations may have been offered by HCWs from other occupational groups. The study nevertheless includes unusually high engagement from diverse HCW occupations. In addition, a positive psychology approach may have inhibited HCWs from freely expressing more negative impacts of workplace conditions. Those troubled by wellbeing may not have felt the study was an appropriate forum to express views. Nonetheless, efforts were made to accommodate less favourable comments (Section 5.3.1.2) within the wider rationale of the positive psychology approach protecting the overall body of HCWs.

The studies identified in the literature review of Chapter 2 were also only chosen by one person, myself, potentially limiting those included. Time constraints in both the PhD study period and in HCW availability contributed to these limitations. Overall, nevertheless, the study reflects the realities of interventions in a real-world healthcare environment.

5.9 Future research

The WbP opened possibilities for other research enquiries. Locally, research interest could focus on the effects of establishing the CSW role on HCW wellbeing and, as medical colleagues received less exposure to study activities, a follow up enquiry to further investigate and compare this group's local wellbeing needs. More widely, the *Headline learning* points offer direction for future research enquiry, within and outside healthcare, including in educational institutions. In contrast to conventional experimental design, interventions could use I/PAR to tailor approaches, and incorporate positive psychology orientations. The effects on employees' sense of compassion and belonging, and on leadership behaviours, could be reviewed in consideration of process and impact. Differences in intervention direction could also be investigated in cases where frontline workers played a more active role in research question and implementation design. Investigating how support worker colleagues' experiences may be optimised could have implications for those individuals and for healthcare services.

Additionally, networking between LW and Organisational Development colleagues began during the WbP, and more recently developed with the university team whose original research prompted the study's initiation. Many interventions to improve culture and behaviour, which leaders are tasked with implementing, have little evidence-base (Kline, 2019). An opportunity is apparent for academic, Organisational Development, and clinical personnel to work together. Uniting these disparate worlds of practice could lead to wellbeing initiatives being informed and designed by theoretical and practical knowledge, potentially expanding studies' impact and practice-based evidence.

Although not directly furthering HCW wellbeing, an alternative dimension of research could include childbearing women's views. Individual and/or group feedback of different points when HCW wellbeing or strain became evident would introduce another element of enquiry to inform HCW behaviour and practice.

5.10 Chapter summary

The value of the WbP was confirmed in its progression towards enhancement of LW HCW wellbeing. Contributions to knowledge were discussed in how local benefit was positively influenced by participant engagement and democratic action. *Headline learning* points were presented for wider application to wellbeing interventions. These included the power of compassion, the benefit of positivity in workplaces, the advantages of distributed leadership, the potential to extend support worker roles, how HCW needs may be supported, and how tailored approaches meet local demands. Chapter 6, *Reflexivity*, explores how WbP process and impact may have been influenced by personal perspectives derived from my positioning in society and the workplace.

Chapter 6 Reflexivity

6.1 Introduction

This chapter focusses on how the concept of reflexivity developed in research practice and how this was integrated into WbP processes. My multiple reflexive preoccupations centred around the influence on processes of *who I was* as an IPARr, how this affected colleague engagement, and how reflexivity in relationship with others contributed to study quality.

6.2 From reflective to reflexive research practice

Reflection is a process of reviewing actions or phenomena to consider what new understanding may thereby be gained (Davis, 2020). Although Kjellstrom and Mitchell (2019) describe models for reflection dating back over 50 years, reflexivity is considered a more recent and separate concept. References to reflexivity began in the 1990s, with a plethora of articles appearing from the year 2000 (Berger, 2015). Its rise stemmed from increasing acknowledgement, particularly in qualitative research, that researcher subjectivity influences every aspect of practice, therein rejecting the positivist claim to researcher objectivity (Crotty, 1998). Reflexivity is presented as a deep pursuit of *reflection on...reflections* (Kjellstrom and Mitchell, 2019, p420). The researcher continually self-evaluates how their personal assumptions, beliefs, and worldviews may influence every stage of research enquiry, including reported process and outcomes (Abma et al., 2019; McNiff, 2016; Berger, 2015). This self-investigation proactively surfaces and acknowledges a personally honest interpretation of those aspects of self which, for example, have evolved from ethnicity, gender, or perceived societal/workplace positional power (Abma et al., 2019; Kjellstrom and Mitchell, 2019; Winter and Munn-Giddings, 2001). *Re-flex-ed* interpretations, those which are directed back onto researchers to reconsider in the context of individuals' life experiences, themselves then constitute new data (Winter and Munn-Giddings, 2001, p247).

The WbP's reflections on reflections - the researcher story behind the ongoing process - may be represented by using different approaches. Marshall et al. (2010) provide a reflexive framework in an ethnographic study, and Davis (2020) one in grounded theory enquiry. Regarding participatory studies, reflexive practice is considered a means of authenticating the researcher's account of actions (Kjellstrom and Mitchell, 2019). Through reflexive reports, other practitioners may situate the stated knowledge claims, potentially strengthening the perceived research quality. I had previously struggled with working through and understanding some academic studies and how to apply findings to maternity

settings, and was keen that the research account clearly articulated practically beneficial information. Its presentation was intended to be relatable and to reflect the sentiment of offering *my story of the good* rather than *proclaiming a universal good* (Gergen and Gergen, 2008, p16). Although I retrospectively find it difficult to distinguish how/when my perspectives were challenged by events, data contributions, or pieces of literature, as all are now interwoven and merged, I elaborate on those reflexive aspects which most impacted my experience as an IPARr. The intention is to offer the most fruitful insights for those engaged in or anticipating similar activity.

6.3 Reflexively researching throughout the Wellbeing Project

As the WbP progressed, I experienced reflexivity as literally the *moment-to-moment* self-critical surveillance described by Wicks et al. (2008, p23). Examples follow of the many factors within the WbP which made me continually recalibrate my views on interactions and events, and therefore on the meaningfulness of WbP phenomena. The account begins with my positions in the workplace and in society and how these may have influenced study processes and consequently study impact. It continues with how reflexivity was integral to colleagues' engagement, and bound up in relationships.

6.3.1 Introspection - all about me

Regarding my positioning in academic study, I considered myself privileged to be undertaking research. I had decided to self-fund to avoid lengthy attempts at financial support and was satisfied with the related freedom to act independently. In addition to not being employed in an academic institution with its own remit for outputs, my NHS contract allowed me to flexibly schedule my duty times around research activity. Furthermore, NHS economic constraints meant that the WbP had to proceed without supplementary funding. This felt surprisingly liberating in that it confirmed the WbP would be an endeavour driven by local effort alone. As related to positioning in the setting, I was white British, around retirement age, had good working relationships in the multicultural environment with colleagues from all occupational groups, and was unaware of any personal characteristics which would hinder research interactions or undermine relationships. In essence, I unremarkably *fitted in*. I would be considered neither junior nor managerial but one of the body of HCWs independently responsible for supporting women with their birth experiences. Although as this middle-grade clinical practitioner I had no access to higher management plans for wellbeing service development, I anticipated having access to all LW HCWs.

Despite this favourable starting point, other issues inhibited me. I was apprehensive as,

although I keenly anticipated being an IPARr, I was somewhat uncertain of others' reactions to my new positioning. Stepping outside one's usual role can leave practitioners feeling more outsider than insider McArdle (2008), as experienced by Nyman who reported feeling unsupported by colleagues and wishing to discontinue as an IPARr (Nyman et al., 2016). I rationalised that Nyman's (2016) midwifery colleagues may have perceived demands being made of them in terms of clinical practice changes, whereas the WbP was instead directed at enhancing colleagues' personal wellbeing. My apprehension was increased by the unusual position of being a clinical midwife PhD student. Initially a solitary figure, I felt pressure to deliver a positive impression of my profession to colleagues yet, being a novice, like Davis (2020) struggled with imposter syndrome. Reflexively, I made efforts to appear confident to inspire interest from others.

6.3.2 Reflexively engaging colleagues

Being an effective IPARr necessitated acting in a manner which would increase the likelihood of engagement and data generation with colleagues. Marshall et al. (2010, p22) referred to this type of reflexivity as *inter-subjective reflection,* within which the researcher deeply considers how relations with potential participants, and thus engagement, may be optimised. I experienced this interplay in two main areas - firstly, in my daily conduct on LW and secondly, in application of data generation methods.

Firstly, encouraging colleague engagement concerned how I physically rooted my presence on LW, and how I approached colleagues. Aware that dress code could influence impressions and attitudes (Marshall at el., 2010) but wanting to differentiate my IPARr and clinical role by not wearing uniform, I wore smart, plain clothing. To support melding into the environment, I stood at the back of Handover, intending to be visible but unobtrusive. Shortly after taking up this position, one HCW saw me making notes (memos to myself), and asked if I was documenting HCWs' practice. Having specifically decided against observational methods, I was frustrated that I had invited this misunderstanding. Fearing misrepresentation of WbP objectives, I resolved to more carefully manage impressions I was giving. Being regularly present in the setting, most colleagues could witness my behaviour and engage at will. Some office-based colleagues, however, had to be actively introduced to the WbP (anaesthetists, for example). This involved *shapeshifting* as described by Greene (2014, p7). I reflexively judged how various (busy) colleagues' interests may be piqued by fore-grounding different WbP characteristics. For one with academic interests, I introduced the fact of PhD-level study. For another who keenly mixed with other professional groups, I introduced the study as a participatory endeavour. One colleague told me that in their country of origin, nurses did not converse with doctors except to receive

instructions, and that UK interactions had shocked them. This alerted me to not presume all colleagues would be at ease with interviewing, or even social conversation, particularly around a subject involving expression of personal feelings. It had to be considered that factors such as my white ethnicity, and being categorised on perceptions of my social class and professional status, may have impacted on HCWs' social comfort in engagement. While not able to profoundly change my behaviour, I consciously approached new-starter colleagues in a reserved, formal manner, in appreciation of cultural norms potentially different to my own.

