Understanding, improving and evaluating mental health practitioners' experiences of well-being at work: an action research study

Understanding, Improving and Evaluating Mental Health Practitioners' Experiences of Well-being at Work: An Action Research Study

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Nicola Jane Moone April 2021.

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'Alone we can do so little, together we can do so much' Helen Keller

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Abstract

The maintenance of well-being at work for those working in the National Health Service (NHS) can be a challenge; for those who work in mental health services, there are added issues of increasing demand and a streamlining of services within economic constraints. Literature suggests that there is a gap in the understanding of mental health practitioners' experiences and factors that are deemed important to well-being, and this gap includes knowledge of how well-being can be influenced by mental health practitioners themselves.

This thesis addresses the ways in which mental health practitioners who work in a community mental health team can improve their experiences of well-being, job satisfaction, teamwork and resilience by active engagement in research and through service improvements. The work that was performed for this thesis emphasised the understanding, improvement and evaluation of well-being at work and this was achieved in this study through adoption of action research methodologies. The choice of this method was influenced by the decision to place importance on empowerment, as this approach engages participants to act as co-researchers to define and instigate interventions to improve well-being.

Findings suggest that mental health practitioners understand their experiences at work and place value on being charged with improving their well-being and that active engagement in research is an important factor in the achievement of that goal. Acting as co-researchers, practitioners can moderate the disconnect that exists between the widespread adoption of quality improvement initiatives in the NHS and those favoured by practitioners themselves.

This thesis concludes that practitioners are best placed to understand, determine and develop interventions to improve their own well-being at work. It is significant that, when practitioners are engaged in action research as co-researchers and stakeholders, perceptions of well-being at work can be altered and this has impacts on engagement at work and feelings of pride in work. Active empowerment as co-researchers and stakeholders increases positive feelings toward work in a supportive environment, lessens feelings of isolation, and makes a positive impact on relationships. Active empowerment is achieved through adoption of a collaborative approach to study.

Contents

Preface: Covid-19 pandemic

The impact of the global coronavirus (Covid-19) pandemic, which has occurred in 2020, without question will influence mental health services and the well-being of mental health practitioners (MHPs) now and in the future (Holmes et al., 2020). As is highlighted within this thesis, before the pandemic began mental health services were struggling to meet the demands and challenges that they encountered. The protection of the well-being at work of MHPs in light of the many challenges that they will face increases the importance of this study.

The impact of the Covid-19 pandemic on the delivery of safe and effective care to those with mental health issues places significant pressure on MHPs. It is not a surprise that MHPs now face particular challenges. These are discussed by Maben and Bridges (2020), who highlight the complexities of the delivery of care to those in community settings when combined with the management of the demands that are caused by Covid-19. Blake and colleagues (2020) suggest that organisations should consider how to protect and maintain the well-being of health workers during and after the pandemic.

It is expected, therefore, that National Health Service (NHS) leaders will be charged with focusing on the needs of staff to ensure that well-being and motivation to work in care settings is maintained (Bailey, West and Kings Fund, 2020). However, Bailey, West and Kings Fund (2020) warn that this may necessitate the development of an overly directive leadership, which may be at odds with strategies that engage and motivate staff; strategies such as those that are explored in this AR study. However, the work that is described in this thesis has demonstrated that MHPs are ideally placed to instigate and make changes that improve service delivery if they are afforded the opportunity to do so. NHS leaders should consider this when they focus on staff well-being in future.

Chapter One – Introduction and background to the study

1:1 Introduction

This chapter provides an introduction and rationale for the study and includes reflections on the researcher's position. This action research (AR) study focuses on ways in which well-being at work can be improved amongst community mental-health practitioners (MHPs) who work in a community mental health team (CMHT). An important component of this AR, is the emancipation of MHPs to improve their experiences at work. Therefore, this iterative AR study incorporates a participatory action research (PAR) approach to empower MHPs to lead and instigate change. This is important because the maintenance and development of well-being at work is complex and is rarely explored from a practitioner's perspective (Johnson et al., 2018; Oates, 2018). The maintenance of well-being requires concerted effort and understanding of the various factors that influence it and this AR therefore, is positioned to investigate this from MHPs' perspectives.

When the study began, the researcher was a MHP who worked within a CMHT. The study was initiated after discussion with peers about their experiences at work. These conversations began the process of trying to understand what MHPs perceived to be the most important factors that affected their sense of well-being and, critically, to ascertain whether MHPs were ideally placed to explore and develop strategies to improve their well-being at work. The MHPs suggested three central themes that they considered to be important for their well-being: enjoyment of what they did and feeling optimistic; ability to cope with stress and difficulties; and being members of a supportive team. A subsequent review of the literature (contained in

Chapter Two, sections four to seven) supported the notion that well-being for MHPs was inextricably linked to the team in which they worked, the satisfaction they experienced in their roles and a sense of resilience and ability to manage difficult experiences at work.

The purpose of this AR study, therefore, was to engender well-being within a CMHT through the development of teamwork, job satisfaction and resilience. To do this, adopting an action research (AR) approach, in which MHPs would act as co-researchers was chosen to ensure that MHPs experiences remained central to the AR as it developed (McNiff, 2017). Hence, this AR study was designed to promote engagement with the research and to ensure that interventions were determined by MHPs (adopting a PAR approach) and relevant to all stakeholders.

The AR approach that was used was chosen in response to the ever-changing demands that are placed on MHPs and the need to safeguard their well-being through their active engagement in the research. To reflect the AR approach, this thesis has been structured to underpin and highlight the AR as it developed. The central focus of this AR study was to understand, improve and evaluate MHPs' experiences of well-being at work. With an intention to make change, the AR was structured to empower MHPs, and the integration of a participatory approach facilitates the emancipation and enablement of MHPs to improve their well-being.

AR has a central focus of change (Bradbury and Reason, 2006). The change process is cyclical in nature; it evolves as those who are involved work through cycles of action. There is an emphasis on problem-solving to create practical solutions (Bradbury and Reason, 2006); this mirrors the nature of mental-health practice, so this methodology was also chosen in order to enhance the acceptability of the research to colleagues who worked in practice within the CMHT. The following steps (McNiff, 2017) were taken:

- **Selection of a Concern -** *maintenance of well-being of MHPs (Chapter One)*
- **Clarification of Theories -** *a literature review to develop a conceptual framework (Chapter Two)*
- **Identification of Research Questions** *(Chapter Two)*
- **Methodological Considerations and Research Design** *(Chapter Three)*
- **Data Collection and Analysis -** *understanding experiences (Chapter Four)*

  Research Question 1. *Development of central themes for action*
- **Findings -** *improvement of experiences (Chapter Five)*

  Research Question 2. *Action - finding solutions*
- **Evaluation –** *judgment of experiences (Chapter Six)*

  Research Question 3. *Evaluation of action interventions*
- **Summary and Conclusion** (*Chapter Seven)*

To support this introduction to this thesis, an account of the key concepts in this AR study as discussed above, is explored next. Exploring well-being, resilience, teamwork and job satisfaction is important to underpin and to develop appreciation and understanding of MHPs' experiences at work as this AR study develops.

1:2 Well-being, resilience and coping, job satisfaction, and teamwork

Central to building well-being at work for practitioners, was a need to ensure that job satisfaction, teamwork and personal resilience were developed by MHPs and that this was supported by the organisation. This presented a challenge: ensuring that MHPs had an optimistic outlook of their role and contribution, alongside understanding the organisations' role in performance. This necessitated a need to understand the concept of well-being, to ensure that positive workplace environments were created for MHPs in this AR study (Imison and Bohmer, 2013; West and Lubovnikova, 2013).

1:2.1 Well-being

In the context of a workplace, the concept of well-being has many different interpretations and viewpoints (Romppanen and Haggman-Laitila, 2017). The concept of well-being at work refers to the individual and to the organisation in which they work. As suggested by Anttonen and Rasanen (2009), well-being at work can be defined as a combination of: health and safety at work, experience of good leadership and change management and the support afforded to an individual to engage in meaningful work experiences. Although there is no definitive definition of workplace well-being, Schulte and Vaino (2010), characterise well-being as quality of work-life including aspects of occupational health and safety. Therefore, well-being at work should include an understanding of the personal health resources of individuals and this includes contribution within the work place, all of these factors are pertinent within this AR.

Well-being refers in general to a positive view of the concept (Utrianinen, Ala-Mursula and Kyngas, 2015). Though well-being is a subjective concept, the contribution of objective factors is increasingly recognised, workplace well-being is viewed as embedded within, rather than separate from, the context of important organisational issues (Shanafelt et al., 2016). Therefore, understanding and supporting well-being at work can benefit both the employee and the organisation by creating a more positive view of experiences and can be interrelated with factors such as sickness and absence (Buffet et al, 2013).

