BMC Health Services Research

RESEARCH

Open Access

Enhancing maternity healthcare workers' wellbeing using insider participatory action research

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Abstract

Background Good healthcare worker (HCW) wellbeing positively impacts service user outcomes, yet the United Kingdom (UK) National Health Service (NHS) is suffering workforce burnout and retention issues. While urgently needing evidence-based wellbeing strategies, participatory interventions using positive psychology have been underinvestigated. We aimed to develop a caring, collegial NHS labour ward environment wherein HCWs created paths to enhancing individual and collective workplace wellbeing.

Methods Insider Participatory Action Research (IPAR) used positive psychology within a social constructionist, pragmatic approach. All clinical and non-clinical HCWs on a consultant-led labour ward in the East Midlands, England, UK were invited to identify current sources of workplace wellbeing on which to collectively construct future ways of working. Qualitative data from several methods (below) were inductively thematically analysed.

Results Between October 2018 and July 2020, data were generated from 83 paper and 13 online questionnaires; 59 interviews; three action groups; six peer participant reviewers; 16 comments on data displays; and three emails. Three themes represented sources of workplace wellbeing: emotional, professional, and physical nourishment. Culture shifted to be more compassionate and inclusive, and morale, positivity, and atmosphere improved. Ways of working changed. Colleagues more proactively cared for each other, worked well together in teams, expressed thanks and feedback, and instigated interventions for colleagues' and women's welfare. Participants proposed that IPAR activities prompted change including: the researcher being considered an accessible colleague wellbeing resource; raised awareness of the importance of HCW wellbeing; and strengthened HCW relationships. The HEARS wellbeing intervention model (HCW driven, Everyone involved, Ask what makes a person feel good at work, Responses displayed, Steps taken) was developed to frame processes by which HCW participation catalysed impact towards workplace wellbeing.

Conclusions To our knowledge, this is the first English language study using IPAR to enhance HCW wellbeing. Colleagues from diverse occupational groups improved individual and collective wellbeing through self-determined action. Using participatory methodology and positive psychology encouraged a more compassionate and inclusive culture. Subject to implementation research evaluating these strategies' impact in different settings, we propose the HEARS wellbeing intervention model and workplace-based Colleague Support Volunteers as actions towards wellbeing and retention in healthcare organisations.

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Keywords Health personnel, Wellbeing, Intervention, Action research, Maternity

Terminology

The terms woman and women include childbearing people whose gender identity may differ from that at birth, and those who identify as non-binary.

Background

The United Kingdom (UK) National Health Service (NHS) urgently needs to act on national guidance equating the importance of healthcare worker (HCW) wellbeing to patient wellbeing [1]. Workplace conditions need to improve in order to sustain those individuals who continue to work despite present pressures, and to encourage their retention to meet service demands. Prior to the Covid-19 pandemic, longstanding knowledge about correlations between HCW welfare and improved patient experience and outcomes [2] had triggered a range of stress-reduction interventions in the UK and overseas [3–5]. Specifically, maternity services in the UK had been affected by persistently poor workplace wellbeing. Workforce shortages had resulted from midwives abandoning their profession [6], citing poor staffing levels and high workloads as compromising quality of care [7]. In a 2017 survey, over two-thirds of almost 2000 midwives reported work-related burnout [8]. In parallel, obstetricians had been suffering burnout [9], and retiring early due to heavy workloads [10]. Obstetric and gynaecology trainee numbers had fallen by 6.8% between 2012 and 2018 [11]. In 2020, the pandemic exposed the lived experiences of NHS HCWs with unprecedented intensity. Acute workforce shortages exacerbating chronic shortfalls laid bare the fragility of service provision. Passive acknowledgement of links between HCW and patient welfare was replaced by multiple health promotion initiatives attempting to maintain services by fortifying HCW wellbeing.

Post pandemic, poor HCW wellbeing and retention remain core problems. Maternity practitioners' burnout levels are high and rising [12, 13]. A fifth of doctors plan to retire early and the same proportion to leave medicine completely [14], and over half of midwives responding to a 2021 survey were considering leaving the role [15]. England carries a minimum deficit of 496 obstetricians and 1932 midwives, with total workforce shortfalls estimated to reach 231,280 of 1,465,716 anticipated NHS posts in 2025 [14].

This paper presents a HCW wellbeing intervention in one NHS labour ward (LW) in the East Midlands, England, UK, and follows two previous publications of preliminary findings [16, 17]. At the time of the study, CW was a practising clinical midwife in the setting and considered all occupational groups' wellbeing to be deteriorating. Colleagues regularly cried at work, left their professions, or sought alternative HCW roles. Few supportive interventions existed [18]. The final catalyst for action was CW discussing the personal impact of emotionally demanding work experiences as a recruit in a research study [19]. For the first time in over 30 years' service, CW perceived an institutionalised expectation that HCWs continue practising unwaveringly after all but the most serious of clinical incidents. With the national and international situation demanding action, the aim of this research study was to develop a caring collegial environment within a NHS LW in which maternity HCWs created paths to enhancing their individual and collective wellbeing.

Interventions for employee wellbeing

Although definitions of wellbeing overlap and interrelate, employment is considered to positively contribute to wellbeing [20, 21]. If given autonomy and control, people enjoy not only income but the challenge of mastering a role, and the related social interaction [21]. A virtuous cycle perpetuates wherein good working conditions improve individual wellbeing, and the improvement of individuals' wellbeing also improves working conditions [21]. For study purposes, this paper's authors positioned HCW workplace wellbeing as:

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

We found in our initial literature search that employee wellbeing interventions do not consistently show positive impact. Most interventions focus on problem identification and solution development and report small to moderate positive effect on mental health, stress, burnout, social/working conditions, performance, and absenteeism [18, 22–27]. Others find no, or mixed, benefit [28–31]. Rather than generic recommendations, the plethora of different healthcare environments require methodologies which prompt locally impactful strategies. The literature suggested that new approaches were needed.