Secondly, in terms of data generation, several issues provoked reflexivity. I considered whether the range of methods was productive, or required modification. One colleague suggested HCWs could interview each other for WbP purposes. After discussion with the Supervisory Team, it was felt this could not be accommodated within a PhD award. It was unfortunate that a colleague who was sufficiently motivated to deepen and extend participation would not have their proposal supported. I was, nevertheless, grateful to be prompted to consider this for future research. In other practical ways too, reflexivity informed data generation. Having heard myself interrupting interviewees in audio-recorded interviews, I resolved to be more self-disciplined, and when colleagues produced the *duplicate printout* (Section 4.6.2.2.4), this also made me reconsider my practice. Data generation evidently depended on my requests being clearer to HCWs.

6.3.3 Relational reflexivity

Relational or collaborative reflexivity in participatory approaches involves researchers and participants exchanging interpretations and feedback on study processes (Vallianatos et al., 2015). This predominantly occurred in the WbP through two routes, one of which may be termed formal, and the other informal.

6.3.3.1 Formal relational reflexivity

I purposefully sought to engage in reflexivity through two channels - one, in peer participant review sessions and two, in consultation with critical friends.

6.3.3.1.1 Reflexivity in peer participant review

Reflexivity was continually practised in peer participant review sessions. Aware of the limited perspective I as an individual could bring, colleagues offered multiple realities to extend data interpretation (Abma et al. 2019). In relation to broad issues, the team of reviewers confirmed the dominance of data related to the *Emotional nourishment* theme but additionally, in more detailed elements, the team acted to collectively authenticate data

interpretations. Several data contributions had suggested HCWs positively enjoyed work. Although pleased and surprised to read/hear this, I was personally reluctant to trust my own judgement on establishing a code for *Joy in work*. Early in my career I had commented to two midwife colleagues that after two days off in any week, I was happy to return to work. Their disdainful looks, and one suggesting I should *get a life*, had since stuck with me. Despite HCW accounts clearly including the word *love* in connection to working, and in relationship with colleagues, I could not trust my judgement and needed the finding to be warranted. More generally, peer participant reviewers' considered and thought-provoking comments served to both confirm the relevance of different data interpretations, and to raise entirely new viewpoints. Rosie differentiated teamworking and belonging, and Neesha shared how a feeling of wellbeing spread to her while peer reviewing written accounts.

I recognised during the WbP that certain data subjects held greater personal appeal as they aligned with my own worldviews. The peer review process made it less likely that I would disproportionately filter transcripts for further confirmatory data. Neesha, by verbalising benefits associated with the review activities, also relieved some of the discomfort I felt in colleagues volunteering their personal time. Additionally, the choice of IPAR with positive psychology was evidently adding beneficial dimensions to the study process.

6.3.3.1.2 Reflexivity with critical friends

Several critical friends read/listened to my accounts and critiqued how convincing my interpretations of situations appeared, and how meaningfully my positions on the data were presented. Such activities support reflexivity by providing honest feedback from which to assess the significance of one's reflections (McNiff, 2016). For example, I wrote in my journal:

Told [critical friend] *that people seem to be coming up to me and talking about how they are feeling, or giving me stories about what's happened to them.* [Critical friend] *commented that maybe what's happening is that there is now a 'unit doula'.*
Journal entry 6-11-18 (two weeks post study start).

The notion that HCWs enjoyed the presence of a person able to provide them with support at work subsequently developed into an important finding. Thus, friends enriched interpretations by provoking reflexivity beyond the boundaries which I as a lone researcher could reach.

6.3.3.2 Informal relational reflexivity

While I actively sought a collaborative exchange in the above scenarios, other unplanned relational dynamics stimulated a reflexive response. The most impactful of these concerned the deepening relationship between myself and colleagues. Three factors were responsible. Firstly, with my regular LW attendance uninhibited by clinical work, general social conversations increased, leading simply to knowing one another better. Secondly, interviews necessitated social interaction and thirdly, as stated earlier, colleagues initiated a series of personal conversations. These conversations made me realise how many issues aside from work concerns occupied colleagues' minds. I became more aware of their vulnerabilities and how they regardless persisted in attending work. I sensed a fragility in colleagues' welfare, a *holding together*, which I felt was both strongly held and yet susceptible to further strain. This perception influenced my feelings and behaviours in several ways. The most powerful sensation was increased respect and admiration. Although believing I had felt similarly at the project start, these feelings became more profound. In terms of research practice, I believed my understanding of the factors affecting wellbeing were heightened and I identified with Adler and Hanson (2012) who considered how researchers chose their topic of enquiry based on compassion for certain phenomena. The imperative to make a practical difference to HCWs' wellbeing intensified.

This deepening relationship was not consistently straightforward. Ross (2017) recalled how, while interviewing, she challenged the boundaries of her role in over-identification and self-disclosure with a participant. Reflecting on this made me realise how I too travelled near that demarcation line when colleagues shared their difficult circumstances. I was concerned that I may become over-involved in personal issues, possibly responding inappropriately when colleagues sought simply to unburden themselves. This concern was compounded by two separate HCWs incidentally commenting on the *counselling* I was providing, an impression which I had never intended to give. My reflexive dilemma consisted of feeling that HCWs, with the capacity to anticipate how their personal wellbeing would be affected, had initiated conversations, yet being at risk of acting outside the researcher role. Simply by being available on LW, and having indicated I was interested in colleagues' wellbeing, may have implied a type of counselling was being offered, for which I felt unqualified. I discussed this with a member of the Trust Organisational Development team who suggested that a short course - *Effective conversations in the workplace* - could provide guidance. Having thereby gained understanding of how to supportively encourage colleagues' self-reliance on independently deciding their next step forward, I felt more confident of hearing stories without straying into potentially unhelpful responses. I nevertheless remained cautious, attempting to be reflexively alert to the different behaviours appropriate to the colleague-

colleague and colleague-IPARr interface.

My reflexive observations acknowledged that this deepening relationship was also altering my conduct with participants. I suspected I was beginning to shield colleagues from different study processes which an outsider researcher may not have been deflected from. For example, posters were displayed inviting colleagues to review data and although six midwives participated, a range of HCWs from other occupational groups would have added wider perspectives. I would have liked to have checked whether the posters had been read but avoided enquiring, so colleagues did not feel obliged to respond. In retrospect, I considered whether my not asking a straightforward question indicated that I was overly sensitive to colleagues' positions and had failed to respect their agency in being able to decline. Thinking more reflexively, I may have unwittingly reduced their choices in participation. Additionally, Covid19 further increased my reluctance to approach colleagues. Staffing numbers had fallen and requests for further discretionary effort appeared inconsiderate. In seeking WbP evaluations too, I hoped that our deeper connections would not tempt colleagues to be more generously assess impact than would have been afforded to an external researcher. Despite reservations, by the end of the study and since then, I have overall viewed closer relationships with colleagues as a strength of the study, believing that colleagues felt encouraged to talk frankly and with ease. Opinions which may have remained unexpressed entered the public arena and acted as catalysts for consideration and learning.

More reassuringly, I rapidly received feedback that my regular presence in the setting was encouraging data generation. After separate impromptu conversations, a support worker and a doctor offered to be interviewed. They incidentally both mentioned that they had seen the WbP invitation email but, despite intending to, had not completed a questionnaire, and stated they anyway preferred to talk. This positively reinforced my practice of regularly attending LW and reflected other researchers' experiences of low questionnaire response rates (Ravalier et al., 2020). Similarly, generating data opportunistically from group discussions proved more practicable than convening consultation groups. While appealing for the depth and breadth of discussion, the volume and pace of LW activity undermined longer consultation groups being undertaken.

The above accounts illustrate the integral place of reflexivity in IPAR, and how constantly awareness of the impact of my behaviour as IPARr had to be maintained. My enthusiasm for the methodology was nevertheless sustained by its positive effects, as reflected in another journal entry. I documented that my friend laughed when we debated her using

PAR methodology and I suddenly declared she needed to *embrace the emotion!* of it. This spoke of my many sentiments during the research process, emanating from the highs and lows of any research journey to the poignancy of colleagues exposing their emotional experiences. Overall, IPAR appeared effective in generating action related to wellbeing and from a reflexive perspective this encouraged my confidence in continuing the research effort.

6.4 Chapter summary

This chapter described how my reflexive research conduct affected WbP processes, and how IPAR principles and values provided a constant foundation to guide my research practice. The chapter emphasised the need for vigilance in assessing how my behaviours affected participant engagement and relationship. As participatory approaches do not aspire to a final project summary but are always incomplete representations of events (Winter and Munn-Giddings, 2001) and renewed critical analysis may be applied to historical data (Mauthner and Doucet, 2003), I do not view this as an account which is permanent, but which reflects my current perceptions. The final chapter, Chapter 7, *Conclusions and going forward*, considers how these knowledge claims may be taken forward to support wellbeing into the future.