Understanding that well-being has direct impact and consequence for an individual and organisation is an important consideration to determine both positive and negative correlations to engagement in work and performance (Tomo and De Simone, 2017). Generally, though an individual can be said to lack well-being, for the purposes of this study, well-being is considered as existing on a continuum from poor to good. This is consistent with the use of measurement scales, whereby the association of scores with other factors can facilitate understanding of the important components of well-being in the workplace and highlight targets for change to improve well-being. Poor well-being at work, can impact on both the individual and on the organisation negatively (Tomo and De Simone, 2017). There is a correlation between poor well-being and less contribution made to the organisation and also to poor decision making (Price and Hooijberg, 1992; De Dreu, Van Dierendonck and Dijkstra, 2004). Poor well-being of MHPs is linked to propensity to make errors and

this is important in understanding the impact of stress and burnout on well-being (Johnson et al., 2018)

It has been suggested that research in healthcare settings is evolving and this has led to attempts to understand the concept of well-being for healthcare professionals (Dow et al, 2019). Within the context of this AR and the experiences of MHPs, the importance of well-being at work is linked to: personal resilience (Foster et al., 2019), work environment (Romppanen and Haggman-Laitila, 2017), their intention to remain in the job (Ott-Holland, Sheperd and Ryan, 2019) and stress and burnout (Johnson et al., 2018).

Levels of well-being can be influenced by a complex interplay of factors and there is no definitive account of what influences well-being. However, In the first instance, well-being within the context of this AR study was understood to include three main components (Fisher, 2014): *subjective well-being***,** which comprises job satisfaction and both positive and negative effects; *eudaimonic well-being*, which is subjective well-being that is influenced by factors such as motivation and engagement; and *social well-being,* which is dependent on the variables of being connected and satisfied, and various relational factors that include leadership. These factors are important to understand the experiences of MHPs as they manage stress and consider ways in which to become more resilient and develop coping strategies to meet challenges at work. However, good coping skills can be linked to well-being but in the climate of working in the NHS, expecting staff to manage and cope with

challenges and demands may not always be realistic. Consequently, being overly reliant on coping may not necessarily ensure well-being.

1:2.2 Resilience and coping

The concept of resilience is considered across different sectors and settings and there are varying interpretations, definitions and constructs used to explore relationships to it (Wiig et al., 2020). Cooper and colleagues (2020) suggest there is a dynamic relationship between the individual and adaptive systems that impact on resilience including biological, social and cultural influences. The concept of high resilience relates to positive adaption and an ability to cope (Fletcher and Sarkar, 2013).The concept of resilience as suggested by Tugade and Fredrickson (2007) can be described as a developing continuum at the core of which lies physiological and psychological factors. However, within the context of healthcare, and this AR, resilience is seen as a factor that helps practitioners to develop psychological skills to function in positive ways (Rutter, 2012).

As such, resilience is context-dependent, and therefore affected by many variables. This has led some to question the scientific value of resilience, with Wild et al. (2013) wondering if it is a poorly articulated concept. Despite this, in mind of what is known about stress in workplace and direct impact on care, it is prudent to ensure MHPs in this AR are supported to adapt in a positive manner and build whatever skills and characteristics are necessary to deliver care effectively.

The value placed on resilience in healthcare has led to various interventions aimed at enhancing practitioners' well-being and self-care through resilience training programmes (Foster, Cuzzillo and Furness, 2018) designed to temper responses to stress. However, as highlighted by Taylor (2019), enhancing coping through such programmes is only one element of well-being at work as often practitioners are working in environments that can impact negatively on resilience. As suggested by Kreitzer and Klatt (2017), practitioners need to build resilience in a system that maybe unhealthy (i.e. due to system processes, conditions of learning and work) and erode individual resilience; this is an important consideration within this AR.

Therefore, resilience needs careful definition and understanding of the influences on this phenomenon including the context of the CMHT in which this AR sits. Wiig and colleagues (2020) define resilience as the ability to adapt and meet challenges and changes within all systems to maintain quality of care, suggesting that being adaptable and having the ability to employ coping strategies is important. There is a growing body of evidence that explores coping and resilience and what enables a practitioner to cope despite the adversities that they may face in practice (Brennan, 2017).

Coping with adversity and being resilient is developed in this AR study as MHPs are supported by peers, the organisation, and develop well-being within a supportive team. The team camaraderie fostered throughout this AR is important to build resilience (Brennan, 2017). An important element of building resilience in this AR study is the coping mechanisms employed by MHPs acting as co-researchers,

engaged in changing work experiences and managing difficulties faced, all of which foster resilience. Therefore, resilience and coping strategies are important factors in developing well-being in nurses (Manomenidis, Panagopoulop and Montgomery, 2019), and this is important throughout this AR. Despite the challenges faced by MHPs in this AR study, resilience enables them to cope with their work environment and is related to: personal traits, workplace characteristics and a social network (Yilmaz, 2017), all of which are positively influenced by active engagement in the AR. Being able to cope and manage difficulties and challenges faced is closely aligned to satisfaction at work for MHPs.

1:2.3 Job satisfaction

A sense of wellbeing at work and job satisfaction is an important factor for MHPs within this AR. The definition of job satisfaction as explored by Hoppock (1935), suggests that job satisfaction relates to a combination of physiological and environmental factors that lead to the sense of being satisfied or not. However, in line with valuing the emotional impact of a working environment, Adams and Bond (2000), define job satisfaction as the degree of affect towards your job and the various components of it. When viewed as a positive concept, job satisfaction is defined as being related to positive aspects of job behaviours. There is no definitive measure of job satisfaction and Utriainen and Kyngas (2009) found that many studies of job satisfaction were dependent on specific measures of the concept.

Davis (1985) suggests that there are clear links between behaviour at work and an increased level of job satisfaction and also job dis-satisfaction. Behaviour at work can often be related to a perceived sense of achievement. Suggestions by Kalinski (2007), directly related a sense of achievement to a greater sense of personal wellbeing, performance and quality of life and also how health-related problems impact on performance. As proposed by Mullins (2007) and subsequently Azuri, Haron and Riba (2014), consideration needs to be given to the individual's internal state bearing in mind that sources of motivation vary greatly between individuals. This is an important consideration in this AR as MHPs are afforded varied opportunities to actively take part in improving work experiences, which acts as a motivating factor to engage in work.

1:2.4 Teamwork

Understanding teamwork and the role and function of teams is pivotal to how care is delivered within health and social care settings. Henrickson Parker, Schmutz and Manser (2018) highlight that there are no definitive measures of teamwork or agreement on how effective teamwork is defined. Previously, there have been attempts to understand the value of teamwork by looking at failure, outcomes of which suggested a direct correlation between effective team working and fewer problems, although this relates to teams that are led by designated procedures and tasks (Catchpole et al., 2007). However, positive links between task and performance have been explored and suggest a clear link between the co-ordination of teams and the behaviour of teams (Manser et al., 2009).

Focused on behaviour and performance of teams, there are suggestions that outcomes of high performance in teams equates to task orientated outcomes (Burtscher et al., 2010; Burtscher et al 2011). Nonetheless, this may not be representative of different settings such as mental health, where roles and tasks are not clearly defined. Teamwork therefore is multi-dimensional and it is inextricably linked to the care that is delivered (Schmutz and Manser, 2015).

Within this AR study, the experiences of MHPs in a team is underpinned by empowerment and emancipation from constraints of process and performance and support from the organisation to make changes. This correlates to a healthy workplace as defined by the World Health Organisation (WHO) (2019) as “workers and managers actively contribute to the working environment by promoting and protecting the health, safety and well-being of all employees”.

Consequently, well-being and the other key concepts in this AR are directly linked to the quality of care that is delivered. It is important to understand that the perception of MHPs of their work experiences can be impacted on in a positive way through engagement in making meaningful changes to their work. Essentially, adoption of an AR approach can engage and empower MHPs to not only be innovative, but also to refine their ability to manage and cope with challenges that they face.

1:3 Context of the study

The setting of the study was a large, urban CMHT that supported individuals who were living in the community and who had serious or complex mental-health

difficulties. At the study planning stage, the team was formed of health and social care staff who were integrated into a single group. However, after the initial engagement of stakeholders, the team structure was changed in response to a local directive that required removal of the social care staff from the team. This change was driven by resource issues and had a big impact on the team. A large, vibrant team that had been made up of health and social care MHPs became a team fraught with difficulty, which was reflected in problems with retention and recruitment of staff. For the researcher, initial fears regarding the possibility that the study would be shelved soon translated into a motivation to continue in order to develop the abilities of MHPs to generate new ways of working and, critically, to ensure that well-being remained at the centre of their experiences. In other words, the need for this research increased.