Interventions are classified as organisational, individual, or a combination. Organisational, or primary, interventions aim to be preventative, encompassing

employees' workplace conditions [32]. Work systems and/or job designs are modified, rationalising that in complex systems such as workplaces, the interaction of multiple components influences wellbeing more than change in specific, isolated elements [3, 23–25, 27, 31]. Individual interventions are classified as either secondary or tertiary. Secondary interventions aim to ameliorate adverse workplace impact through self-care training (for example in stress, sleep), or through physical and psychological activity (for example in yoga, mindfulness). Tertiary interventions apply to those taking sickness-absence and were not investigated within this workplace-based enquiry. Combined approaches use secondary interventions within organisational interventions [26].

Defined, small-group, individual intervention programmes are moderately stress-reducing [26] and potentially more economically and operationally feasible than the large-scale engagement required for organisational interventions [27, 31]. Individual interventions nevertheless risk employees feeling accountable for their poor wellbeing, rather than organisations taking responsibility to address this [18, 31]. Unchanged workplace stressors also threaten ongoing maintenance of any related individual improvement [27]. Combining organisational and individual interventions is proposed to enhance outcomes [25–27, 31] and prolong effect [26]. Additionally, by incorporating participatory study design within this combination of interventions, employee engagement is fostered [3, 26, 31].

Participatory Action Research (PAR) methodology offers those potentially affected by interventions to co-create changes for local benefit [33]. Shared ownership of the enquiry enables participants to form action groups to collectively agree research questions, review data, plan action, generate data, take action, evaluate outcomes, and modify future plans in a continuing dynamic [33]. As few wellbeing interventions adopt participatory methodologies [26], we further scrutinised the literature by critically reviewing specifically the effectiveness of PAR in enhancing HCW psychosocial wellbeing [34]. Firstly, the review analysed the methodological elements related to reported effect and secondly, the review identified processes potentially modifiable to increase effect. As an example, and the only one identified in a maternity setting, one study aimed to support midwives through work changes by developing self-awareness during clinical supervision sessions [35]. Another study sought to use workshops for social workers to develop a mental health wellbeing strategy [36]. Overall, the review indicated that interventions effected significant improvements in psychological status, social support, effort-reward balance, decision-making, burnout, job satisfaction, and absenteeism. We nevertheless anticipated even greater impact by enabling bottom-up, HCW-initiated projects; including all HCW groups; applying positive psychology; increasing frontline HCW decision-making; and generating qualitative participant process/evaluation data. All of the 13 included studies were initiated by academics and/or managers, leaving untested the capacity of HCWs to self-organise local wellbeing interventions.

As CW planned to initiate the study, this constituted Insider PAR (IPAR), wherein an employee undertakes research within their workplace [37]. Prior local knowledge as a frontline HCW was gauged to potentially facilitate better navigation of problematic issues identified in the review such as: broken HCW/management relationships being unknown to external researchers; interdisciplinary disputes; and disrupted communication between researchers and HCWs. Although one other LW study had been identified as applying action research with an insider researcher, this had been a Swedish service-centred, rather than HCW-centred, intervention [38]. Although three authors provide this account of the study, it is intermittently written in the first-person voice in acknowledgement of the subjective nature of IPAR. As the IPAR researcher (IPARr), this voice specifically represents CW and her experiences during study activities.

Study question and objectives

The study question indicated that progress towards individual and collective wellbeing depended on, and aimed for, colleagues' active contribution. It took an intersubjective approach whereby I positioned myself alongside my colleagues in the collective *we.* The study question asked:

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

The study objectives applied a positive psychology approach as the authors' review findings had indicated. Problem identification, as commonly adopted in wellbeing interventions, was judged to risk compounding the stress already threatening HCW wellbeing. The use of positive psychology intended to direct the research enquiry toward the seldom investigated narratives of positive HCW experiences. Focusing on what made HCWs feel good at work was anticipated to buoy affect and maintain whatever feelings drove HCWs to persevere in demanding roles. This premise was therefore applied to the first two study objectives. The intervention constituted HCWs using current sources of LW wellbeing as foundations for building ongoing routes to further wellbeing:

Objective 1—To collate factors identified by HCWs as encouraging wellbeing
Objective 2—To collectively construct future ways of working.

In line with PAR, a hypothesis was not proposed, and the direction of research activities was guided by participant data. The authors plan to address the third and final objective of evaluating IPAR's role in outcomes in a forthcoming paper.

Methods

Patient and public involvement

Since this study focused on HCW wellbeing at work, patient and public involvement was not considered to be directly applicable.

Research design

The study's philosophical perspective was based on an ontology of subtle realism and an epistemology of social constructionism. Subtle realism acknowledges an independent comprehendible reality but considers that assumptions transmitted from the prevailing contextual culture prevent direct entry to that domain [39]. Social constructionism similarly maintains that the way human beings report on their world is historically and culturally specific [40]. Healthcare worker views were therefore regarded as representations of individuals' temporary reality, and irremovable from the unconsciously absorbed influence of LW culture. Pragmatism was adopted as the theoretical perspective for its major focus on theory being applied for practical use [40]. Both social constructionism and pragmatism align with PAR's aim to achieve social impact through community with others [41], and also accord with all LW HCWs being involved in co-creating knowledge to build desired futures [33]. Thematic analysis techniques were used to support participatory principles by inviting members of different occupational groups, anticipated to have varying degrees of research experience, in data review [42].

Research setting

Approximately 5000 births occurred annually in the setting's consultant-led LW which included 13 birthrooms; two theatres; and high dependency, induction, and assessment units. Women's care depended on the dynamic of different teams' interaction, and HCW team members constantly changed shift to shift. For each shift, a senior midwife, the coordinator, liaised with medical colleagues to organise the work of approximately 20 HCWs. Activity was typically high and regularly required interdisciplinary teams to rapidly attend the operating theatre for emergency caesarean sections and other obstetric procedures.

Participants

Posters were used to invite participation to the Wellbeing Project (WbP), as the study was termed. All HCWs were eligible and, in order of highest numbers, occupational groups included midwives, obstetricians, operating theatre practitioners, anaesthetists, health care assistants (HCA), receptionists, housekeepers, and domestic personnel. Study documents and related online links were emailed to HCWs by groups' administration leads, and paper copies were also made available. The IPARr presented information on study processes at shift changeovers; in management, research, and operating theatre meetings; and to new-starter HCWs.