Chapter 7 Conclusions and going forward

7.1 Introduction

The most powerful driver of the WbP was the belief that LW HCWs could surface, make palpable, and share collective wisdom towards wellbeing. This belief was realised. Frontline HCWs created a cultural shift towards nurturing wellbeing. It is proposed that by adopting WbP processes within workplaces, organisations would address the imperative that they meet the basic human needs of their employees. This chapter lays a foundation in practice as to how HCW wellbeing may be fundamentally enhanced. Critically, retention rates promise to be positively impacted by the creation of an inclusive and compassionate workplace environment. Practical ways forward to explore the important question of how HCWs feel at work is presented in a framework for action in practice, policy, and education. Recommendations follow the chapter summary. It is important to emphasise that the WbP's ambitions lay in enhancing wellbeing within a local setting. It was not anticipated to remedy the existing NHS structural problems of workforce shortages and chronic excessive workload (West et al., 2020).

7.2 Wellbeing Project aspirations realised

Healthcare workers from all occupational groups within one NHS Labour Ward in England participated in the first known IPAR study towards enhancing HCW wellbeing. The WbP aimed to develop a caring collegial environment within which paths to enhancing individual and collective wellbeing would be created. The research question explored *how* this may be progressed. A positive psychology enquiry was designed to uphold colleagues' affect, and IPAR methodology to draw frontline HCWs into research activities.

Over an 18-month period, colleagues created a self-perpetuating momentum of positivity. Improved morale and camaraderie shifted the prevailing culture toward nurturing wellbeing. This was realised by sharing daily work-life experiences which uplifted wellbeing, and raising awareness of the needs of others. Dialogue and learning were stimulated, which together increased proactive compassionate behaviours and teamworking. Reaching out to colleagues, whose views were not conventionally considered, softened hierarchical divides and emphasised each person's value. Practical changes - for colleagues and women - were made in both clinical practice and in the environment. Communication networks beyond LW were instigated and continue to expand and improve wellbeing resources. In March 2022, as a result of the WbP findings, a Colleague Support Midwife (CSM) role was established for Trust maternity services. Eight midwives have taken up part-time posts. I am now working

15 - 22.5 hours per week as a CSM and intend to explore a similar role for volunteers. The next challenge lies in utilising WbP learning within national and international interventions for HCW wellbeing. While fears concern the condition of the entire NHS organisation, the WbP demonstrated the strengths of frontline HCWs in generating restorative action. The following makes the case for cultures to be shaped bottom-up.

7.3 Why local initiatives

With an intensity never seen before, the Covid19 pandemic threw the spotlight onto HCWs' lives, exposing the fragility of service provision. Suddenly, the reality of acute HCW shortages, imposed on pre-existing chronic deficiencies, raised alarm. Since inception of the WbP in 2016, the profile of HCW health and wellbeing has expanded beyond any previous level known in UK consciousness. From muted acknowledgement that good HCW welfare held advantages beyond individual health, an immense related industry has been constructed.

There is an urgent need to address the crisis in the healthcare workforce. England's maternity services carry a minimum deficit of 496 obstetricians and 1932 midwives (House of Commons Health and Safety Select Committee [HCHSCC], 2021a), contributing to high levels of burnout in UK practitioners (Bourne et al., 2019; Hunter et al., 2018). The projected NHS workforce shortfall is estimated to represent 231,280 of the 1,465,716 anticipated funded posts for 2025 (HCHSCC, 2021a). Retention is a core problem. A fifth of doctors plan to retire early, once Covid19 abates, and the same proportion to leave medicine completely (HCHSCC, 2021a). Over half of midwives responding to a RCM survey in 2021 were considering leaving midwifery, 57% within the next year (RCM, 2021). A pressing need exists to improve working conditions, not only out of respect for HCWs who overwhelmingly apply themselves to their roles and continue to work despite high burnout (Dixon-Woods et al., 2014), but to meet future service demands. National guidance has now explicitly stated that HCWs' wellbeing matters to the same degree as patients' wellbeing (NHSE, 2020). There is a strong imperative to translate this statement into action. Reports indicate continued deterioration of the ill-heath in HCW populations, including mental ill-health contributing to 25% of NHS absences (Copeland, 2019).

National UK policy prioritises inclusive and compassionate cultures being established (NHSE, 2020; Welsh Government, 2019; Scottish Government, 2017; Northern Ireland Government, 2016). Accelerated by Covid19 demands, a multitude of tools related to improving workplace conditions has been developed. Two are used to illustrate the type of

resource provided. The first, a *Workplace behaviour toolkit* (RCOG, 2022), focusses on promoting desirable workplace behaviours and the second, *Improving staff retention* (NHS Employers, 2022), guides managers and employers in factors affecting workforce retention. Although addressing different aspects of NHS concern, proposed solutions are derived from a common aspiration, namely, shaping a positive culture. The same behaviours which nourish wellbeing are those which induce HCWs not to leave. All the methods - including offering compassion, listening to HCWs, giving positive feedback, offering gratitude, checking in with new-starters, leading by example, being always civil - are included in both sets of tools. The shared ambition is to create cultures in which HCWs desire to belong. Health bodies present cultures fostering inclusion, compassion, and belonging, as transformative to HCW health (HCHSCC, 2021b, NHSE, 2020). Lack of provision of practically applicable strategies has, nevertheless, provoked significant criticism (HCHSCC, 2021a). A dissonance exists between the lived experiences of HCWs and, for example, the People Plan recommendations (NHSE, 2020). Despite the paucity of food outlets worsening HCW difficulties and being considered fundamental to improved wellbeing (HEE, 2019; West and Coia, 2019), the subject is not addressed in recommendations. By contrast, Schwartz rounds are recommended, albeit that HCWs report being too mentally exhausted to engage with such (often inaccessible) resources (Quirk et al., 2018), and talk of simply surviving daily demands (Ravalier et al., 2020). Wellbeing activities unaligned to work demands risk HCWs becoming alienated, and feeling their daily realities, being misunderstood, will remain unresolved. This is likely to make HCWs withdraw from relationships beyond their work-unit culture and from the terminology of *our peopl*e, which dominates NHS literature on culture (NHSE, 2020; NHS Employers, 2022).

The terminology of *our peopl*e conceivably intends to unite the entirety of workers under the umbrella of one culture. The issue lies in failing to reflect the kaleidoscope of NHS cultures, and to acknowledge the fluctuating subcultures which constantly produce change in workers' interactions (Shale, 2019). Wellbeing Project participants were keen to describe feelings of family and belonging to LW, but none extended these sentiments to the Trust. Workplace cultures are often unrelated to overarching organisational cultures (Dixon-Woods et al., 2014), and HCW loyalties are liable to become increasingly localised as breaks/training away from workplaces occur more rarely. Hence, calls for systems to develop local plans (NHSE, 2020) merit being as local as individual wards. The literature review of Chapter 2 found no quick-fix solutions. Both structural and cultural problems impact factors around HCW wellbeing and consequently patient safety. In the absence of sudden reversal of structural issues, there is urgent need for rapid expansion of positive cultures to actively protect these concerns. Healthcare workers *generally have the solutions* (HCHSCC, 2021b,

p18). When trusted to act independently, they thrive in terms of reduced stress (West and Coia, 2019), indicating that initiatives may more successfully be engineered bottom-up than top-down. Despite the NHS being a large organisation welcoming standardisation across its heath-units (Ballatt and Campling, 2011), when control is relinquished more locally, changes necessary to building desirable cultures are effected (HEE, 2019). As witnessed in the WbP, changes need to be role-modelled from within, embracing and enveloping all those in the setting, as opposed to being addressed as discrete phenomena (Shale, 2019).

When HCWs aspire to achieve an intended objective, a unified group approach embeds the initiative. Labour Ward HCWs expressed a need to belong, to the extent of identifying a sense of family. When social connections were given the opportunity to develop, a culture emerged which cultivated compassion - both horizontally and vertically - between HCW peers, leaders, and new-starter colleagues. Healthcare workers need to be recognised as active participants in producing their own work-world and creating the cultures they live in (Crowther et al., 2016; RCOG, 2011). The ways in which the WbP fostered this type of personal responsibility - as well as how methods can be applied within the wider NHS community - is important to consider. The WHO (2010) recommends that case studies promising good effect are used to guide workplace changes. It considers processes may be as impactful as final effects, and that details of process experiences should consequently be described. In sharing WbP process, elements considered instrumental to enhancing wellbeing offer a foundation for other similar workplace initiatives, as follows.