1:4 Rationale for the study

The NHS is charged with delivering effective and good quality care to its patients. To do this however, staff need to work in environments that support their well-being so that they are able to "thrive at work" (NHS, 2018 and 2019). With an increasing focus on the well-being of its staff, the NHS has developed a well-being framework to ensure that NHS organisations can meet standards to ensure that staff are supported to feel well and happy at work (NHS, 2019). Building on evidence of health and organisational factors that influence the well-being of staff, NHS organisations are charged with defining ways to improve well-being within their organisation. However, fostering well-being for staff is complex and there is a plethora of challenges faced by those working in the NHS and each organisation needs to investigate and understand the experiences of its staff at work. This AR

study positions itself to afford greater insights into the well-being of staff within a CMHT setting and organisation.

There is little question that employment in healthcare settings presents a challenge for MHPs (Oates, 2018). For those who work directly with clients who have mental-health problems, the challenge is two-fold: to develop integrated teams and partnerships across professional boundaries whilst also streamlining services to meet a quality-improvement agenda that is bound by economic constraints (Johnson and Sollecito, 2018). Within this political landscape, the staff experience increased levels of burnout (Salyers et al., 2015; Johnson et al., 2018) while they face unique challenges within the provision of mental-health services (Kelly et al., 2016; Renwick et al., 2019). These factors are important, since there is a direct link between staff satisfaction and the satisfaction that is experienced by those who receive care (Happell and Koehn, 2011; Hall et al., 2016).

It is increasingly evident that work-related stress can influence the well-being of healthcare professionals and impact negatively on their perception of their ability to influence and control the development and improvement of work-related experiences (Bliese, Edwards and Sonnentag, 2017). However, job satisfaction can ensure an increased sense of well-being for MHPs (Osborn and Stein, 2016); healthcare professionals who report enjoyment in their roles say that this motivates them to work in such settings (Dahiten, Lee and MacPhee, 2016). The establishment of a culture in which staff can develop and strengthen teamwork, job satisfaction and resilience for themselves and others within their role can begin a process through

which staff are empowered to meet organisational demands and to re-establish a sense of well-being in the workplace (Alenzi, McAndrew and Fallon, 2019).

Before the researcher undertook the study and the subsequent critical evaluation of practice, the researcher deemed it essential to understand the current context of healthcare. The quality agenda within healthcare has had a far-reaching impact (Ham, Berwick and Dixon, 2016). The emphasis of quality initiatives on the improvement of healthcare and the experiences of both service users and providers requires staff to be motivated to participate in and engage with these initiatives. This was an important consideration for this AR study (Shea et al., 2018). Service managers are tasked with the improvement of clinical effectiveness and simultaneously the demonstration of cost effectiveness (Bauer et al., 2015; Kings Fund, 2015). Challenges that must be overcome to meet the quality agenda relate to the people who are involved in the process, their commitment, the culture of the organisation (Foster, Cuzzillo and Furness, 2018) and the leadership and incentives that are afforded within the initiative (Dixon-Woods et al., 2014; Fitzgerald and Biddle, 2019). For the researcher, being mindful of these challenges has been essential during critical appraisal of practice and MHPs' experiences at work.

The researcher was also aware that quality improvement initiatives in healthcare often result in little or no change and that this is in part due to the complexity of healthcare systems and delivery of services (Davidoff et al., 2015). Therefore, a key theme of this AR was to reflect on the processes that underpin quality initiatives. The

processes that were used in the AR study were iterative and reflected the ongoing, evolving nature of both practice and improvement initiatives.

The use of an AR approach to empower the MHPs who acted as co-researchers to influence practice and to enhance their well-being was intended to engage all those who were involved. There are many examples of AR used in healthcare settings as a means to empower practitioners. Incorporation of a PAR cycle within this AR study builds on the success of other participatory studies that have sought to ensure active engagement of practitioners to manage and instigate change through empowerment of participants. This is discussed by Liang et al. (2019) in a study to build resilience in student nurses. It was found that PAR led to positive results for participants who were able to build self-awareness through active engagement in the research.

The challenge of practitioner ownership lies at the core of issues related to embedding research into practice. Attempts to develop collaboration amongst practitioners and researchers are influenced by interplay of many factors (Rycroft-Malone et al., 2013). However, engagement in AR and PAR can encourage practitioners to take an active role in the research process and, in part, this is because the approaches and methods that are used are often more familiar to them. Cusack et al. (2018), in a study with public health nurses, suggested that the results both in participants and system change may not have been possible without the use of a PAR approach. Cusack and colleagues (2018) emphasised that engagement of participants and understanding lived experiences facilitated empowerment and leadership which would not have been possible without adoption of PAR. This is

important in this AR study as the incorporation of PAR aims to engage MHPs to lead and instigate change and, critically, to be empowered to do so.

Alongside the growth and development of MHPs in this AR study, the researcher position that is explored next recounts opportunities to share knowledge and growth with co-researchers as the AR evolved.

1:5 Researcher position

When this study was conceived, the author worked at the CMHT as an 'insider researcher' who planned to undertake the study from within her team. She then became an 'outsider researcher' after a change of employment to a teaching role (McNiff, 2017). This privileged position enabled her to share experiences of growth and knowledge alongside her co-researchers. In addition, her previous experience as a clinical specialist and manager afforded useful insights that helped to guide the AR.

The researcher's values stem from both a personal and professional standpoint, and they have guided and informed the study as it has evolved (McNiff and Whitehead, 2011). For the researcher, well-being at work and well-being in all aspects of life is of value, since skills and knowledge are readily transferable and inform self-development. Specifically, values of collaboration, belief in lifelong learning and the wish to foster hope and optimism in herself and others influenced this work. These values are coupled with a commitment to democracy, honesty and integrity in the conduct of the research (McNiff, 2017). By stating these values explicitly, the

researcher was able to use them as a framework to evaluate the process of the research.

1:6 Background: healthcare delivery and service improvement

Delivery of high-quality, safe and effective care by skilled practitioners is the cornerstone of the National Health Service (NHS) (Mossialos et al., 2018). However, the NHS faces a plethora of challenges that impact directly and indirectly on delivery of care (Salyers et al., 2017; 2015).These include: an organisational culture that is reactive and regularly operates in a crisis model with poor leadership (McIntosh, 2017); ongoing staff shortages and a workforce that struggles to meet the challenges it faces (Sizmur and Raleigh, 2018); and increased demand for services with accumulative complexity of care issues, which are faced due to an ageing population and a rise in the incidence of long-term conditions (Hignett et al., 2018).

There is evidence that the capability of the NHS to deliver services is compromised by staffing issues, specifically staff shortages (Alderwick and Dixon, 2019) and a lack of capacity to make the best use of skills that are available in the workforce (Buchan et al., 2017).

The demands that are placed on MHPs are primarily centred on delivery of safe, effective and cost-efficient services within an ever-changing environment that is focused on outcomes and fraught with expectation (Cohen, 2017). The Royal College of Psychiatrists predicts that demands for mental-health care will increase in the midst of added pressures that are caused by funding restrictions and a workforce recruitment and retention crisis (Tracy et al., 2019). In some areas of mental-health

care, such as adolescent care, existing services are unable to meet the need in the face of increasing demand (Gunnell, Kidger and Elvidge, 2018).

There is an expectation that MHPs will develop and sustain partnership working across multi-agencies to meet changing mental-health needs of the wider community, in line with social inclusion policy (Department of Health, 1998). Despite the concept of social inclusion being absent in mental health policy in the United Kingdom over the last decade (Department of Health, 2011), clinicians are still striving to meet an inclusion agenda (developing activities and opportunities for those with serious mental illness (SMI) to support recovery) against a backdrop of social exclusion (Wight and Stickley, 2013). As highlighted by Walker and Thunus (2020), social inclusion presents a challenge for mental health services to support inclusion of those with SMI into the community and conversely for those with SMI to be able to access mental health services. Managing the discourse of social inclusion, can compound the stressors faced by MHPs in practice, as challenges persist to mitigate the barriers that perpetuate exclusion faced by those with SMI This means that challenges must be managed during work across health, housing, social care and third-sector services (voluntary and community organisations) to meet mental-health needs (Delaney et al., 2018). Work in this challenging environment can contribute to stress and have a negative impact on the staff's sense of well-being (Buchan et al., 2017; Clearly et al., 2020).