Data generation methods

Six data generation methods were planned.

1. Questionnaire-paper, online.
2. Individual/group interviews-qualitative, semi-structured.
3. Online consultation group-closed, asynchronous (not real-time) on social networking site.
4. Comments added to data displays.
5. Action groups.
6. Peer participant review (PPR) of data.

The first five methods were employed from the study start date 23 October 2018 to 30 April 2020. Posters were used from early September 2019 to invite all LW HCWs to act as PPRs in reviewing data until 31 July 2020.

Questionnaires comprised two questions:

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

What was happening at the time to make it possible?

Interviews similarly exploring positive experiences were formal and pre-planned, in participants' chosen location, or informal, arising spontaneously. See Prompt guide wellbeing interview: Supplementary information Additional file 1. Notes were taken if participants declined consent for audio-recording. Posters were used to invite HCWs to join action groups (AGs), act as PPRs, and/or add comments to data displays. In anticipation of discussions developing from data generated from objective 1, no questions were prescribed for AGs. Following verbal information on thematic analysis processes, the PPR role involved reviewing data transcripts

for comparison to other PPR/IPARr interpretations. Further detail is given under Data Analysis and Results. Data were transcribed by the IPARr apart from those of longer pre-planned interviews which, to economise on time, were sent in an encrypted file to a transcription service. According to the original study protocol which received ethical approval, anonymised data were transferred to the transcription company under suitable confidentiality agreements.

Throughout the study period as data unfolded, and following IPAR practice, data content and preliminary analyses were shared with those who were intended to learn and/or be inspired to act in response [33]. In addition to ward-based HCWs, this included regular meetings with the LW manager, and discussions with the wider Trust as represented by Organisational Development, People Services, Senior Management, and Health and Wellbeing teams.

Evaluations of the intervention were actively sought in March and April 2020 using the same study questionnaire. A noticeboard posted a request for HCWs to document any learning over the past 18 months related to what made them/the team feel good, and any perceived study-related changes. These evaluations were requested in addition to evaluations already spontaneously given in questionnaires and interviews. To facilitate data generation, I attended the LW up to four times a week from 23 October 2018 to 30 April 2020 (approximately 900 h total), aiming to be unobtrusively accessible. When LW activity precluded data generation, I regularly took tea-trolleys into the clinical area and delivered drinks and snacks to colleagues unable to leave work tasks. To differentiate my midwifery and IPARr roles, I wore uniform only when working clinically.

Data analysis

Those involved in participatory research seek to analyse data, or practise 'sense-making' from data, as judged appropriate to the particular context [33]. Findings are intended to be understandable, credible, and meaningful for those who the research was intended to impact [33]. Sense-making in the WbP aimed to provide a practically informative and applicable narrative for HCWs based in clinical areas. Emphasis was on keeping a momentum of enquiry going forward, rather than deep, to effect ongoing reflection and action.

Data analysis ran concurrently with data generation throughout the study period. Transcripts were inductively thematically analysed by repeatedly reading data line by line, collating initial codes, categorising codes into themes, and producing a narrative synthesis. I started these processes when data were first generated. Later, PPRs and I together compared our interpretations and created codes and themes until these were all agreed. Peer review intended to avoid the risk of my personal assumptions, beliefs, and worldviews blinding me to new insights. I also undertook continual reflexive self-evaluation of the impact of my presuppositions on study processes, data collection, and data interpretation [33].

Regarding my presuppositions, I am white British, was around retirement age, had good working relationships with colleagues from all occupational groups, and was unaware of personal characteristics likely to hinder research interactions. I felt I unremarkably *fitted in* as a well-known middle-grade practitioner usually supporting women on LW. Although comfortable inviting colleagues to participate, unusually combining PhD studentship/IPARr and clinical midwifery roles, I felt I was under pressure to be a positive role model for my profession. Reflexively, I aimed to appear confident and approachable to inspire participation.

Ethical considerations

The concepts of dependability, credibility, and transferability support this study's qualitative trustworthiness. Dependability was upheld by providing details of study processes and contexts to cohere with knowledge claims. Credibility of interpretations met international PAR criteria requiring participants to actively engage in ethical processes towards social change [33]. Transferability was met by illustrating sensitising concepts for other investigators [43].

To minimise the potential for distress related to any personal issues, participants were advised they could stop/pause participation in data generation at any time. Plans were also made for senior midwives to meet any upset participants, and study documents featured Trust wellbeing resources. To avoid participation out of friendship or perceived obligation, HCWs' participation was not in the first instance pursued by the IPARr but volunteered by HCWs through contacting the IPARr after reading study documents.

Consent process

Written consent was required for interview, AG, and PPR. Consent was considered as given for those completing questionnaires, requesting membership of an online consultation group, and adding comments to displays. As participatory methodologies support public recognition of participant contributions towards publications [33], two different consent forms offered participants to optionally include role descriptor and/or self-identify by name. See below: Declarations, Consent for Publication.

Fig. 1 Participant data display wall

Table 1 Number and occupational group of interviewees

Occupational group	Number of practitioners in group (estimate)	Number participating in individual or group interview
Midwife	150	32 (21%)
Obstetric doctor	60	5 (8%)
Theatre practitioner	45	5 (11%)
Anaesthetic doctor	21	4 (19%)
Healthcare assistant	20	10 (50%)
Housekeeping, domestic, receptionist	13	5 (38%)
Totals	**319**	**64 (19%)**

Results

Data were generated from 83 paper questionnaires; 13 online questionnaires; 51 individual interviews; eight group interviews; 16 comments added to displays; three AGs; and six PPRs' responses to the first 40 interview transcripts. Data were also generated by three participants who individually emailed WbP evaluations. Data initially included narratives of positive work experiences related to objective 1, whilst participants later more frequently added comments evaluating WbP changes related to objective 2. Throughout the study period, data quotes were exhibited for all HCWs to view. Colourful excerpts were widely posted on a full display wall as demonstrated in Fig. 1, and on noticeboards and posters in training, rest, office, changing, and theatre areas, and updated at least monthly.