7.4 A framework for action in practice

Wellbeing strategies need to comprehend and embrace the complexities inherent in workplace cultures and build local responses for HCW wellbeing. No two workplaces include the same working conditions, yet particular elements of the WbP may hold relevance for other settings. Two factors considered as most effective in enhancing LW HCW wellbeing particularly justify further attention. Firstly, the general processes which effected the culture shift towards nurturing wellbeing and, secondly, the more specific positive influence of a support person in the workplace. Firstly, IPAR methodological approaches supported colleagues acting in community. Insider PAR allowed LW HCWs to learn first-hand how much difference a smile makes, using a name, reaching out to be useful to another. A feeling emerged of not simply working together but being authentic as people, not only as HCWs. Although the WbP derived from an academic enquiry, a research orientation is not a prerequisite to initiatives. To facilitate improvements in practice and in

environmental conditions, colleagues may independently start the process using the elements presented in Figure 7.1 - First steps to wellbeing initiatives.

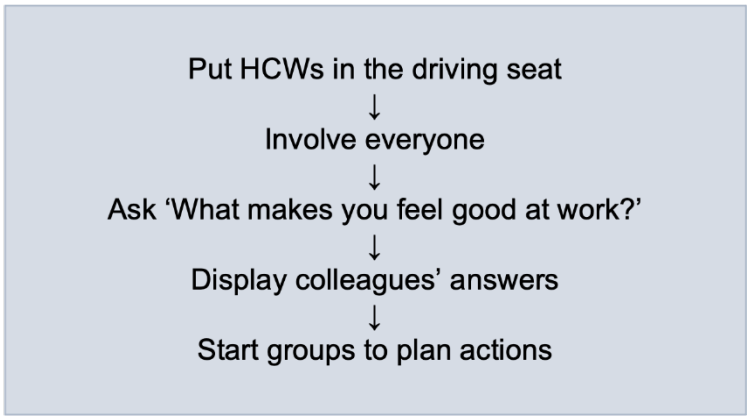

Figure 7.1 First steps to wellbeing initiatives

The intention of the WbP was to avoid imposition of pre-defined activities, and instead to celebrate positive experiences which held significance for HCWs. While there may be broad understanding around inclusivity and compassion, Kline (2019) talks of how teams and organisations struggle to know how to implement culture change, and how few interventions have been systematically evaluated. Liberati et al. (2021, p445) refer to *actionable guidance* being more useful than generalised recommendations. The WbP may be viewed as a tangible tool from which the first steps can be taken. The elements could be introduced into leadership programmes to provide a platform for simple and achievable action. Experience and confidence could build, whether in a team of medical secretaries, or in an Emergency Room. Although some nationally planned proposals may feel disconnected from HCWs' lived experience, the WbP may be perceived as more locally relevant and attainable. The setting is comparable to other healthcare areas, evidence confirms action has been implemented, and promising effects have been demonstrated. A practical, inexpensive strategy is offered.

Furthermore, the WbP was located in the HCW workplace, a strategy which has been identified as encouraging more effective engagement (Quirk et al., 2018). Historically, HCWs fail to appreciate the psychological impact of their roles on their mental health (HEE, 2019) and performance (Manser, 2009). Research has confirmed that maternity HCWs have neglected self-care by both hiding emotional distress (Hunter et al., 2018) and by failing to access support, even after traumatic events (Slade et al., 2020). Labour Ward culture, as a living phenomenon, was nourished from within. Minimal HCW exertion was demanded, and progress built gradually forward. Such a dynamic may attune to those unaccustomed to recognising the need for and seeking self-care.

Secondly, the CSM/W role is proposed as a strategy to provide direct systems support to HCWs during duty hours. A CSM/W regularly available in the workplace would offer opportunities for HCWs to talk with a non-clinical person. Mental health is recognised as a fluid, variable condition (HEE, 2019), and poor workplace conditions are associated with increased risk of mental health issues (Harvey et al., 2017). The intention would not be for CSM/Ws to provide a therapeutic response, but to be accessible as a listening ear, and to guide HCWs to local and national resources. Such a role would complement national guidance recommending that every HCW engage, at least annually, in a health and wellbeing conversation (NHSE, 2020). There is also potential for creation of a volunteer service. Healthcare workers can develop strong loyalties to workplaces. Both they and their colleagues are likely to benefit from a role of volunteer in part-time employment or semi/post retirement stages.

No single factor determines critical change in any workplace. Nevertheless, combining cultures nurturing wellbeing with implementation of CSW support would signal to HCWs that their needs were acknowledged and being responded to. Witnessing such behaviour from the organisation would potentially extend HCW connection and belonging beyond base workplaces. The language of *our people* may resonate more authentically, and the organisational culture be more relatable to individual workplaces.

7.5 Action in policy and education

Policymakers are responding to the need to build compassionate and inclusive healthcare cultures (NHSE, 2020; Welsh Government, 2019; Scottish Government, 2017; Northern Ireland Government, 2016). Nevertheless, health policy appears under-developed in how this may be achieved. Proliferating advisory documents (NHS Employers, 2022; NHSE 2020) direct managers in driving cultural change, without equally strongly positioning power and control within the much larger body of frontline workers. Within LW, once the WbP was sanctioned, the manager merged within the colleague group. Dependency for action and change was directed away from the individual manager, and shared learning and interdependency conveyed back. To reap rewards, policymakers need to focus on the capacity of frontline workers. Shifting policy to include this group will draw from a much larger reservoir of those who are not only committed to improving their own wellbeing, but are intimately conversant with real-world conditions. As the WbP illustrated, when motivation lives within the community of HCWs, nurturing a positive culture is rooted in everyday ambitions. Funding must follow to allow protected time for initiatives to be established in a bottom-up direction, supported by relevant training.

Additionally, actions towards positive workplaces promise to be more effective if those entering workplace settings possess pre-understanding. This would include new-starters from all occupational groups during induction programmes, and in formal educational settings. The latter may include student midwives, student doctors, and student theatre practitioners. These groups' registered practitioners' standards of practice all require understanding of how patient safety depends on both maintenance of one's personal health and collaborative, interdisciplinary teamworking (NMC, 2019; Health and Care Professions Council, 2018; GMC, 2013). The theoretical development of the LW culture shift was presented in Figure 4.8. This, or a similar model, could introduce learning around behavioural dynamics to encourage preparedness and perspective-building prior to clinical experience. Human factors training relates to:

> *Environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.*
> (Health and Safety Executive, 2022)

Understanding of human factors' impact on patient outcomes provides the rationale for those who work together to train together, as exemplified in interdisciplinary *PRactical Obstetric Multi-Professional Training* (PROMPT) educational sessions (Liberati et al., 2019). Within human factors training, appreciation of the individual and collective responsibility entailed in culture-building could be developed. Practice scenarios could illustrate the clinical impact of HCW psychological safety and teamworking. Tools such as the pre-operative checklist, for example, exist to avoid error in surgical procedures (WHO, 2009). Nevertheless, if the patient dies because the surgeon's intimidating behaviours inhibit a HCW reporting signs of deterioration until too late, these are rendered worthless. Additionally, much attention concentrates on less compassionate behaviours, such as bullying, yet new-starters/students could use the model to learn the impact of more constructive behaviours. Rather than conforming to a given culture, individuals could proactively role-model a different and more desirable reality.

Section 5.9 discussed future research related to the WbP experience. Although largely referring to UK healthcare environments, messages concerning compassionate and inclusive cultures, and associated restorative behaviours, would resonate nationally and internationally, regardless of service configuration differences. Applying WbP learning, and principles and practice of participatory approaches, is likely to be profitable wherever human beings engage in group enterprises. The WbP demonstrated the simple, daily ways in which cultures nurturing wellbeing could be encouraged.

7.6 Chapter summary and recommendations

Healthcare workers navigate challenging circumstances daily. Motivated by personal drivers and by a feeling of belonging within a group of colleagues, they strive to create optimum experiences for those in their care. In this insider participatory action research study, shared aspirations grew from collaborative learning. Enhancing the wellbeing of LW colleagues, by nourishing basic human needs, successfully fostered the growth of a compassionate and inclusive culture. The WbP thus provides an example of how the *feel-good factor* flourishes in processes which value the positive, participatory, and practical. It is anticipated that by sharing our experiences, organisations and practitioners will be inspired to enhance colleagues' individual and collective wellbeing. The vital importance of healthcare organisations meeting their employees' basic human needs cannot be overemphasised. Wellbeing requirements must be addressed in order to retain the HCWs essential to maintaining NHS services.

7.6.1 Recommendations

1. Embed the ambition for cultures which nourish wellbeing in health policy and in all HCW education, induction, continuing professional development, and leadership programmes

2. Invest in, and trust, frontline workers to independently drive wellbeing initiatives

3. Emphasise and build on positive workplace experiences

4. Create imaginative methods to share colleague accounts and planned/achieved actions

5. Invest in regular interdisciplinary opportunities for wellbeing dialogue and action planning

6. Undertake research into the impact to HCW wellbeing of the CSM/W role and subsequently the potential for volunteer support workers.

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Appendices

Appendix 1 Search strategy

This table provides the Medline database search strategy on 10-5-17, using ProQuest on Healthcare Databases Advanced Search.