Current national and organisational drivers of care delivery are underpinned by attempts to assist MHPs to work with the many challenges that they face in practice

(Alenzi, McAndrew and Fallon, 2019; Gillet et al., 2019). NHS Trusts aim to equip staff to manage their work environments and they have adopted broader approaches to understand whole systems of healthcare through the exploration of practices and challenges and the identification of collective approaches (Fleury et al., 2018; Dow et al., 2019). A systematic review has been undertaken of whole system approaches to the improvement of health and well-being at work of healthcare workers in the United Kingdom (UK). The review found that there was a need to: engage and involve staff; to understand local needs and to respond accordingly; and to 'up skill' senior leaders and managers to be responsive to concerns regarding the well-being of staff (Brand et al., 2017). Against this backdrop, it is clear that practitioners although often at the heart of care delivery are rarely involved in transformational changes that are emancipatory in nature and borne out of a sense of empowerment to improve their experiences, practice or knowledge, all of which have propensity to impact of their well-being.

Conversely, evidence that was taken from a recent NHS national staff survey suggested that there had been: a slight increase in the number of staff who felt unwell due to work stress in the three months previous to the survey date; a decrease in staff satisfaction regarding the care that they delivered; and a decline in the number of staff who considered that they could contribute to service or care improvements (National Health Service Staff Survey, 2017). The subsequent NHS staff survey (2018) indicated that 39.8% of staff had felt unwell in the previous 12 months due to work stress, yet only 26.6% of staff thought that their organisations took positive action on health and well-being. This figure was down from 31.8% in

the previous 2017 survey (Thornton, 2019). Findings specific to the NHS Trust in which the study sits, suggests that 41% of staff had felt unwell due to stress in the previous 12 months and that 52% of staff had attended work in last 3 months despite feeling unwell due to perceived pressure from managers, colleagues or themselves.

More recently the NHS staff survey (2019) indicated that 52% of staff feel involved in changes made in their team, 53.4% report strained relationships in their team and 40.3% report work related stress, all of which are important factors to their well-being (Kings Fund, 2020). Findings that specifically relate to the MHPs in this AR study (i.e. NHS Trust specific data) suggest that 93% of staff feel that they have put themselves under pressure to go to work, and in last 3 months 55% of staff have been at work despite feeling unwell and that 47% feel relationships at work are strained. These results are not dissimilar to the national picture and suggest a need to counter factors that have potential to impact staff well-being at work and to safeguard well-being at work for MHPs in this AR.

By engagement in a process of facilitating changes in practice as in this AR study, MHPs can be encouraged to develop a sense of being able to make changes and in part influence work experiences. However, MHPs' abilities to change their situations may be limited in part due to a perceived external locus of control; that is, MHPs may believe that they are unable to exert influence and, instead, they have a sense that the direction of service improvements is determined by others (Pascoe, 2016). A

shift to an internal locus of control, encourages MHPs to develop and to make changes whilst they acknowledge that they may need support to do this.

This AR study takes rhetoric of ‘ownership’ of change away from a notion that practice based studies and projects are primarily driven by expected outcomes and predetermined intentions (White, Wells and Butterworth, 2013). Notwithstanding the issues faced to engage practitioners in innovation and research, there is a sense that greater attempts are being made to proactively seek to promote a greater sense of ownership, with specific relation to performance (West and Dawson, 2012; Jones and Woodhead, 2015). Therefore, an optimistic outlook by MHPs of their work and the contribution they make, alongside understanding the role that the organisation itself plays, can enhance a sense of ownership of changes and innovation made in practice towards an internal locus of control (Pascoe, 2016).

In response to the researcher’s understanding of the difficulties that are faced by MHPs, this AR aimed to promote a sense of optimism in the workplace for MHPs and to give them a sense of value and empowerment through their involvement as co-researchers. The intention was that MHPs would be able to self-determine strategies to build essential elements of workplace well-being, which were: job satisfaction (Osborn and Stein, 2016), resilience (Foster et al., 2019), and teamwork (Fleury, Grenier and Bamvita, 2017 and Fleury et al., 2018).

To do this, as previously mentioned, the researcher employed an AR approach and utilised service improvement methodologies (which were commonly used in

healthcare and were familiar to MHPs) such as plan, do, study, act (PDSA) cycles, which could bridge the gap between theory and the reality of practice settings (Casey, O'Leary and Coghlan, 2018). In addition, formative evaluation and reflection sessions ensured that opportunities for improvement were akin to service and organisational priorities and the effective engagement of MHPs.

Finally, a critical aspect of this AR study was the use of a collaborative approach that merged the culture and context of working in healthcare with the initiation of and 'actioning' change and the empowerment and emancipation of MHPs to do this. Staff qualities and practices are embedded in an organisation's culture and cannot be studied in isolation (Blake and Lloyd, 2020). This research, therefore, was designed to understand how MHPs viewed resilience, job satisfaction and teamwork but also to understand how these could be developed to enhance well-being.

As a novice researcher and to inform and guide the development of the AR process, initial ideas of personal interest, topical research and a theoretical framework were positioned using a conceptual framework (Ravitch and Riggan, 2016). This was used to underpin the process of ensuring that the study retained trustworthiness as it developed. A dynamic and iterative approach enabled clarification of the area of interest (well-being) which could then be amended after the completion of the subsequent review of the literature (Chapter Two).Through the completion of this process, the theoretical perspectives of the researcher were developed (Straughair, 2019).

The initial conceptual map that was drawn up at the outset of the study is shown in Figure 1. It demonstrates how the evidence and reflections that have been discussed above related to the overarching construct of interest – 'well-being at work'.

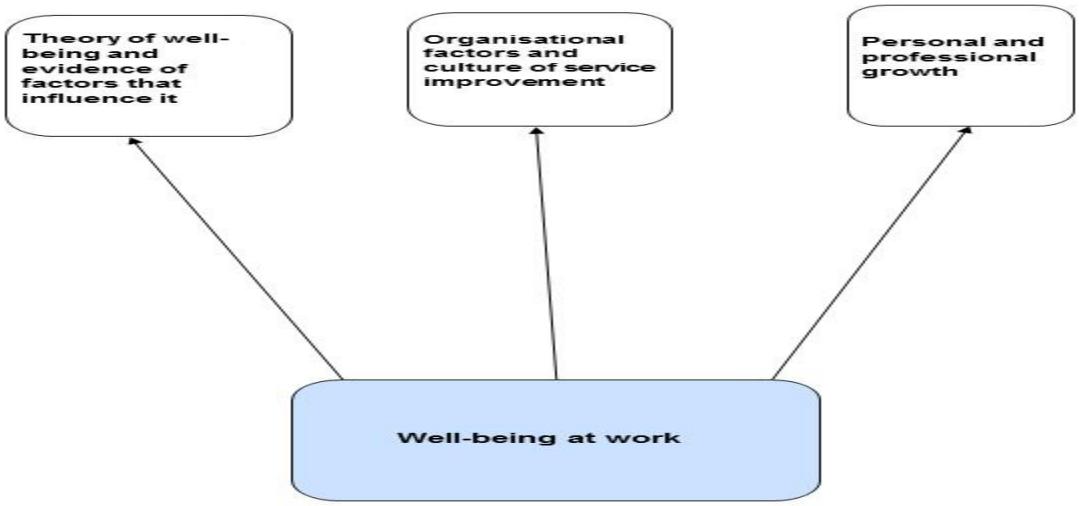

Figure1- Initial conceptual map

1:7 Summary

In this chapter, the researcher has described her personal and professional reasons for the selection of her research topic. She has set this in the context of the current state of the NHS, and the specific setting for the work (i.e. a CMHT). She has also demonstrated how her values and experience led her to select AR as her methodology. She has explored her understanding of the overarching construct of interest – well-being at work – and has highlighted the importance of optimism, resilience, job satisfaction and teamwork. The following chapter reviews the existing literature in relation to these contributing factors and informs the conceptual framework of the study.

Finally, for any novice researcher, in this case an action researcher, there is an additional aim of personal and professional growth. In order to understand this, the researcher engaged in an ongoing cycle of reflection and evaluation of her own and the study's progress; excerpts from field notes that were made throughout this research 'journey' are provided throughout to illustrate this.

Researcher field notes February 2018

> *I am worried that I won't be able to deliver! Feel panicked that my interest in well-being has guided the study and I now have created an interest in the team that I may not be able to deliver on. I don't want to exploit my relationships with the team and must remember it is about them and not me! I am not sure how I will marry up the different concepts and how action research will work. The Trust is supportive, as is the clinical director, but I still feel unsure about how it will all develop. Need to be sure about action research, service improvement and challenges faced in making changes in a team that has been struggling, in order to avoid making the situation worse*

Chapter Two - Literature Review

2:1 Introduction

This chapter contains the literature review that was used to inform and develop the conceptual framework of the study (which is highlighted in Chapter One, section 1:6) and the research questions of this work. It was evident that methodologies that were used in the literature may not have been reflective of the collaborative focus of the present study. However, the evidence provided a background to the study and ensured that the study was developed with consideration of the gaps in the literature and provided a focus for the researcher to refine and re-define her initial thoughts regarding potential study design. Published literature that related to well-being and MHPs' experiences was reviewed. The aim of the review was to identify how others had conceptualised the key study constructs: well-being and its development, and experiences of MHPs. This identification informed the ways in which the constructs would be operationalised and the approaches to improvement that were most likely to influence and enhance MHPs' experiences.