Table 1 demonstrates the range of occupational groups which took part, as exemplified in interview activity. Healthcare workers who only worked on the LW participated in higher numbers than those who rotated around the different maternity wards. Over half of interviewees self-identified by first or full name. Interview data varied from one-hour sessions away from clinical areas to short comments captured from exchanges with the IPARr on LW. Questionnaire data similarly spanned from one sentence to a packed A4 page. It was not possible to gauge self-identification levels in questionnaires as in March 2020 a group of midwives independently duplicated questionnaires to distribute at shift changes, and omitted the optional role/name section, affecting 21 submitted forms.

Coordinator, Theatre, and HCA AGs were respectively established in response to reports of how coordinators' behaviours impacted HCW wellbeing, the role of HCAs, and HCW experiences in operating theatres. See Action group activity: Supplementary information Additional file 2 for AG activity, and Fig. 2 for timing of AGs within the study period. One online consultation group began for HCAs but as it was largely used to arrange AG meetings, new data were not generated. From March to July 2020, impact from the pandemic impaired generating, sharing, and participants reviewing data. Planned WbP events, including a large social outing and the first maternity interdisciplinary Schwartz round [44], were cancelled.

In the following findings section, excerpts of participants' *verbatim documentation* and role/name entries are presented. Acronyms are used to identify the data source: AG = Action group: Anon = Anonymous; Int = Interview; Q = Questionnaire; OQ = Online questionnaire. *Some participants chose to shorten their names, omit roles, and/or include unconventional role descriptors.* Data related to the study's aim and objectives are initially presented, including the *how,* the mechanisms, of study outcomes as proposed by participants. The section concludes with a wellbeing

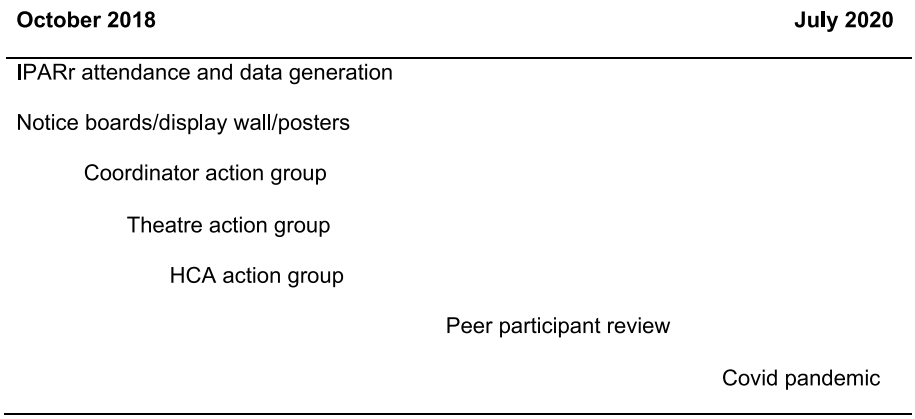

Fig. 2 Timing of action groups within study context

Table 2 Wellbeing project evaluations

'For the first time in many years I am eager…to work on LW…My colleagues are genuinely caring, compassionate and supportive no matter what role. We pull together…especially in the current situation [pandemic]. The project has made a huge difference to the general mood and morale.'(Anon, role omitted Q49)
'I…had sick leave for workplace stress…I felt broken, and it's taken six months, and your study really helped because I felt somebody was saying we were important, because I didn't feel important, loved, or needed.'(Anon, Senior Clinical Midwife Int48)

intervention model named HEARS which was developed to reflect how IPAR study processes were applied.

It is important to note that although the overwhelming focus of data related to colleagues' compassionate gestures, accounts of employees feeling undervalued/hurt featured in interactions related to displayed data (see participant quotes Table 2 below). Healthcare workers fed back their related feelings to the LW manager, the lead researcher, in action groups, and in informal group conversations which regularly arose around wellbeing.

Findings related to study aim

The study aimed to develop a caring collegial environment on LW in which HCWs created paths to enhancing individual and collective wellbeing. Table 2 provides evaluation data indicating change in a positive direction. Although difficult to separate into discrete categories, as impacts were often interrelated, 28 individuals provided 38 comments on improved culture, morale, positivity, and atmosphere. No participant recorded a negative study effect.

Findings related to study objectives

Objective 1 sought to collate the factors identified as encouraging HCW wellbeing. Three themes were established from the data: *Emotional, Professional,* and *Physical nourishment. Emotional nourishment* included 286 comments from 98 individuals, *Professional nourishment* 81 comments from 69 individuals, and *Physical nourishment* 47 comments from 47 individuals. Table 3 presents the related themes, sub-themes, and illustrative quotes.

Emotional nourishment

Data related to emotional nourishment were connected to sub-themes of colleagues showing caring gestures, to appreciative communication, welcoming behaviours, a positive environment, a sense of belonging, and to feeling joy in work. Participants referred to feeling good by both experiencing and witnessing caring actions within and between occupational groups, and in seniors' role-modelling of such behaviours. Appreciative communication related to enjoying both giving and receiving positive feedback and gratitude. These were conveyed in verbal exchanges, emails, texts, cards, and social media, and reportedly provided HCWs with reassurance. Being welcomed to LW by greetings, smiles, being shown respect, and being addressed by one's name similarly appeared in data as encouraging wellbeing, as did camaraderie, banter, humour, and an upbeat atmosphere. A number of participants connected their good feelings with being part of LW family/team. Related data were initially categorised as *Teamworking* but during PPR Rosie (Core Midwife, Birth Centre) stated:

> *'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 showed the importance of personal relatedness beyond purely professional connections, and

Table 3 Themes, sub-themes, and illustrative quotes related to factors encouraging healthcare worker wellbeing