Current search strategy: MEDLINE 10-5-17

	Database(s)	Search Term		
1	Medline	(participatory).ti,ab	View Results (8,690)	Edit
2	Medline	(participative).ti,ab	View Results (1,013)	Edit
3	Medline	(action research).ti,ab	View Results (32,819)	Edit
4	Medline	*(1 OR 2 OR 3)*	View Results (41,071)	
5	Medline	(intervention).ti,ab	View Results (448,529)	Edit
6	Medline	(evaluation).ti,ab	View Results (976,356)	Edit
7	Medline	(stress management).ti,ab	View Results (18,808)	Edit
8	Medline	(wellbeing).ti,ab	View Results (59,587)	Edit
9	Medline	(well being).ti,ab	View Results (186,613)	Edit
10	Medline	(well-being).ti,ab	View Results (54,263)	Edit
11	Medline	*(5 OR 6 OR 7 OR 8 OR 9 OR 10)*	View Results (1,568,789)	
12	Medline	exp "HEALTH PERSONNEL"/	View Results (437,058)	Edit
13	Medline	*(4 AND 11 AND 12)*	View Results (571)	
14	Medline	*13*	View Results (571)	
15	Medline	*13 [DT 2000-2017] [Human age groups Adult] [Languages English]*	View Results (147)	

All | Rerun Searches | Refresh Search | Copy | AND OR Combine | Delete Selected | Export Options

Medline terms formed the basis of searches, but were adapted according to search terms available on individual sites.

The content lists of the following online journals were searched 3-6-17:

- Action Research
- Systemic Practice and Action Research
- International Journal of Action Research
- International Journal and Organizational Renewal

The following databases were searched 19-8-17, 13-10-17, and 3-1-18:

- Centre for Reviews and Dissemination, University of York
- Campbell Collaboration Database
- Evidence for Policy and Practice Information and Coordinating Centre (EPPI-Centre)
- Cochrane Database of Systematic Reviews

Google pages were searched regularly during the literature search period, until no new literature appeared.

Appendix 2 Interview prompt guide

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Individual interview

Preamble, make comfortable, offer drink and light refreshments

- When have you felt really good within yourself, while you've been working on Labour Ward? Can you tell me about the experience?
- What's really important about this experience? What made you value it so much?
- What other things were in place around you at the time to make it possible for this to happen?
- In relation to what you have just said, what sort of things do you think we could be doing more of on Labour Ward, to make ourselves feel as good as we can?
- If you had one wish for yourself, your team, or your organisation in relation to how you and your colleagues feel at work, what would it be?
- Is there anything else that you would still like to talk about?

Thank for time, and say any further discussions would be welcome if wished

Group discussion

Preamble, make comfortable, offer drinks and light refreshments

Face to face group only - activity in pairs (10 mins)

- What's been one of the best experiences of your professional life?
- What's been really important about this experience? What made you value it so much?
- What do you value most about your work?
- Without being overmodest, what do you value most about yourself and the way you do your work?

Face to face and online group:

- In relation to how you feel working on the Labour Ward, what experiences leave you feeling good within yourself?
- If you can think of a particular experience that made you feel good, what other things were in place at the time to make it possible for this to happen?
- Given all the examples you have offered, what sort of things could we be doing more of to make these experiences happen more regularly?
- If you had one wish for yourself, your team, or your organisation in relation to how you and your colleagues feel at work, what would it be?
- Is there anything else that you would still like to talk about?

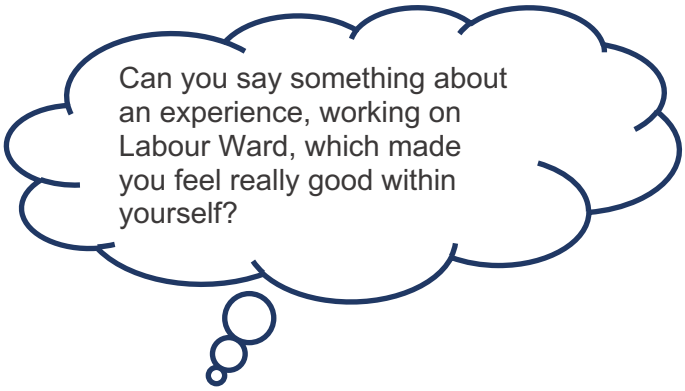
Thank for time, and say any further discussions would be welcome if wished

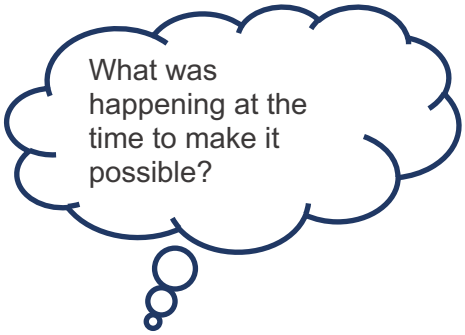
Appendix 3 Questionnaire

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Please read the Participant Information Sheet before choosing if you would like to carry on. This gives details of how information you give will be used and stored. Submitting the questionnaire will be considered as giving consent to taking part. Unless you add your name at the bottom of the form, your identity will not be known.





… and that maybe we could do more of…

*You do **NOT** need to respond to this section unless you choose to*

To maintain anonymity, no names or job roles will appear with quotes from these questionnaires.

If you DO wish your name to appear on Labour Ward displays and in publications with quotes of what you have written, please record your name here:

If you DO wish job role to appear on Labour Ward displays and in publications with quotes of what you have written, please record this here:

Thank you very much

Appendix 4 Cover email study start

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Dear colleague

My name is Claire Wood and I am a midwife on the Labour Ward at the [Hospital Name]. I will try to be short as I appreciate you will have limited time.

I am starting a project aimed at building our own and each other's wellbeing at work. It is based on the belief that workers themselves know best what they need at work and what will make a difference to their health. All staff working on Labour Ward staff are to be involved and, as you regularly work there, your opinions and input would be very valuable. The essence is to explore experiences which made us feel positive at work and use these to bring about practical differences in how we work, and in how we feel at work.

There are many ways in which you might be involved, ranging from putting short comments on a questionnaire, to giving an interview, or being part of a group making changes (based on colleagues' feedback). The different options are given in the Participant Information Sheet, which also tells you how any information you give will be used and stored. The initiative is expected to run until early 2020.

I have attached two forms:

- a **Participant Information Sheet** - to read the details of the study before you consider taking part

- a **Questionnaire** - anonymous (if you wish), with 2 questions

You are welcome to print off the questionnaire, write some comments, and post it in the Wellbeing boxes on Labour Ward (Handover and Staff Sitting rooms), **or** you can follow this link https://www.smartsurvey.co.uk/s/LabourWardWellbeing/ to complete the questionnaire online. It can take only a few minutes – it depends on the length of your comments. Quotes from questionnaires will be displayed on Labour Ward staff areas for others to see and add

comments to. No-one will know who the quotes are from unless you choose to identify yourself on the questionnaire. If you add your name to the questionnaire, your name will be added to any quotes used on Labour Ward displays and publications. There is no limit to how many times you may submit a questionnaire.

Please contact me if you have any questions or comments. I will be spending long periods on Labour Ward, so you can talk to me there, or telephone [Number] or email claire.wood14@nhs.net.

Thank you very much.

Best wishes

Claire Wood

Appendix 5 Prompt guide – Implementation process and effect

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Individual interview/group discussion

Preamble, make comfortable, offer drink and light refreshments

Process - Intervention

- How did you hear about the wellbeing project?
- Do you know when this was (roughly)?
- Do you know how you could have taken part if you wanted to?
- Do you know of any activities which have been started since the study began?
- Are you aware of any feedback from activities which has been available to staff?
- If you have taken part in any activities, have you been involved in making any decisions?
- Has there been anything about the project which has put you off offering your views?

Process – Context

- Have you had any changes in your role or workplace which might have affected how the project activities could develop?

Process – Mental models

Statement: The goal of the study activities is to develop how good we feel at work

- To what extent do you think the activities have affected how you feel at work?
- How do you think Labour Ward staff feel about the potential for their wellbeing to be affected by the study activity?
- What do you think about the project goals overall?
- How do you feel about the project activity from when you first heard about it to now?

Effect

- Since the project started, do you feel you are doing anything differently in your role on Labour Ward?
- Since the project started, do you feel you are thinking differently about anything related to your role on Labour Ward?
- (If interviewer does not already know this) Have you got involved in any way in the project?
- Is there anything you would like to be changed so that you could take part/take a greater part?
- Are you aware of any changes which the project activities have brought about on Labour Ward?
- In relation to your health and wellbeing at work since the project started, have you yourself felt any differences?

Thank for time and say any further discussions would be welcomed if wished

Appendix 6 Health Research Authority approval

Mrs Claire Wood
Faculty of Health, Social Care and Education
Kingston University and St George's, University of London
6th Floor, Hunter Wing
Cranmer Terrace
SW17 0RE

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

03 September 2018

Dear Mrs Wood

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach**
IRAS project ID:	**239900**
REC reference:	**19/HRA/0334**
Sponsor:	**Kingston University, London and St George's, University of London**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)

- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. After entering your IRAS ID you will be able to access a password protected document (password: **White22**). The password is updated on a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Commencing research activities at any NHS organisation before providing them with the full local information pack and allowing them the agreed duration to opt-out, or to request additional time (unless you have received from their R&D department notification that you may commence), is a breach of the terms of HRA and HCRW Approval. Further information is provided in the "*summary of assessment*" section towards the end of this document.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Professor Andrew Kent
Tel: [redacted]
Email: [redacted]

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **239900**. Please quote this on all correspondence.