2:2 Search strategy

The strategies that were used for this literature review were developed in line with suggestions from Aveyard (2014) and Aveyard, Payne and Preston (2016). Advanced searches were performed for peer reviewed and empirical literature that had been published in the English language. Searches were undertaken using the Elton B Stephens Company (EBSCO), which carries databases that are specific to health and social care such as the Cumulative Index to Nursing and Allied Health Literature (CINHAL), MEDLINE and OVID.

Initial searches yielded many ‘hits’ and required some modification to ensure that the number of results was manageable and the results themselves were relevant. In line with guidance to manage a literature review (Aveyard, 2014), different combinations of terms were applied and titles and abstracts were screened for relevance. An initial critique of abstracts of research papers led to decisions regarding whether the full papers were to be included.

Search terms were developed as the search progressed. They are summarised in Table (1). The initial search delivered wide-ranging and extensive results. Many of these hits were not directly relevant, so further modification was undertaken through application of different search terms such as experiences OR perception OR attitudes OR views. This led to production of a more manageable number of relevant results. Advice was sought from a specialist university librarian who supported the final searches.

Table 1- Search terms applied during literature review

Title
“well-being” OR “wellbeing” AND “Mental Health Nurses” “Healthcare” “Nurses”
AND
“experiences” OR “perception” OR “attitudes” OR “views” OR “feelings” OR “effects” OR “impact”
AND “development”
AND
“strategies” OR “methods” OR “techniques”

To supplement the process and ensure that all relevant papers were identified, hand searches were conducted of reference lists and citations in the identified studies. Additionally, publications that were relevant to the research question and well-being at work in the NHS were included.

2:3 Study selection and critical appraisal

Potentially relevant studies were then critically appraised in more depth through critical reading, as has been suggested by Aveyard (2014). Notwithstanding the methodological approach of the studies, the appraisal of the literature included consideration of the focus and design of the research, the populations that were studied, and the interventions and outcomes that were tested, including their alignment with the intention at the outset. Deliberation was given to whether all the extracted studies should be included in the review, particularly when the study was based in a practice setting where national guidance and organisational factors could be influential. Emphasis was given to studies that explored the relationship dynamic between researcher and participants.

The rigour of all studies was explored, with specific focus on results and variations alongside ethical issues. As suggested by Aveyard (2014) and Aveyard, Payne and Preston (2016), before final selection, the relevance and probable contribution of the selected studies to the current research were assessed. To ensure that a systematic approach was taken to the review and to help frame the selection process, inclusion and exclusion variables were followed (Table 2) (Coughlan and Cronin, 2016).

Table 2 Inclusion and exclusion criteria for literature review studies

Inclusion criteria	**Exclusion criteria**
Full text only Well-being in title Measures of well-being in title or full text	Publication before the year 2000 Outside healthcare Language other than English Public health / health promotion to raise awareness rather than to study the experiences of healthcare staff or students; regarded as insufficient to be used as evidence

Practitioner experiences of well-being in title or full text Care delivery and well-being in title or full text Strategies to enhance well-being in title or full text Population: healthcare professionals or students; nurses, midwives, medics, occupational therapists Practitioners acting as co-researchers National surveys of healthcare staff well-being Full text articles pertaining to well-being of NHS staff	Well-being in the broader sense as a concept (does not specify practitioners in full text) Co-researchers in settings other than healthcare Well-being, practitioners, experiences, care delivery or strategies are not in the abstract/full text

Empirical literature that was excluded from the review included papers that did not contain any of the key concepts that are outlined in the title of the research study. Papers were not excluded based on participants' settings or based on any discipline that worked in healthcare settings; therefore, studies that were conducted in both mental-health and non-mental-health settings were included to understand both commonalities and distinctive findings. Initially, no publication dates were mandated; this was to ensure that both seminal works and contemporary studies were captured. As the process developed, date restrictions were applied that were specific to the development of mental-health nursing after 2000, when mental-health treatment moved away from large institutions toward more community-based services (Turner, 2004). This choice was made to ensure that selected studies were relevant to current practice and to this study. To highlight the process of study extraction further, a preferred reporting items for systematic reviews and meta-analyses (PRISMA) diagram (Figure 2) was drawn up to detail the process of selection and inclusion that was applied in this review (Moher et al., 2009).

2:4 Literature review: data synthesis

Broad definitions were used at the outset to guide the iterative nature of this critical review. Key concepts that were in line with this review and the intention of the research were explored through a combination of different methodologies (from positivist to critical inquiry) and various philosophical and theoretical positions, and through exploration of whether there was consensus or not. This iterative process highlighted the dynamic and complex interplay of the variants that influenced the key concepts of the study.

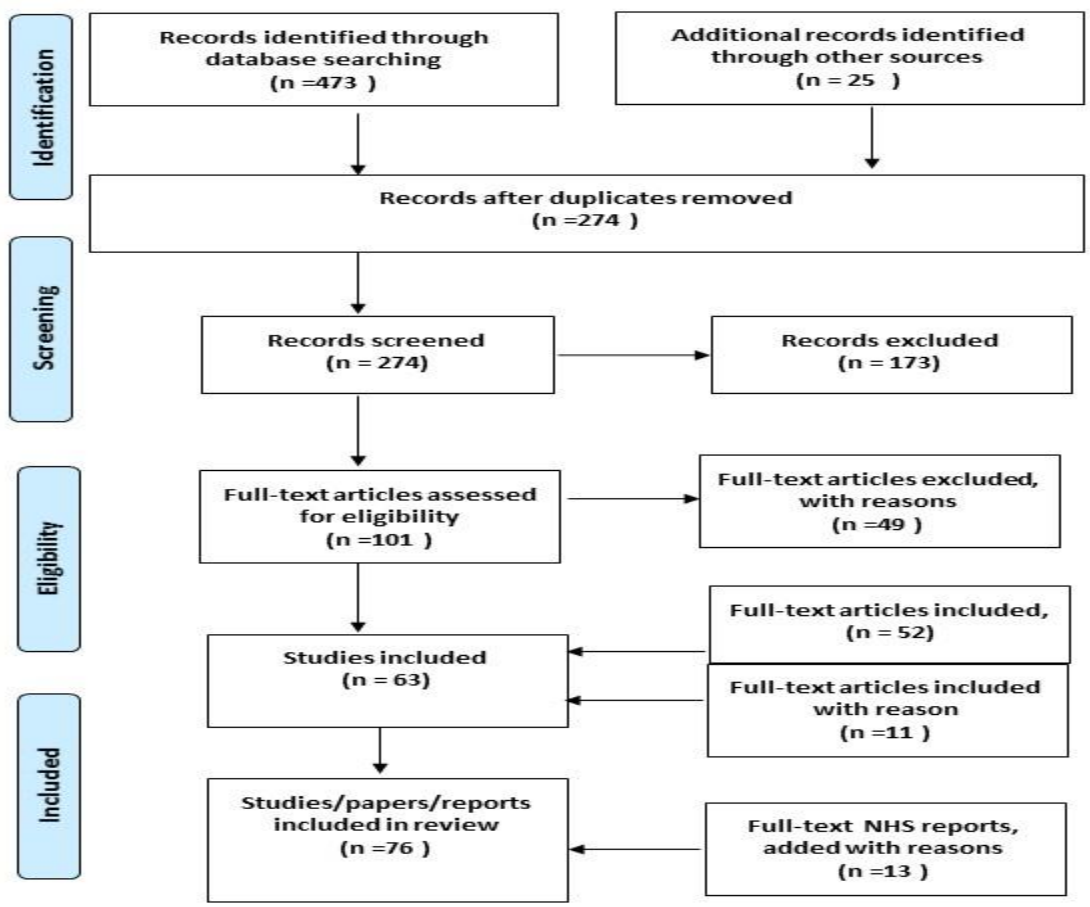

Figure 2: PRISMA flow diagram of the screening process

Synthesis of the literature involved repeated reading and re-reading of the included studies to identify themes and related sub-themes that were relevant to the study objectives and to the initial proposed conceptual framework for the study. Although not exhaustive, themes represent the principles of a narrative inductive method and demonstrate progressive combination and integration of differing research studies (Dixon-Woods et al., 2005). Therefore, the review was structured to reflect a narrative composition of the critical analysis of the literature (Machi and McEvoy, 2016).