Theme	Sub-theme	Illustrative quotes
Emotional nourishment	Colleagues caring *103 comments*	*[Felt unwell, sat, and cried. Colleague stayed and] '…brought me toast and a drink, and it made me feel looked after and comforted.'(Anon, Midwife Int15)* *[Midwives noticed participant wasn't themself and asked if they were ok] 'I liked it but didn't want to share it. I liked it.'(Anon, Doctor Int37)*
	Appreciative communication *62 comments*	*[Felt good] 'Receiving a thank you card from a midwifery colleague for the support I had given her as the registrar on call.'(Mark, SpR [Specialist Registrar] in O&G [Obstetrics and Gynaecology] OQ12)* *'She'll say [LW manager] "you're really coming into your own"…just a passing comment on the corridor, but she puts a little spring in your step…that's important…our…perception of ourself is we're rubbish.'(Sophie Nabbs, Registered Preceptorship Midwife, PMW, [newly qualified midwife in programme transitioning from student to accountable midwife] Band 5 Int39)*
	Welcoming behaviours *43 comments*	*'I feel welcome [to LW]. All the people, midwives, everybody, welcome to me. I don't feel odd here…if it's a doctor or a midwife, I feel the same…When a room needs doing [cleaning]…I have good feedback…housekeepers, HCAs, midwives, everybody.'(Anon, role omitted Int12)* *[Felt good] '…being known by my name not just my job title.'(Anon, role omitted Q69)*
	Positive environment *32 comments*	*'Bit of fun goes a long way. I like it when the music's on…everyone's humming…there's a good vibe and a different energy. It changes the whole atmosphere.'(Anon, role omitted Int40)*
	Belonging *24 comments*	*[After a colleague helpfully intervened in a challenging situation] '…made me feel part of something…now I never feel on my own…I can feel the supportive team around me all the time.'(Anon, Preceptorship Midwife Q47)*
	Joy in work *22 comments*	*'I love my job. I love coming to work…we're very privileged to have such a wonderful job.'(Anon, Senior Clinical Midwife Int27)*
Professional nourishment	Teamworking for good outcome *52 comments*	*'The case…this morning …in theatre…was a very difficult, complicated case and you wouldn't have known that there was any difference between theatre staff and midwifery staff…The whole team was amazing…We kept in tune with each other the whole time. Communication was brilliant. We had a good hug at the end and said, "Well done" to each other. It couldn't have gone better.'(Lucille Griffiths, Senior Operating Department Practitioner Int42)* *[Teamworking] '…makes it a failsafe mechanism…a critical situation when has a good outcome, it makes you feel good to think that you have made a difference as a team.'(Anon, role omitted OQ11)*
	Satisfaction of individual motivators *29 comments*	*[Bereavement care episode] '…to me represented true midwifery care—being wholeheartedly with woman, treating her at all times with kindness, dignity and compassion…I hope that I will always remember feeling proud of the care that I have provided.'(Anon, Preceptorship Midwife Q12)* *'I take pride in cleaning a room. I find it a privilege that a baby is going to be born there…it's the first place the baby will be.'(Jodie Allsop, HCA Int59)*
Physical nourishment	Rest and refreshment *47 comments*	*'We don't have structured breaks. [Tea-trolley] Is a good recognition of this.'(Anon, Doctor in training Int5)* *[Feels good] '…When toast is made on nights.' (Anon, Registrar in Obstetrics and Gynaecology Int1)*

how tea-trolleys provided more than simply physical sustenance. Being gathered at the tea-trolley was frequently cited as the environment where HCWs could break from tasks to talk, learn, and relate. *Teamworking* continued as a sub-theme, but earlier data interpretations were reviewed for potential recategorisation to a *Belonging* sub-theme. Slightly different to this deeper interpersonal connection, other participants expressed how everyday interactions with colleagues and practising their role made them joyful.

Barriers to emotional nourishment nevertheless existed. The attempts of new-starters to befriend colleagues were reportedly challenged by working with numerous different colleagues and by perceived unyielding established friendship groups. Being physically isolated in specific work areas away from most colleagues (for instance, in the reception area) was reportedly similarly disconnecting:

> *'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).*

Professional nourishment

Professional nourishment included the sub-themes of teamworking for good outcomes and satisfaction of individual motivators. The former related to collective wellbeing, and the latter to individual wellbeing. Participants reported that teamworking raised wellbeing through communication and learning, and through '*professional bonding* '*(Anon, Midwife Int55).* Many expressed how colleagues, regardless of role and hierarchy, willingly offered practical support in a collective effort to provide optimum care to women and babies. Data, however, also indicated participants perceived self-worth in striving to perform as individuals. Reported achievements towards these individual motivators included practising high quality care, contributing to potentially saving a life, learning, teaching, and acting autonomously.

Physical nourishment

The sub-theme *Rest and refreshment* reflected the many HCW references to how opportunities for food and drink improved their wellbeing. Tea-trolleys with snacks were regularly cited as a means of refuelling to '*keep going' (Senior Clinical Midwife, Int27).* Although drinking and eating were reportedly physically sustaining, many related references also included emotional overtones as offering refreshments was viewed as HCWs caring for each other.

Objective 2 focussed on collectively constructing future ways of working. This section confirms the occurrence of changes in ways of working by providing related HCW data reports. These reports are followed by factors that participants suggested as instrumental to these changes.

New ways of working

New and improved ways of working were described around four main topics: the care colleagues offered each other (25 comments); teamworking (12 comments); expressions of gratitude and feedback (10 comments); and HCW initiation of interventions for women's and colleagues' benefit (eight comments). After presenting these, there follows the LW manager and wider Trust's responses to data.

Regarding colleagues offering each other care, participants noted an increase in compassionate gestures, including proactive offers of clinical support and provision of refreshments, and deeper enquiries into others' welfare.

> *'It [WbP] has made a difference. [HCAs] wanting to help. There's less, "That's not my job…" The tea trolleys more frequently. More confident to go and make trolleys. Before it was more strict.' (Charlotte, Midwife Int45).*

Data related to improved teamworking were both described specifically in relation to the multidisciplinary team and to general teamworking.

> *'Big change in the atmosphere…very much more positive—with the multi-disciplinary team working much more effectively together and having a positive appreciation of each other.' (Anon, senior clinical midwife Q37).*

Colleagues also commented on more frequently giving and receiving thanks and positive feedback.

> *'Coordinators [say at end of shift]… "Thank you for your hard work". It has made a big difference that way…before…you'd just go home.' (Anon, HCA Int36).*

> *'I have been noticing and receiving more feedback from the midwifery team when we do a procedure.' (Anon, role omitted Q72).*

The last principal change in ways of working referred to HCWs autonomously initiating several interventions for women's and colleagues' benefit. These included housekeeping and HCA colleagues independently fundraising for refurbishment of HCW and women's sitting rooms/bathroom, and reorganising dining areas to offer women more social interaction.