Yours sincerely

Aliki Sifostratoudaki

Assessor

Email: hra.approval@nhs.net

Copy to: *Professor Andrew Kent, Kingston University and St George's, University of London, Sponsor contact*
Ms Joanne Thornhill, Research and Development, [Hospital] R&D contact

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below

. Document	*Version*	*Date*
Copies of advertisement materials for research participants [Poster Study Start - Appendix 1]	1.0	25 July 2018
Copies of advertisement materials for research participants [Poster Online Facebook Consultation Group - Appendix 8]	1.0	25 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Kingston University clinical trials insurance 2018-19]		01 August 2018
Interview schedules or topic guides for participants [Prompt Guide Wellbeing Interview - Appendix 7]	1.0	25 July 2018
Interview schedules or topic guides for participants [Prompt Guide Implementation Process/Effect - Appendix 11]	1.0	25 July 2018
IRAS Application Form [IRAS_Form_23082018]		23 August 2018
Letter from funder [Funding Confirmation (Royal College of Midwives)]		
Letter from funder [Funding Confirmation (Faculty of Health, Social Care and Education)]		

Letters of invitation to participant [Cover Email Study Start - Appendix 4]	1.0	25 July 2018
Letters of invitation to participant [Cover Email and Online Questionnaire - Appendix 5]	1.0	25 July 2018
Letters of invitation to participant [Cover Email Online Facebook Consultation Group - Appendix 9]	1.0	25 July 2018
Non-validated questionnaire [Questionnaire - Appendix 3]	1.0	25 July 2018
Other [Sponsor details IRAS 239900 30-8-18]		
Other [Contact Sheet - Appendix 6]	1.0	25 July 2018
Other [Ground Rules Online Facebook Consultation Group - Appendix 10]	1.0	25 July 2018
Other [References IRAS form]		14 August 2018
Other [Kingston University employers liability certificate 2018]		01 August 2018
Other [Kingston University professional indemnity insurance 2018-9]		01 August 2018
Other [Kingston University employers, public, products liability 2018-9]		01 August 2018
Participant consent form [Consent Form 1 - Appendix 12]	1.0	25 July 2018
Participant consent form [Consent Form 2 - Appendix 13]	1.0	25 July 2018
Participant information sheet (PIS) [Participant Information Sheet V1.1 30-8-18]	1.1	30 August 2018
Referee's report or other scientific critique report [Scientific critique report]		01 June 2018
Research protocol or project proposal [Protocol V1.0 25-7-18]	1.0	25 July 2018
Summary CV for Chief Investigator (CI) [Mary Chambers CV July 2018]		02 July 2018
Summary CV for student [Claire Wood CV 2-8-18]		02 August 2018
Summary CV for supervisor (student research) [Jayne Marshall CV June 2018]		02 June 2018
Summary CV for supervisor (student research) [Karen James CV 2018]		02 August 2018
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Protocol Flowchart 25-7-18]	1.0	25 July 2018

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	The Applicant confirmed that Kingston University is the Sponsor for research and enterprise activity undertaken by the Joint Faculty of Kingston and St George's which is a joint venture of both institutions. Therefore it is responsible for the management and governance of research projects, including ensuring that insurance arrangements are in place.

2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	As this is a student study operating at a single site and with no REC review, a Statement of Activities and Schedule of Events would not be expected. Although formal confirmation of capacity and capability is not expected of all or some organisations participating in this study, and such organisations would therefore be assumed to have confirmed their capacity and capability should they not respond to the contrary, we would ask that these organisations pro-actively engage with the sponsor in order to confirm at as early a date as possible. Confirmation in such cases should be by email to the CI and Sponsor confirming participation based on the relevant Statement of Activities and information within this letter.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	This study is receiving funding from Kingston University and St George's, University of London, Faculty of Health, Social Care and Education and the Royal College of Midwives (PhD and fellowship funding). The funding letters have been provided.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments

6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one site type in this study – research sites. Research sites will be responsible for all activity as listed in the Protocol.

If this study is subsequently extended to other NHS organisation(s) in England or Wales, an amendment should be submitted, with a Statement of Activities and Schedule of Events for the newly participating NHS organisation(s) in England or Wales.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Principal Investigator (PI) would be expected at this site type. The PI has been identified as the Chief Investigator.

GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

No access arrangements are expected as all study activity at the participating NHS organisation will be undertaken by NHS staff who have a contractual relationship with the organisation.

Appendix 7 NHS permissions

Tue 02/10/2018 16:41

Sent on Behalf of the [Site] Study Set Up Team

Dear Claire,

Study Title:	Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach
DHFT Study Reference:	DHRD/2018/091
IRAS ID:	239900
Chief Investigator:	Claire Wood
Sponsor:	Kingston University
Funder:	Kingston University

Further to the above study being issued with HRA/REC approval, this email confirms that [Trust name] agree to take part in the above study **at the following site(s):**

[Trust name]

Should there be any changes to the study please send notification of any amendments [Email address].

Also, please find below the list of HRA and R&D approved documents, for this study:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Poster Study Start - Appendix 1]	1.0	25 July 2018
Copies of advertisement materials for research participants [Poster Online Facebook Consultation Group - Appendix 8]	1.0	25 July 2018
Interview schedules or topic guides for participants [Prompt Guide Wellbeing Interview - Appendix 7]	1.0	25 July 2018
Interview schedules or topic guides for participants [Prompt Guide Implementation Process/Effect - Appendix 11]	1.0	25 July 2018
IRAS Application Form [IRAS_Form_23082018]		23 August 2018
Letters of invitation to participant [Cover Email Study Start - Appendix 4]	1.0	25 July 2018
Letters of invitation to participant [Cover Email and Online Questionnaire - Appendix 5]	1.0	25 July 2018
Letters of invitation to participant [Cover Email Online Facebook Consultation Group - Appendix 9]	1.0	25 July 2018
Non-validated questionnaire [Questionnaire - Appendix 3]	1.0	25 July 2018
Other [Contact Sheet - Appendix 6]	1.0	25 July 2018
Other [Ground Rules Online Facebook Consultation Group - Appendix 10]	1.0	25 July 2018
Participant consent form [Consent Form 1 - Appendix 12]	1.0	25 July 2018
Participant consent form [Consent Form 2 - Appendix 13]	1.0	25 July 2018
Participant information sheet (PIS) [Participant Information Sheet V1.1 30-8-18]	1.1	30 August 2018
Research protocol or project proposal [Protocol V1.0 25-7-18]	1.0	25 July 2018
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [Protocol Flowchart 25-7-18]	1.0	25 July 2018

Please contact us using the contact details below if you require any further information.

Yours sincerely,

[Name]
Clinical Trials Manager

[Site address and contact details]

Appendix 8 Participant information sheet

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Claire Wood, Professor Mary Chambers, Professor Jayne Marshall, Dr Karen James

Invitation to participants

You are invited to take part in a study exploring how to make an impact on your own and your colleagues' wellbeing at work. My name is Claire Wood and I work as a midwife on the Labour Ward at [Hospital Name]. Please take time to read the following information and discuss it with others if you wish. The study is towards a Doctor of Philosophy (PhD) degree awarded by Kingston University, London. Please feel free to ask me any questions - see my contact details and those of my supervisory team on the last page.

What is the purpose of the study?

Wellbeing means health and happiness and the whole way we feel about our lives. The purpose of this study is to find ways to develop our wellbeing and to bring about practical differences in how we work, and in how we feel at work, by building on experiences which we remember as being positive.

Why have I been invited to take part?

As you regularly work on the Labour Ward, you know best what would make a difference to how you feel at work. All staff are being invited to take part (including receptionists, healthcare assistants, medical staff, domestic staff, housekeepers, midwives, and theatre staff) to include everyone's ideas.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part, you can commit as much or as little time as you like to being involved. You are free to stop or pause at any point, without giving any reason and without any detriment to you.

What will happen if I do take part?

You can take part at any point during the study in different ways:

- one to one interviews
- group discussions
- questionnaires in writing or online

Initially you can offer your views as to what makes you feel good at work by taking part in an individual interview or in a group discussion. These may be pre-planned discussions or ones which take place at work as the opportunity arises, and will vary in length depending on what you and others decide. You can also complete a short questionnaire in writing or online. Summaries of what staff say will be displayed on Labour Ward for you to add comments to. All of this information will then be reviewed by Action Groups. These groups will be made up of Labour Ward staff volunteers who will plan how we might work differently, put plans in action, and assess how much impact the action had, before planning further

action. Various groups may work on different topics. As plans progress, you may also give feedback on your experience of the project, as an individual or in a group.

If you do take part, you will be given a copy of this information sheet to keep. You will be asked to sign a consent form if you take part in any interviews or group discussions. All information from these and from questionnaires will be made anonymous and kept confidential on Labour Ward displays/any publications unless you choose to identify yourself by including your name. Audio-recording pre-planned interviews and group discussions helps accuracy but, if you prefer, written notes will be used instead.

What are the possible benefits of taking part?

Being part of such a study has been reported as enjoyable in itself, and the study is designed to bring about positive changes in our wellbeing, but it is not known whether you will directly benefit. New knowledge from this study may be used by other workplaces in future.

What are the risks of taking part?

There are no physical risks. If you find any aspects of discussions difficult or upsetting, you are free to take a break at any time, or stop taking part. Contacts of suitably qualified staff who can provide you with additional support are detailed at the end of this information sheet and on study posters displayed on Labour Ward.