Structuring the review in this manner provided the researcher with an overriding understanding of the gaps that occurred in the literature. It also formed a process by which the researcher could establish the informed decisions that were required about the research design and the research questions to be addressed in this study. A comprehensive data extraction table is included as Appendix (1) and this provides an overview of the studies that were included and the salient themes that underpinned this review.

2:4.1 Well-being: developing a thematic narrative of the literature

The definition of well-being at work is open to contention through its consideration under different theoretical positions, and, if taken in isolation, the concept can be broadly interpreted (Chapter One, 1:2.1). Thus, influences are multifaceted and dependent on variables such as: the practice setting, length of practice experience of MHPs, the support that is available, organisational and leadership factors and the perceptions of participants regarding the concept.

To guide the development of the thematic narrative of the literature, an overview of the included studies suggested that despite the complex interplay of many factors and no definitive account of what well-being at work is, there were central themes that were of importance to this AR study. When considering MHPs' perception of well-being, it is evident that understanding the importance of well-being is of value and therefore warranted further consideration as a theme in this review. Literature included in this theme (importance of well-being) suggested that the health and well-being of staff in the NHS can impact on care received and correlates with stress and burnout. The importance of well-being is verified by the NHS prioritising staff well-being (NHS, 2018). The importance of well-being in this instance is based on the premise that quality of care can be linked to staff well-being. For staff, a prerequisite of well-being is a working environment that supports them to make choices that maintain their well-being, as in this AR study.

Well-being is a complex concept, and there are gaps in evidence of its effects, particularly during attempts to understand practitioner experiences of well-being. To build on the importance of well-being in this narrative thematic review, it was apparent that well-being could be dependent on a complex relationship between different factors, with no conclusive account of what influences well-being. To explore and understand MHPs' experiences began a process of consideration of factors most likely to impact on their experiences. Clear links can be seen between factors such as stress and job satisfaction, and also the value of recognition of and managing competing demands. If the AR study was to promote a sense of optimism and well-being in the workplace, giving a sense of value and empowerment, understanding factors most likely to impact on MHPs' perception of well-being was

critical to success. Therefore, a theme that included factors that impact on well-being was important to find commonalities and influences and to gain clear understanding of MHPs' experiences at work.

Evidence suggests that organisations play a key role in well-being of staff and this can influence change and innovation. Therefore, central to this AR study and the well-being of MHPs is having a shared sense of responsibility for performance between the individual and the organisation. There is a need to ensure that MHPs have an optimistic outlook on their role and contribution, and an understanding of the role of the organisation in performance and in maintaining their well-being. A theme that emphasised the value of an organisation in the well-being of staff within the NHS, enabled scrutiny of the factors that warranted consideration from a workforce development viewpoint. Studies suggested that even the smallest of opportunities to manage well-being at work can result in both personal and professional development of practitioners.

Therefore, the thematic narrative of literature includes: the importance of well-being, the factors that influence well-being and the organisational factors that influence well-being and are these are highlighted next.

2:5 Theme: the importance of well-being at work

The papers that were included in this themed section of the review (n=23) included a combination of empirical studies (n=13) and literature reviews (n=5). These were supplemented by reports on NHS staff well-being that highlighted further the

challenges and resource issues that were faced by MHPs (n=5). The majority of studies that were discussed used survey instruments (n=7) and questionnaires (n=4) to measure influences on well-being. These influences were: stress; burnout; intention to stay; workplace factors such as environment and workload; and, critically, the impact of all of these on care delivery.

Methodological quality was considered during the process of selection of studies for inclusion. However, there were some considerations that warranted ongoing deliberation, which included: no benchmark measure of well-being or indicators of how it was measured; complexity of influential factors; bias that was introduced during the survey process; gaps in the evidence to understand well-being experiences of staff; and strategies that could be used to improve work experiences. Two studies used a mixed method, but the qualitative data were not specific to the experiences of practitioners. The subsequent discussion highlights evidence that suggests that working in the NHS can impact on well-being, and this was important in the current AR study.

It is evident that there is an acceptance that working in healthcare can be demanding and stressful, and this acceptance is at odds with an expectation that work in healthcare settings should be gratifying and enjoyable (Kinman and Leggetter, 2016). Work in the NHS, as suggested by the National Health and Safety Executive (2015) (Chana, Kennedy and Chessell, 2015), leads nurses to be at greater risk of work-related stress than other occupational groups. The negative impact of stress on nurses can result in changes in mental health and well-being and can lead to anxiety and depression (Bronkhorst et al., 2015).

With regard to the well-being of MHPs, which was considered in this study, the increasing effects of stress that is caused by challenges that are faced in clinical roles can lead to increasing levels of burnout and may influence retention rates of staff (Bliese, Edwards and Sonnentag, 2017). Poor retention of staff, and the consequential overload of work on those who remain, can be linked directly to job dissatisfaction (Baum and Kagan, 2015). Therefore, exploration of how MHPs can adapt to the many challenges that they face and build resilience is critical to ameliorate the negative impact of stress on the physical and mental well-being of MHPs (Kelly et al., 2016).

The differences between the staff in mental healthcare and those in other healthcare settings is that stress and burnout are linked with the 'emotional labour' of caring for patients who are in particular, emotionally difficult situations: they may be detained and treated against their will, or may have self-harmed or are in danger of doing so, or they may exhibit other challenging behaviours (Johnson et al., 2018). Gillet et al. (2019) state that nurses who work in mental healthcare face particular factors that are associated with well-being at work; for instance, they must handle on a regular basis the unpredictable behaviours of patients (such as violence, disruption and challenging actions). MHPs must meet these needs, and clinical issues that impact on their well-being, within a context of national recruitment and retention issues (Oates, 2018) and scarcity of resources (King's Fund, 2015).

These findings support the researcher's thoughts about the unique challenges that MHPs face and how these challenges can have adverse impacts on well-being at

work. Consequently, within a working environment that is fraught with expectations and demands as highlighted by Renwick et al. (2019), staff who work in mental health services report that work stress has a negative impact on their health and well-being. The factors that influence well-being for MHPs include: personal resilience (Foster et al., 2019), work environment (Romppanen and Haggman-Laitila, 2017), their intention to remain in the job (Ott-Holland, Sheperd and Ryan, 2019) and stress and burnout (Johnson et al., 2018).

2:5.1 Sub theme: care delivery

As has been stated, there is a direct link between emotional exhaustion, burnout and psychological distress for nurses who work in the NHS across specialities (Chana, Kennedy and Chessell, 2015). There is evidence that nurses' burnout and psychological distress are linked with their caring roles (Foster et al., 2019) and that levels of depression, distress and emotional exhaustion correlate with caring behaviours (Chana, Kennedy and Chessell, 2015).

Therefore, the notion of therapeutic optimism is essential to understand the individual responses that occur in practice to decisions that are made. Jackson, Firtko and Edenborough, (2007) suggest therapeutic optimism as one looking at the positive side of a situation and, in being optimistic, having an expectation of a positive outcome. In an exploration of the use of seclusion in mental-health settings, Happell and Koehn (2011) found that there were clear links between the use of seclusion (which if overused can be harmful to patients) and the levels of therapeutic optimism and emotional exhaustion among the staff who imposed the seclusion.

Participants who had increased levels of therapeutic optimism and less emotional exhaustion were less likely to support the use of seclusion than those who were more emotionally exhausted and less therapeutically optimistic. Therefore, the levels of MHPs' optimism can be directly related to their experiences at work and the care they deliver.

However, as highlighted by Maben et al. (2012) a staff member's level of work-related stress can impact negatively on their sense of well-being and on their sense of being able to exert influence and control over the development and improvement of their work-related experiences. Maben et al. (2012) used case studies (*n=18 staff interviews, n=18 carer and patient groups)* to explore the relationship between patient experiences and staff motivation to offer high-quality care, and the effects on staff well-being. The findings provide an understanding of the link between care delivery and staff experiences. The researchers found that variations in the patients' experiences of care were dependent on how well the staff adjusted to and managed their feelings of inability to influence the challenges they faced, combined with poor leadership and relationships with peers.

Salyers et al. (2015) examined the relationship between stress and burnout in a sample of community mental health workers (*n=113)* and the quality of care the workers offered. Participants in the study self–reported the quality of care they gave on a scale that comprised three main factors: client-centred care, general conscientiousness and few errors. The findings suggested that feelings of

accomplishment led to reports of high-quality care and those who felt burnt out reported low-quality care.