> *'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 Int44).*

Beyond immediate colleagues' interactions, the LW manager's response to data became evident in action towards changed ways of working, for example: in enabling the use of the large wall for data display; facilitating launching action groups; and in expressed personal adaptation of behaviours. The wider Trust teams which were informed of the data content (see above Data generation methods) welcomed accounts of good workplace experiences while acknowledging and supporting the opportunity for addressing action for those participants reporting concerning experiences. For example, after being raised in participant data, commitment was given to establish colleague support roles to serve HCWs in clinical areas.

Factors instrumental to changes in ways of working

Participants spontaneously suggested several factors which contributed to changes in ways of working. These included: exposure to IPAR/r activity; raised awareness

of the importance of enhancing HCW wellbeing; and strengthened HCW relationships.

The first factor, exposure to IPAR/r activity, was reported to originate from both the IPARr's individual action and from action associated with IPAR practice. In relation to the former, one participant suggested:

> *'[The IPARr] has rubbed off on people.' (Anon, role omitted Q61).*

Simply seeing the IPARr in the setting was reported to remind participants to be alert to others' wellbeing and, similarly, the IPARr providing drinks for others was described as '*role-modelling*' and having a '*cascading effect*' *(Anon, role omitted Q22).*

> *'Like drip-feeding, nurturing…like an aura…in the background.' (Anon, Midwife Int54).*

Participants also expressed how IPARr actions held personal significance for how they felt at work.

> *'Made a difference…made us…feel valued that you—somebody's interested in how we feel.' (Anon, Midwife Int33).*

A further unanticipated phenomenon also developed from the start of the WbP. Colleagues from all occupational groups and seniority levels confided personal homelife and workplace concerns with the IPARr, often in lengthy exchanges. These included families' relationships and health, adolescent behaviours, personal anxiety, and many more, with several such exchanges occurring daily. Few had knowledge of, or had accessed, formal Trust wellbeing resources and several referred to these conversations as offloading feelings rather than seeking advice.

> *'Changes I've seen…improvement in staff mental wellbeing by having [IPARr] available for chat and debrief…having someone in a permanent role… would be a massive asset as [IPARr] has demonstrated what a difference it can make.' (Anon, role omitted Q43).*

The potential for this IPARr activity to have influenced ways of working is suggested in one evaluation:

> *'The [WbP] has certainly helped me to…engage in more conversations about how you're actually feeling, instead of the generic answer "yeah, are you?" when asked if you're ok". (Jodie Allsop, HCA Q34).*

Regarding IPAR practice of sharing data, participants stated that data displays had prompted them to consider others' wellbeing and had encouraged individual change in ways of working:

> *'[WbP] made me think about doing things differently. You are more aware of the impact you have on someone else. You do reflect on things you read on the [display] wall.' (Carol Greasley, Housekeeper Int29).*

The second factor frequently suggested to prompt new individual and collective behaviours was raised awareness of the importance of enhancing HCW wellbeing, both to benefit HCWs' and women's experiences.

> *'I'm…more aware of what I say or the way…I say it…a little more measured…I've had greater awareness that the medical staff also feel vulnerable.' (Kate, Senior Midwife Int62).*

> *'Recognition that it's important—this stuff saves lives.' (Anon, role omitted Q35).*

Potentially related to raised awareness, the involvement of all HCWs in the intervention was considered impactful.

> *'[Including all HCWs]…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, role omitted Q30).*

The third factor proposed as influential to improved ways of working was the strengthening of relationships between HCWs:

> *'The atmosphere…has…improved and friendships have blossomed.' (Anon, role omitted Q51).*

Participants described more open communication between different occupational groups and offering more compassionate gestures.

> *'Communication of feelings, needs & appreciation between the MDTs [Multidisciplinary Teams] is improved. Instead of…moaning…concerns are being shared.' (Anon, role omitted Q68).*

Action groups apparently similarly fostered these HCW relationships. One Theatre AG participant described:

> *'Trying to become one team, not them and us.' (Louise Humphries, Senior Operating Department Practitioner, AG meeting).*

Another suggested that new understanding of each other's positions was instrumental to change.

> *'I have witnessed big changes as a result of [Theatre AG]…the reasons for this are that we were able to discuss our roles with each other, and gain an understanding and appreciation of each other's roles.' (Anon, Senior Clinical Midwife Q83).*

H	**H**ealthcare worker driven **-** intervention derives from those potentially affected by change
E	**E**veryone involved **-** all HCW groups acknowledged as instrumental in sustaining wellbeing
A	**A**sk 'What makes you feel good at work?' **-** enquiry is positive, exploring wellbeing sources
R	**R**esponses displayed **-** others' experiences are accessible to colleagues
S	**S**teps taken **-** potential individual behavioural change; group plans for changes in ways of working

Fig. 3 HEARS wellbeing intervention model

A table including this section's participant data as related to generation method is available in Supplementary information Additional file 3. Following findings related to the first two objectives, the HEARS wellbeing intervention model is presented.

The HEARS wellbeing intervention model

We developed the HEARS model in Fig. 3 to demonstrate how IPAR processes were practically applied during the study. The model implies active listening and mirrors LW HCWs' ready participation and agency within the WbP. Its development was intended to facilitate similar wellbeing initiatives in other settings.

Discussion

This IPAR intervention for HCW wellbeing grew from a bottom-up approach rooted in NHS clinical workplace experiences. An overarching organisational approach encompassed all HCWs' workplace conditions while enabling individual interventions to develop according to local need. Despite conditions and workforce numbers remaining unchanged, participants reported improved culture, morale, positivity, and atmosphere.

Evidence continues to support the effectiveness of participatory approaches in fitting individual workplace needs [45], yet leaders struggle to formulate creative strategies [46]. Unlike conventional top-down approaches, the WbP met the current preferred strategy of influencing wellbeing through cultural change [1]. Individual, prescriptive, generic interventions may be insufficiently tailored for the complex needs of diverse healthcare environments [45]. Examples of such top-down interventions include programmes' contents mismatching employee needs [47], lunchtime walking initiatives in the absence of lunchtimes [48], and wellbeing resources inaccessibly situated [49].