What should I do if I want to take part?

I intend to be available for long periods on the Labour Ward until early 2020. If you wish to take part, you can tell me in person, phone or email me, or complete a Contact Form to post in one of the Wellbeing Boxes in the Handover Room and Staff Sitting Room.

What will happen to the data (information) you give:

All information will be handled in confidence and, unless you choose to be identified, will be made anonymous so that you cannot be identified. Information which you give will be reviewed within Action Groups and by myself and my supervisors. Kingston University is the sponsor for this study based in England and will be using information from you in order to undertake this study and act as the data controller. This means that Kingston University are responsible for looking after your information and using it properly. Kingston University will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as Kingston University need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, Kingston University will keep the information about you that it already obtained. To safeguard your rights, it will use the minimum personally-identifiable information possible. You can find out more about how your information is used by contacting myself (Claire Wood) or my supervisors.

Information will be collected from you at [Hospital Name] for this research study, in accordance with Kingston University instructions. Individuals from Kingston University and regulatory authorities may look at research records to check the quality and accuracy of the study. The only people in Kingston University who will have access to information that identifies you will be people who need to contact you to audit the data collection process. [Hospital Name] will not keep any identifiable information about you.

Your information could be used for any aspect of health research. Where this information could identify you, it will be held securely with strict arrangements about who can access the information. Where there is a risk that you can be identified, your data will only be used in research that has been independently reviewed by an ethics committee.

Should any unsafe clinical practice become known, Trust policy will be followed.

What will happen to the findings of the study?

As the study progresses, findings and plans for developing wellbeing will regularly be displayed on Labour Ward and discussed at staff meetings. Once the study is over, a written report will be made available to you. I will write up the findings in a thesis as part of my PhD studies and will submit the findings to a suitable journal. In any publications, reports, or conference presentations you will not be identified in any way unless you wish to be. Copies of any publications and conference reports will be made available in staff areas.

Who has reviewed this study?

The study has been reviewed by the Health Research Authority and an independent group within Kingston and St George's Faculty of Health, Social Care and Education (FHSCE) Research Ethics Committee to protect your safety, rights, and dignity. They have given a favourable opinion. [Hospital] has also approved the study.

Who is organising and funding the research?

The FHSCE at Kingston and St George's is sponsoring the study. I, Claire Wood, am organising and funding the research with part-funding from FHSCE fellowship funding and the Royal College of Midwives Ruth Davies Bursary award 2018.

What if I have a complaint?

If you wish to complain about the conduct of the study, please contact a member of the supervisory team using the details below. If you remain unhappy and wish to complain, you can do this through the NHS Complaints Procedure, details of which the Trust will provide.

Researcher and supervisory team contact details:

Researcher
Claire Wood
Midwife
Labour Ward
[Hospital details]

Telephone: [Mobile]
E-mail: claire.wood14@nhs.net

Supervisor
Professor Mary Chambers
Professor of Mental Health Nursing
Faculty of Health, Social Care and Education
St. George's, University of London
Hunter Wing, 6th Floor
Cranmer Terrace
Tooting, SW17 ORE

Telephone: [redacted]
E-mail: m.chambers@sgul.kingston.ac.uk

Supervisor
Professor Jayne Marshall
Foundation Professor of Midwifery
School of Allied Health Professions
College of Life Sciences
George Davies Centre
University of Leicester
University Road
Leicester LE1 7RH

Telephone: 0116 373 6849
E-mail: jayne.marshall@leicester.ac.uk

Supervisor
Dr Karen James
Post-doctoral researcher
[redacted]

Telephone: [redacted]
E-mail: [redacted]

*** Occupational Health** provide a wide range of services for well-being of employees.
Tel: [Hospital Details]

*** Counselling** by CiC offers independent, free, confidential expert guidance to all staff 24/7, including practical and emotional support with work or personal issues.

- Counselling and emotional support

- Debt and Financial Management
- Legal and tax advice
- Family care

Tel: 0800 085 1376 **e-mail:** assist@cic-eap.co.uk **Web page:** well-online.co.uk

Thank you very much for taking the time to read this information sheet

Appendix 9 Poster study start

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Calling all colleagues!

I will be starting a project on the Labour Ward from [Date], exploring how we can develop our own and each other's wellbeing at work. Everyone is welcome to be involved, to whatever extent they choose, looking at what makes us feel at our best at work, and how we can make that happen. Once the project starts, information sheets will be available on the Labour Ward, and emailed to you, to let you know how you can take part.

If you would like to talk about any aspect of the project in the meantime, please contact me in person - Claire Wood - or claire.wood14@nhs.net or [Mobile]

The research project is towards a Doctor of Philosophy (PhD) award with Kingston University, London and St George's, University of London.

Thank you very much

* **Occupational Health** provide a wide range of services for well-being of employees.
Tel: [Hospital details]

* **Counselling** by CiC offers independent, free, confidential expert guidance to all staff 24/7, including practical and emotional support with work or personal issues.

- Counselling and emotional support
- Debt and Financial Management
- Legal and tax advice
- Family care

Tel: 0800 085 1376 **e-mail:** assist@cic-eap.co.uk **Web page:** well-online.co.uk

Appendix 10 Cover email and online questionnaire

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Dear colleague

Please read the Participant Information Sheet (attached to email linked to this questionnaire) before choosing if you would like to carry on. Submitting the questionnaire will be considered as giving consent to taking part.

This questionnaire is part of a study exploring how to enhance our own and each other's wellbeing on Labour Ward. Any feedback you give, and your colleagues' feedback, will be used by staff Action Groups to decide which areas to focus action on. A cross-section of responses will be available on Labour Ward for you to see and add comments to.

- It can take only a few minutes to complete the two main questions, but this depends on the length of your comments.

You cannot be identified from the questionnaire unless you choose to leave your name. The Participant Information Sheet provides details of how your information will be used and stored.

Please contact me if you have any questions or comments. I will be spending long periods on Labour Ward, so you can talk to me there, or telephone [Mobile] or email claire.wood14@nhs.net

Thank you very much.

Claire Wood

[The link took participants to a questionnaire including the following]:

1. Can you say something about an experience, working on Labour Ward, which made you feel really good within yourself?

2. What was happening at the time to make it possible? … and that maybe we could do more of…

*You do **NOT** need to respond to this section unless you choose to*

To maintain anonymity, no names or job roles will appear with quotes from these questionnaires.

- If you DO wish your name to appear on Labour Ward displays and in publications with quotes of what you have written, please record your name here:

- If you DO wish job role to appear on Labour Ward displays and in publications with quotes of what you have written, please record your job role here:

Appendix 11 Consent form 1 (Anonymous)

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

	Please initial boxes
1. I confirm that I have read the information sheet (Date 30-8-18 Version 1.1) for the above study. I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. I understand that should I withdraw then the information collected so far cannot be erased and this information may still be used in the study analysis.	☐
3. I understand that data (information) collected from the study may be read by individuals from Kingston University, London and St George's, University of London, and regulatory authorities where it is relevant to my taking part in the study. I give permission for these individuals to have access to this data and to collect, store, analyse and publish information obtained from my participation in the study. I understand that my personal details will be kept confidential and that all other information will be made anonymous.	☐
4. I agree to take part in the above study.	☐

	Please initial boxes	
	Yes	No
5. I agree to the interview/group (delete as appropriate) being audio-recorded.	☐	☐
6. I agree to Action Groups reviewing the complete written record of interview/group audio-recordings, or to the researcher notes if audio-recordings were not made.	☐	☐
7. I agree to my role being added to any quotes of what I say on Labour Ward displays and in publications.	☐	☐

8. If the answer was YES to Question 7, please write your role as you would like it to be recorded:

	Please initial boxes	
	Yes	Not applicable
9. As part of an Action Group, I agree to keep all data (information) anonymous and confidential unless a participant has consented for his/her name and/or role to be used in publications	☐	☐

_____	_____	_____
Name of participant (PRINTED)	Signature	Date
_____	_____	_____
Name of researcher (PRINTED)	Signature	Date

Researcher: Claire Wood. Supervisory team: Professor Mary Chambers, Professor Jayne Marshall, Dr Karen James

Appendix 12 Consent form 2 (Identifiable)

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

	Please initial boxes
1. I confirm that I have read the information sheet (Date 30-8-18 Version 1.1) for the above study. I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. I understand that should I withdraw then the information collected so far cannot be erased and this information may still be used in the study analysis.	☐
3. I understand that data (information) collected from the study may be read by individuals from Kingston University, London and St George's, University of London, and regulatory authorities where it is relevant to my taking part in the study. I give permission for these individuals to have access to this data and to collect, store, analyse and publish information obtained from my participation in the study.	☐
4. I agree to take part in the above study	☐

	Please initial boxes	
	Yes	No
5. I agree to the interview/group (delete as appropriate) being audio-recorded	☐	☐
6. I agree to colleagues in Action Groups listening to my interview/group (delete as appropriate) audio-recordings	☐	☐
7. I agree to colleagues in Action Groups reviewing the complete written record of interview/group audio-recordings, or to the researcher notes if audio-recordings were not made.	☐	☐
8. I agree to my name being added to any quotes of what I say on Labour Ward displays and in publications.	☐	☐
9. I agree to my role being added to any quotes of what I say on Labour Ward displays and in publications.	☐	☐
10. If the answer was YES to Question 9, please write your role as you would like it to be recorded:		

	Please initial boxes	
	Yes	Not applicable
11. As part of an Action Group, I agree to keep all data (information) anonymous and confidential unless a participant has consented for his/her name and/or role to be used on Labour Ward displays and in publications		

Name of participant (PRINTED)	Signature	Date
Name of researcher (PRINTED)	Signature	Date

Researcher: Claire Wood. Supervisory team: Professor Mary Chambers, Professor Jayne Marshall, Dr Karen James

Appendix 13 Poster online Facebook consultation group

Hospital logo

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Your views are important!