A systematic review of levels of staff well-being, quality of patient care and safety suggested that well-being and burnout were linked to patient safety (Hall et al., 2016). This review found significant links between poor levels of staff well-being and poor patient safety outcomes (*n=22 of 27*). The studies that were reviewed also showed an association between higher levels of burnout and an increased number of errors (*n=25 of 30).* These findings were also evident in a study of patients' satisfaction with the care they had received. It was found that low feelings of well-being and higher levels of burnout correlated with poorer levels of patient satisfaction with care received (Salyers et al., 2017). Taken together, these findings suggest that feelings of poor well-being and high burnout are linked with poor care delivery and patient safety (Johnson et al., 2018).

Reduced levels of well-being furthermore have direct impacts on quality of care through their negative impact on staff retention rates (Laschinger and Fida, 2015; Masum et al., 2016). In mental-health services, high levels of staff turnover has been linked to: reduced use of evidence-based practice in care delivery (Woltman et al., 2008); and in care homes, to retention and quality of care that the residents receive (Van Bogaert et al., 2013).

Overall, it seems that the health and well-being of staff who work in the NHS is essential to those who receive care (Johnson et al., 2018) because of their impact on

staff retention rates and links between levels of staff burnout and stress and the impact they have on patient care (Dow et al., 2019). Those who work in healthcare often experience high levels of mental illness and workplace stress (Boorman, 2009). In the United Kingdom, the NHS has placed priority on the addressing of issues that are associated with staff well-being (NHS, 2018).

It also give the impression that, in mental-health settings, well-being is particularly influenced by high levels of stress, burnout and emotional exhaustion that MHPs experience in relation to the challenges they face at work, compared with other work settings. This can impact on the care that MHPs deliver. The ways in which the challenges of staff retention, lack of resources and difficult clinical situations are managed influence the well-being of MHPs. Workplace factors such as leadership and work environment cause further effects.

However, there is evidence that development of hopefulness and optimism in MHPs can mitigate the negative impact of stress and safeguard the quality of care delivery (Cleary et al., 2016). Cleary and colleagues (2020) suggest that MHPs need a sense of hope, both personally and professionally; without this, they cannot engender hope and motivation in service users. Critically, this sense of hope relates to a sense that they are appreciated and their belief in their abilities as a MHP (Oates, 2018). These and other factors that influence practitioner well-being at work are explored next.

2:6 Theme: factors that influence practitioner well-being at work

Included in this section of the review were papers that related specifically to the factors that influenced levels of practitioner well-being at work (n=39). The researcher considered methodology of the studies during their selection (as previously discussed), but questions remained that suggested there was no conclusive understanding of factors that impacted on well-being. There appeared to be a lack of studies that had explored well-being from a practitioner perspective, both from a qualitative viewpoint that offered in-depth understanding of experiences and of ways in which practitioners themselves could influence their well-being. However, quantitative studies were included that provided clear accounts of the complexity of practitioners' levels of well-being and could be used to form a detailed picture of the many potential influences.

Papers that gave accounts of the current work climate in the NHS were included to provide a backdrop to discussion (n=7). Empirical studies that were included involved critical literature reviews (n=11), surveys and questionnaires (n=14), intervention studies (n=3), concept analysis (n=1) and studies that sought to explore practitioner experiences using grounded theory or interviews (n=3). The subsequent discussion highlights evidence that suggests that working in the NHS itself can impact on individual well-being, which was important in the current AR study.

Within the UK, there is a national recruitment and retention crisis in mental-health nursing, which adds to the many challenges that are faced by those who deliver care (Buchan et al., 2019). Burnout and stress are closely linked with high rates of staff

turnover, with the quality of care that is delivered (Johnson et al., 2018) and with poor mental well-being in MHPs (Oates, Jones and Drey, 2017). The removal of job stress is not feasible, but burnout can be decreased. Some studies indicate that staff programmes can influence factors such as the levels of emotional exhaustion that practitioners experience (Salyers et al., 2017). These studies are discussed below.

2:6.1 Sub theme: stress and burnout

A review of the literature that was specific to the experiences of community MHPs, which was performed by Edwards et al. (2000), suggested that there were clear links between levels of stress and burnout. The review (*n*-19) reported on studies that used qualitative measures to determine which factors accounted for stress in MHPs. The findings highlighted three elements: firstly, the nature of the job (workload, patient and staff safety issues), secondly, the role in which the practitioner was employed (function, level of responsibility and changes in role) and, finally, relationships with others (lack of supervision, dysfunctional teams). More recent evidence suggests that challenges that relate to these factors remain commonplace for MHPs (McTierman and McDonald, 2015; Salyers et al., 2015).

Pryjmachuk and Richards (2007), found that mental-health pre-registration nurses differed from their peers in other fields of nursing in terms of the quantity and characteristics of the types of stress they faced. A cross-sectional survey of pre-registration nurses (*n=1362)* for all nursing fields (learning disabilities, adult, child and mental health) considered self-reported measures of stress and methods that the nurses used to cope. The researchers found that mental-health student nurses perceived fewer demands on them than the other nurses and they adopted a range

of emotion-orientated coping strategies to manage stress. Pryjmachuk and Richards (2007), suggested that this may have been because more male students were attracted to the mental-health field than to other areas of nursing. However, the potential influence of stress factors that were due to the home-work interface in 2007, when the study was conducted, may not indicate current issues of home-work balance (such as childcare) and gender influence in 2020. This notion that male MHPs are more resistant to stress and that gender-related stereotypes influence the findings is not in line with current evidence of increasing levels of stress in MHPs (Johnson et al., 2018). It also does not concord with the researcher's experience. It is possible that the methods that were used may have introduced bias; surveys may impose answers and stress itself is a sensitive issue that can engender positive responses to questions about coping or managing.

McTiernan and McDonald (2015) explored occupational stressors, burnout and the coping strategies of community and in-patient MHPs. A between-group design of *n=69* participants (8 males and 61 females) completed a survey that comprised three stress and coping scales. The findings suggested that nurses who worked in community settings had a greater sense of accomplishment at work and lower depersonalisation scores than those who worked in in-patient settings. Across both groups, stress was attributed to lack of resources, heavy workload and a lack of organisational structures and processes. However, burnout was not found to be significant in either group. These findings are of relevance to this study, as understanding MHPs' perception of their work may be intrinsic to understanding the roles that resilience and coping with stress play in the maintenance of MHPs' well-

being, and because the study that was performed for this thesis was set within a community setting.

It is interesting to note findings that suggest higher accomplishment scores (in coping with stress and the prevention of burnout) among community MHPs. These findings may be linked to the performance by these MHPs of more autonomous work than their counterparts in in-patient settings. However, this should be interpreted with caution as autonomous work can cause additional stress. MHPs in community settings may have less opportunity (in the immediacy of clinical work) to share decision-making with a team and this could lead to feelings of isolation and being unsupported. This adds significance to the use of AR, which encourages inclusive and collaborative approaches.

It is evident that MHPs need support to adapt to their stressful roles in a positive manner and to build whatever skills and characteristics are necessary to deliver care effectively and to enhance their well-being. One factor that can influence burnout and stress is job satisfaction and this may be linked with positive outcomes in well-being and care delivery and with the prevention of burnout and stress (Cleary et al., 2020); this is explored further in the next section.

2:6.2 Sub theme: job satisfaction

Job satisfaction is linked to well-being at work and, as suggested by Castaneda and Scanlan (2014), can be explained in terms of an affective reaction that is inextricably linked with outcomes that are coveted, expected or deserved. There are few studies that have sought to understand predictors of job satisfaction, but factors that relate to organisational traits such as work climate, career development, a sense of

ownership and organisational citizen behaviours seem to be important (Lu, Zhao and While, 2019). Correlates of job dissatisfaction include the complex requirements of their patients, unpredictable work environments, low levels of managerial support and increased demands that they manage risk-related patient behaviours (Rodwell and Munro, 2013; Laschinger and Fida, 2015; Dahiten, Lee and MacPhee, 2016 and Masum et al., 2016).

Studies that are relevant specifically to MHPs suggest that their job satisfaction is linked to: management of the unique challenges that are faced in mental healthcare (Rossler, 2012); relationships with service users (Osborn and Stein, 2016); intention to leave (Baum and Kagan, 2015); and work environment (Wilson and Crowe, 2008).

Attempts have been made to explore and understand the role that job satisfaction plays in widely documented stress and burnout, which are common in healthcare settings. In a study of well-being of MHPs, Walsh and Walsh (2002) explored the sizes of caseloads. The findings suggest that a sense of control or lack of it, alongside support and the individual MHP's role, were important factors that influenced well-being. Variables for this were service-user needs and the clarity of the role for the practitioner. This evidence supported the researcher's initial thoughts about well-being and its link to job satisfaction and work environment (detailed in Chapter One, section 1:6).