The study processes, implemented from the findings of our critical review of PAR's effectiveness in enhancing HCW wellbeing (see Background) [34], are considered to have been effective towards progressing the study aim. The bottom-up approach included all HCW groups and, despite medical colleagues' engagement being particularly rare in wellbeing interventions [50], members of all occupational groups participated. Sharing the qualitative data, generated by several methods, illuminated good workplace experiences and increased HCWs' decision-making towards initiating change in ways of working.

Positive psychology, applied to amplify conditions making life worth living [51] and encourage individual thriving [52], aimed to avoid the employee disillusionment which interventions focussing on workplace deficit and challenges may risk provoking [53]. This approach has, however, attracted criticism from different branches of psychology [54]. One particularly relates to positive psychology's core onus on individuals cultivating their own level of happiness, specifically as associated with organisations adhering to neoliberal philosophy [55]. As applied to the NHS context, neoliberal practices of reducing costs through perceived inefficiencies encourages privatisation of such services as food outlets, affecting employees both providing and accessing these. Lack of readily available refreshment reduces HCW morale [56] yet if positive psychology were applied, the organisation producing the adverse conditions would direct employees to self-manage any wellbeing issues, burdening them with adopting

optimistic and appreciative behaviours despite the new less favourable situation.

The WbP pragmatically introduced positive psychology's basic principle of enquiry around what makes (work-) life worth living as a sensitive method of engaging stressed HCWs within IPAR. It differed, however, from the above critique in that the focus was held only on the individual in relation to whether and/or how they chose personal action to influence a larger group. This may have included adopting different ways of working or behaving in response to colleague data, or choosing not to engage at all. This aligns with IPAR in which community and relationship are considered fundamental to transitioning to new ways of acting [33]. Additionally, LW HCWs may be viewed as having catalysed organisational action by reorientating the Trust's relationship with employees through listening to and valuing their insights. This was indeed realised during the WbP to the extent that the Trust committed to establishing support volunteer roles for clinical areas. In summary, the WbP outcomes may be considered to outweigh the risks of appearing complicit with positive psychology's association with neoliberal ideology. Alternatively, as IPAR is a community-based endeavour, it could be argued that the methodology could simply have been based on a positively-orientated enquiry without introducing positive psychology. In so doing, any potentially misplaced emphasis on individuals self-managing their own wellbeing issues would have been avoided.

Study objectives sought to identify factors encouraging wellbeing and to construct future ways of working. In objective 1, the *Emotional, Professional,* and *Physical nourishment* themes represented sources of LW HCW wellbeing. The themes' data fit the three core needs considered fundamental to securing wellbeing and flourishing in healthcare work [56]. These comprise autonomy, belonging, and contribution. Autonomy reflects the need for control of one's working life, and contribution refers to working effectively for desired outcomes. Within the *Professional nourishment* theme, both elements were illustrated by LW HCW narratives of competently fulfilling personal work ambitions and offering valuable interventions in teamworking scenarios. To belong in a workplace, a person needs to be allied with colleagues, feel cared for and valued, and be able to care for others [57]. *Emotional nourishment* data suggested this element was fuelled for LW HCWs by welcoming gestures, and reciprocal caring and appreciation. Parallel findings for all three themes were found in the literature. For *Emotional nourishment,* UK and New Zealand midwives describe mutual acts of compassion sustaining them at work [58]. For *Professional nourishment*, early career UK midwives illustrate individual motivators being satisfied by facilitating natural births and taking leadership roles [48]. For *Physical nourishment*, the importance of refreshment breaks is stressed, while acknowledging the normalisation of their scarcity [56].

In objective 2, data demonstrated how IPAR activities catalysed a shift towards a more compassionate, inclusive, and positive LW culture. Healthcare workers' ways of working reportedly changed. Colleagues cared for each other more proactively, expressed thanks and positive feedback more frequently, worked better together in teams, and autonomously initiated beneficial interventions for colleagues and women. Participants proposed mechanisms for these changes as through exposure to IPAR activity; raised awareness of the importance of enhancing HCW wellbeing; and strengthening of relationships between colleagues. Theory supports these three mechanisms concurrently interacting towards the cultural shift, as detailed below.

Participants stated that feeling valued by IPAR/r activities, and reading colleagues' data describing how their wellbeing was enhanced, raised mindfulness around workplace wellbeing and stimulated caring actions towards others. Caring, compassionate behaviours elevate mood, positive emotion [59], and a sense of wellbeing [60], and also consolidate social connections [60] and feelings of belonging [61]. Feelings of belonging in workplaces further nourish compassionate behaviours, prompting a self-perpetuating cycle [61]. This is important in terms of retention as experiencing and witnessing workplace compassion encourages employees' commitment to organisations [59]. Additionally, compassionate behaviours are most commonly directed to those who are known or liked [59]. In our study, however, LW HCWs' raised awareness of the importance of enhancing HCW wellbeing may potentially have extended attention to less familiar colleagues, accounting for data related to both caring behaviours and to strengthening colleague relationships and team working. Broaden and build theory suggests that experiencing positive emotions primes the non-conscious mind for similarly uplifting experiences and encourages continuation of these ways of working in an upward spiral known as positive potentiation [52]. Emotional contagion, the transfer of moods between people [62], may have intensified this effect such that the LW HCW body sought to reproduce positive emotions by more proactively caring for colleagues, thereby shifting group norms to a more compassionate and inclusive LW culture. It was previously noted that the cumulative impact of everyday interactions can be both a source of support and the cause of suffering. Study participants reported positive change in the dynamics between colleagues. This suggests the way in which the balance shifts may be contingent on the collective power exercised daily

in HCW behaviours. In summary, a theoretical basis supports HCW rationales for reported changes in ways of working. Considering objective 1 findings, HCWs' changed ways of working may be viewed as an extension of the need to belong, and while no data were generated rationalising HCWs' increased initiatives for women's and colleagues' welfare, it is conceivable that these behaviours reflected HCW needs for further autonomy and contribution.