Join our Facebook Group and tell us what you think

A 'Secret' Facebook online group is being started as part of the ongoing project exploring how we can develop our own and each other's wellbeing on Labour Ward.

- What sort of things make you feel good at work?
- How can situations be made to maintain our wellbeing at its best?

You can give your opinions at a time which suits you, in as much or as little detail as you like, and exchange experiences with colleagues in an ongoing discussion.

You will shortly receive an email with the necessary information to join the group

If you would like to talk about any aspect of the project in the meantime, please contact me in person – Claire Wood – or on claire.wood14@nhs.net or [Mobile]

Appendix 14 Email online Facebook consultation group

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Dear colleague

An online group is being started as part of the ongoing study exploring how to develop our own and each other's wellbeing on Labour Ward. It offers an alternative to attending group meetings in person. Your feedback, and your colleagues' feedback, will be important for the staff Action Groups in deciding which topics to focus on.

The group is a 'Secret' group within the social networking site Facebook so you will need a Facebook account to take part. Only those requesting membership and being accepted onto the group by the Administrator (myself) will have access to the posts. Accepting an invitation to join the group will be considered as giving consent to take part in the study. To encourage members to be open, you are asked to keep each other's identities confidential within the group. Some posts will be quoted in the study in the same way as, for example, face to face interview comments might be, and will be made anonymous, so your identity will not be known beyond the group. You may however also choose to attach your name to posts. If you do attach your name to posts, it will appear with any of your quotes used on Labour Ward displays and in publications. Please see the Participant Information Sheet for details of the ethical approval which has been given, and how your information will be used and stored.

It is entirely up to you whether or not you take part in the study and you are free to post as much or as little as you like and stop without giving a reason.

It may be that discussions make you aware of concerns about your own wellbeing. Details of Trust resources which may support your wellbeing are included at the end of the Participant Information Sheet. *Please read the Participant Information Sheet before choosing if you would like to proceed (same attached, and same as originally sent at start of the study).*

What to do if you would like to take part in the group

Please email me as the group Administrator
You will then be contacted with information about how to join

Please contact me if you have any questions or comments. I will be spending long periods on Labour Ward, so you can talk to me there, or telephone [Mobile] or email claire.wood14@nhs.net

Thank you very much.

Claire Wood

Midwife [Hospital], PhD student (Kingston University, London)

Appendix 15 Ground rules consultation group

Exploring how to enhance staff wellbeing on a Labour Ward: a participatory action research approach

Ground rules of online secret Facebook Consultation Group

Thank you for your interest in this Consultation Group.

By taking part after you have read the Participant Information Sheet and these Ground Rules, it is considered you are giving informed consent.

As a closed group, only Labour Ward staff who have consented to take part in this study will be able to read and contribute to the discussion.

To encourage group members to feel they can be open and honest about their views, you are asked to act in a respectful way, and have regard for each other's privacy by not repeating any discussions with people outside the group.

Finally, please avoid including posts which might identify colleagues or service-users.

Thank you very much.

Appendix 16 Poster presentation Obstetric Anaesthesia Annual Scientific Meeting 2021

Obstetric Anaesthesia
Annual Scientific Meeting 2021 goes virtual
10-11 June 2021

Labour Ward theatre:
Insider participatory action research exploring how to enhance practitioner wellbeing

Claire Wood Midwife PhD Student[1], **Professor Mary Chambers[1] and Professor Jayne E Marshall[2],**
1. Faculty of Health, Social Care and Education, Kingston and St George's, University of London, UK 2. School of Allied Health Professions, University of Leicester

Kingston University London | St George's University of London | Hospital logo

Introduction

Healthcare worker (HCW) wellbeing impacts positively on patient experience[1], yet there is global concern regarding HCW welfare[2]. This qualitative study explored how to enhance Labour Ward (LW) and theatre colleagues' individual and collective wellbeing within a larger LW.

Methods

- Exploratory insider participatory action research in a consultant-led LW, initiated by a practising midwife - 900 hours in setting over 18 months
- All clinical and non-clinical LW and theatre colleagues described experiences making them feel good at work
- Data excerpts from 96 questionnaires and 62 interviews were displayed throughout LW
- Theatre Action Group planned practical actions responding to theatre-related HCW accounts. Thematic analysis informed findings

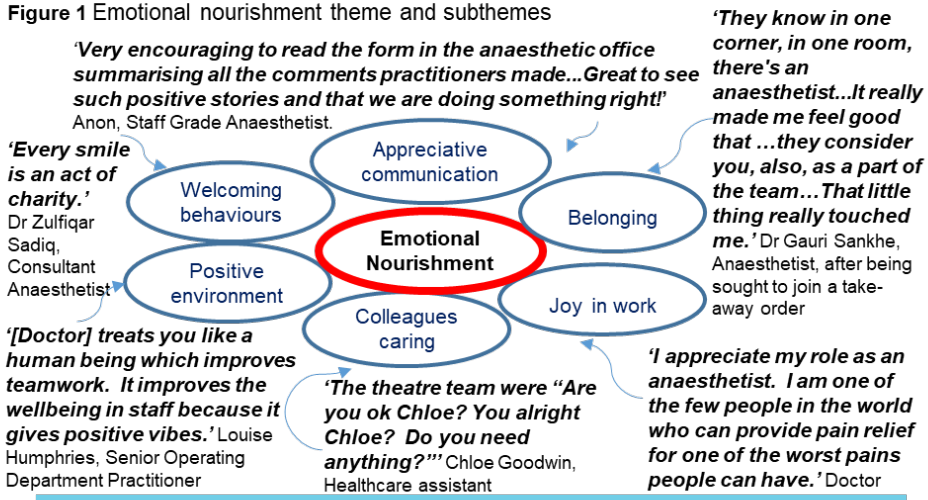
Preliminary findings

(i) **Thematic analysis (Figure 1)**: Themes related to HCW needs centred on emotional, physical and professional nourishment. Emotional needs outweighed those of the other categories.

(ii) **Theatre Action Group** impact:

- Communication and expressions of gratitude/feedback increased, different occupational groups learning which behaviours others found beneficial to wellbeing
- Cloth hats displaying names/roles were introduced, enabling inter-teamworking and relationship, and supporting patient/family experience
- A Scribing Framework was developed, facilitating Healthcare Assistants' documentation
- Patient-centred initiatives developed, including placing monitoring leads on women's backs to encourage skin to skin contact.

Figure 1 Emotional nourishment theme and subthemes



Discussion

Increased awareness of the impact of our behaviours on colleagues' wellbeing encourages further positive behaviours. Ways forward:

- **Ask the question as to what makes colleagues feel good in theatre**
- **Make their stories known**
- **Using colleagues' accounts, plan the future in small interdisciplinary groups**

References

1. Maben, J., Peccei, R., Adams, M. et al. Patients' experiences of care and the influence of staff motivation, affect and wellbeing. Phase II case studies: Annexe to final report National Institute of Health Research Service Delivery and Organisation programme, 2012.
2. Montgomery, A., Panagopoulou, E., Esmail, A. et al. Burnout in healthcare: the case for organisational change. BMJ, 2019, 366:193-195

Enquiries please contact claire.wood14@nhs.net. HRA and Health and Care Research Wales gave ethical approval.
Thank you to my supervisors and to Dr Zulfiqar Sadiq for support and encouragement.

Appendix 17 National and international dissemination

Journal publication
Wood, C., Chambers, M. and Marshall, J. E. (2021) Exploring how to enhance healthcare worker well-being on a labour ward: insider participatory action research **MIDIRS Midwifery Digest** 31(2): 170-172. Wood, C. and Chambers, M. (2021) Labour ward theatre: insider participatory action research exploring how to enhance practitioner wellbeing (abstract) **International Journal of Obstetric Anesthesia** 46(1):11.doi.org/10.1016/j.ijoa.2021.103009
Oral presentation
Wood, C. and Smith, S. (2021) **Labour ward insider participatory action research: exploring how to enhance practitioner wellbeing** RCM Research Conference, March 23rd https://vimeo.com/user49383017/review/520992543/c7e8a94d13 Wood, C (2021) **Enhancing labour ward practitioner wellbeing: An insider participatory action research approach** Virtual International Day of the Midwife May 5th, https://vidm.org/vidm-2022-programme-archive/
Poster presentation
Wood, C., Chambers, M. and Marshall, J. E. (2021) **Labour ward theatre: insider participant action research exploring how to enhance practitioner wellbeing** Obstetric Anaesthetists' Association Annual Scientific Meeting, June 10th, online (Highly commended prize)