Although enhancing LW HCW wellbeing and strengthening colleague relationships is important for HCWs, it is also crucial for patient safety. The latest of numerous maternity reports illustrate how poor HCW relationships lead to women's and babies' mortality and morbidity [63, 64]. Poor HCW wellbeing diminishes compassion and makes patients vulnerable to psychological trauma [65]. By contrast, collective wellbeing correlates with improved role performance [66] by encouraging psychological safety, the group relationship in which members respect, review, and act on others' workplace safety concerns [67]. The improved HCW relationships reported in our study therefore promise to support ongoing patient safety.

Extending the value of the wellbeing project

To extend the value of study findings, we propose testing a combination of two routes in a range of settings: applying the HEARS wellbeing intervention model (HEARS), and establishing Colleague Support Volunteer roles.

HEARS

The HEARS model provides a new, simple, low-cost, and readily implementable strategy for workplace wellbeing. Advisory documents direct managers towards positive culture change but fail to position power and control within the larger body of frontline workers [68]. Cultures continually transform and caring cultures cannot be implemented on demand [69] but instead depend on ongoing supportive group behaviours [67]. Applying HEARS could meet these cultural challenges by enabling colleagues to generate positive preferred behaviours and cultural norms, as demonstrated in the WbP and supported in theory [52, 62]. As discussed above, HCW wellbeing is also associated with positive impact on patient outcomes [2], strengthening the case for action towards supportive workplace environments.

Colleague support volunteer roles

Struggling HCWs need effortless access to wellbeing support. Organisations need HCWs to feel sufficiently valued to stay. Even after traumatic events [70], many HCWs neglect self-care and hide emotional distress [8]. In the current study, LW HCWs reported feeling valued and purposefully engaged with the IPARr as an accessible person with a self-declared interest in colleague wellbeing. Refreshments and a listening ear were easily obtainable. Translating what HCWs considered beneficial into a formal Trust Colleague Support Volunteer (CSV) role offers the potential for embedding a source of physical and emotional nourishment in workplaces. Establishing CSV networks, provided by retired or part-time HCWs with relevant previous work experience, accords with recent calls for Trusts to strategically operationalise volunteers [71]. Placed within organisations' Health and Wellbeing Teams, CSVs trained as Wellbeing Champions could additionally signpost HCWs to local and national wellbeing resources.

Limitations

As only English language studies using IPAR for enhancing HCW wellbeing were searched, studies published in a language other than English will not have been identified. Unpublished studies in any language will also have been omitted. Participatory approaches aspire to include participants at every stage of the research process. This occurred formally only after the study started. Future studies would benefit from HCWs contributing to the research question and study design prior to study commencement.

The WbP was specific to one English NHS LW. The attitudes and responses of the setting's HCWs and those of local and senior management, the setting's readiness for the intervention, the culture towards colleague wellbeing, clinical activity levels, existing teamworking, all influenced study processes and outcomes. The IPARr's personal characteristics and behaviours would also be expected to affect participant engagement and commitment. While these factors challenge generalisation of the resulting impact on HCW wellbeing, the HEARS model distils IPAR processes for potential application in other settings. Unusually, HCWs from many different occupational groups participated in study activities but, as data were often anonymous, related proportions cannot be quantified.

Theoretical positioning around social constructionism was foundational to the authors' views of the nature of reality as expressed in HCW accounts. In order to swiftly return data to the HCW arena, however, deep enquiry into meaning within the linguistic form, as may be expected, was not undertaken. For the purposes of promoting action within IPAR, the more experiential form of thematic analysis was used [72]. Participants were assumed to be experts of their own emotional experience as to what made them feel good at work. Data analysis focused on the participants' consciously intended meanings. There may be circumstances in which this

assumption does not hold, for example, if the degree of emotional distress distorts an individual's insight into their own emotional experience. Existing time restraints from high clinical activity limited participant engagement, and were exacerbated by the pandemic, yet reflect the realities of undertaking research in current UK healthcare environments.

Conclusions

To our knowledge, the WbP was the first English language study to use IPAR to enhance HCW wellbeing. Colleagues from diverse occupational groups participated and reported improved culture, inclusivity, morale, positivity, and atmosphere. Methodological processes prompting increased awareness of the importance of HCW wellbeing strengthened HCW relationships and shifted culture to be more compassionate and inclusive. The authors developed the HEARS wellbeing intervention model to reflect IPAR processes and enable application in other healthcare settings. Subject to implementation research, we propose that in addition to establishing CSV roles, HEARS provides positive, participatory, practical, and economic steps that organisations could take towards improving HCW wellbeing and retention.

Abbreviations

AG	Action group
CSV	Colleague support volunteer
HCA	Healthcare assistant
HCW	Healthcare worker
IPARr	Insider participatory action research researcher
LW	Labour ward
PPR	Peer participant reviewer
PMW	Preceptorship midwife
WbP	Wellbeing Project

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-12331-6.

Additional file 1. Prompt guide wellbeing interview.

Additional file 2. Action group activity.

Additional file 3. Table 1 Data generation methods and related data.

Acknowledgements

We are deeply grateful for the support of participants and colleagues without whose commitment the research would not have been possible.

Authors' contributions

CW designed and conducted all study processes as part of a Doctor of Philosophy degree and compiled the first draft of the manuscript. MC and JEM acted as PhD supervisors, agreed final themes, and contributed critical revisions before approving the final manuscript submitted for publication.

Funding

CW would like to thank the Royal College of Midwives for the Ruth Davies Research Bursary 2017/8;the Faculty of Health, Social Care and Education, Kingston University, London and St George's, University of London for a Student PhD Fellowship; and Charitable Funds, University Hospitals of Derby and Burton NHS Foundation Trust for provision of open access fees.

Data availability

The datasets used and/or analysed during the current study are available from the authors on reasonable request.

Declarations

Ethics approval and consent to participate

The study was conducted according to the Declaration of Helsinki. Health Research Authority and Health and Care Research Wales granted ethical approval 19/HRA/0334. Informed consent to participate was obtained from participants.

Consent for publication

Written informed consent for publication was obtained from participants whose personal details are included in this publication.

Competing interests

The authors declare no competing interests.

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Received: 12 May 2024 Accepted: 24 January 2025
Published online: 31 January 2025

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