In a small study of MHPs (*n=12*), Wilson and Crowe (2008) investigated what the subjects found satisfying rather than 'dissatisfying'. This is an interesting approach,

since much of the literature has sought to explore and identify factors that are associated with job dissatisfaction rather than satisfaction. Although the findings are not necessarily generalisable because the sample size was small, outcomes suggest that ‘knowing self’ and ‘knowing how’ are important in the determination of equilibrium between practitioner and service-user dynamics and of role performance. For the AR study, the researcher needed to consider the individual’s internal state and, essentially, the idea that what motivated individuals varied greatly. This warranted consideration as co-researchers in this AR study would determine the content of interventions based on personal experiences and expectations.

In contrast with the Pryjmachuk and Richards (2007) study that has been previously discussed, Ward (2011) used a qualitative critical feminist perspective to explore the lived experience of (*n=13)* female MHPs who worked in acute in-patient settings. The study findings reinforce the notion that the work of a MHP is stressful and that there are clear links between stress management and job satisfaction. Limitations of the study are the size of the sample and its relevance to the wider population of MHPs. However, understanding the factors that influence MHPs’ well-being and stress levels was pertinent for the intended study, as Ward’s findings suggested a correlation between nurses’ personal resilience levels and their abilities to focus on the patient and to facilitate change. Ward (2011) also noted that the recruitment and retention of MHPs was problematic and that this may have been related to a perception that the role brought poor job satisfaction. For the researcher, the importance that was discovered in the study of MHPs being able to manage and facilitate change reinforced the value of using an AR approach to her study to

improve both well-being and satisfaction at work and to safeguard the retention of MHPs at the CMHT.

Further consideration of well-being and of mental well-being at work was explored by Rossler (2012), who described job satisfaction and the emotional impact of role and burnout with reference to mental-health problems that were experienced within the workplace. It is a myth that job satisfaction can ensure a greater sense of well-being for an individual due to complex influential factors. The mental well-being of MHPs who experience mental-health problems can be unfavourably influenced by work factors such as violence and poor relationships with colleagues (Kelly et al., 2016).

Work by Hayes, Douglas and Bonner (2015) emphasises the link between work environment and job satisfaction. Hayes and colleagues (2015) found that variables, such as age and experience, were related directly to a favourable opinion of the work environment, irrespective of a favourable view of job satisfaction. This is of note as, in NHS settings, emphasis is placed on support and development as key elements of job satisfaction for less experienced staff, and this relates to being supported by those who understand the job ‘better’ through experience.

Osborn and Stein (2016) offer further insights into factors that influence the perception of experiences at work. They suggest that the relationships that MHPs have with service-users during their recovery journeys can be directly correlated with both professional growth and with increased job satisfaction. The researchers used an online self-report questionnaire that was completed by MHPs (*n=105).* They

found that job satisfaction in this instance was validated by the practitioner's levels of professional and personal well-being. For the author of this thesis, finding ways to ensure the well-being of MHPs and to provide opportunities to promote and manage work experiences were critical to the informing and adoption of an AR approach to the study.

Similarly, it has been reported that job satisfaction can be increased when MHPs understand the team culture in which they work (Kinman and Leggetter, 2016). Predictors of job satisfaction are reported to include the performance of empowering behaviours by leaders, feelings of job control, and a sense of interpersonal justice (Rodwell and Munro, 2013; Dahinten et al., 2016). These findings warranted further consideration within this review. This was of importance as MHPs, as co-researchers, would instigate the development and adoption of strategies to enhance their well-being. This in turn would foster a collaborative approach to improve experiences at work and would consequently improve job satisfaction, which in part might be linked to ability to manage challenges that were faced in the workplace.

2:6.3 Sub theme: resilience and management of adversity at work

The term 'resilience' as applied to health professionals refers to their ability to cope with, or manage, the emotionally challenging aspects of a role (Brennan, 2017). Delgado et al. (2017) determined from a review of the literature that a lack of protective factors such as internal and external resources could hinder professional performance and reduce nurses' well-being. Delgado and colleagues further suggested that resilience was essential to address workplace stress and the risks

that were associated with expenditure of emotional labour, which required the management and regulation of emotions in relationships at work.

Studies suggest that strong resilience and high-quality self-care can decrease burnout and help with the management of stress (Kravits et al., 2010). These levels of self-help are associated with increased levels of well-being and with the experience of fewer mental health-related symptoms such as anxiety and depression (Foster, Cuzzillo and Furness, 2018). Increased resilience, therefore, may also be linked to good mental health and well-being (Kim et al., 2019), a reduction in emotional exhaustion and increased engagement in work (Yu et al., 2019). With specific relevance to MHPs, increased resilience may result in improved self-efficacy to manage emotional responses to stress (Foster, Cuzzillo and Furness, 2018).

In respect of coping with stress and with relevance to nurses' resilience, Hart, Brannan and De Chesney (2014) conducted an integrative review of 462 qualitative and quantitative studies. The findings suggest that resilience is a personality trait that enables nurses to recover quickly after setbacks. The factors that contribute to nurses' resilience may include coping skills, self-efficacy, hope and psychological capacity. Hart and colleagues (2014) proposed factors that could build resilience amongst nurses; these were related to the nurses' abilities to reframe cognitively (to dispute maladaptive thoughts and build a positive interpretation), to form good working relationships and to develop emotional toughness. Therefore, the environment at work was important to support the development of resilience and to ensure that positive attributes were valued and advanced by MHPs, which would in turn improve experiences at work.

It is important that MHPs can overcome or manage workplace adversity in order to prevent the widely acknowledged impact of stress on well-being at work. A qualitative study by Foster, Cuzzillo and Furness (2018) explored the perspectives of MHPs (*n=29)* who participated in a resilience programme. The findings suggest that participants felt that, through their participation, they had improved their self-efficacy and their abilities to evaluate stressful situations and to temper emotional responses to stress. Although the study used a participatory AR approach, the study stopped short of involving MHPs in the development of the programme to strengthen their resilience. The opportunity for staff empowerment, collaboration and self-determination may have been missed. The AR study that was conducted for this thesis addressed this by positioning staff as co-researchers to determine and lead interventions.

In this AR study, the involvement of MHPs as co-researchers was expected to foster a sense of autonomy and to increase levels of interpersonal factors such as motivation and relationships, all of which were expected to enhance well-being. In an integrative review of international literature that considered resilience and MHPs, Foster et al. (2019) examined the understanding and knowledge of resilience. Twelve papers met the aims of the review, which were to understand the perspectives on resilience in mental-health nursing and the state of knowledge regarding MHPs' resilience. The findings suggested that MHPs could strengthen their resilience through application of a range of strategies. Finally, the findings suggested that well-being could be influenced by the teams in which MHPs worked. For the researcher, an understanding of environmental factors of well-being such as

teamwork and its influence on resilience would be of value to inform the content of interventions.

Hence it can be stated that the fostering of an ability to face adversity increases engagement in the workplace. Findings by Yu et al. (2019) largely suggest that nurses can build resilience and that they require strategies to support this development in practice. The researcher envisaged that use of a collaborative approach to the AR study would enable her to work alongside MHPs as co-researchers to build emotional intelligence, improve work-life balance and integrate into work hours the opportunity to reflect. There are links between the resilience of MHPs, their well-being, their behaviour at work and the quality of the care they deliver, and this suggests that there is benefit in understanding the subjective well-being of MHPs.

2:6.4 Sub theme: subjective well-being

Consideration of the subjective well-being of MHPs adds another facet to the interpretation of coping and well-being (Oates, 2018). This builds on the notion that a positive psychology standpoint can be explored to understand the positive effects of coping and the interventions that are required to build well-being (Oates, 2018). The premise builds on subjective well-being research that suggests that nurses are lifelong learners and that training and career development are linked with work commitment (Brunetto et al., 2013). This was important as the AR study would empower MHPs to develop and determine strategies to improve their well-being.

To understand well-being and specifically MHPs' subjective well-being, Oates, Jones and Drey, (2017) explored subjective well-being at work with the aim of establishing an understanding of workplace and demographic factors that correlated with subjective well-being measures. A secondary aim of the study was to identify MHPs who showed high subjective well-being scores and who would be willing to take part in qualitative interviews. In the initial study (2017), 225 MHPs completed three surveys to measure their levels of subjective well-being. Although the findings may not be generalisable because of the methodological design, low response rate and limited sex and age determinants, this was the first study that had sought to interpret the factors that influenced MHPs' subjective well-being. Unlike previous authors who had studied other professional groups, Oates and colleagues (2017) suggested that demographic and workplace factors were not the only determinants of subjective well-being of MHPs, and that gender, age and their household size might be important. They suggested that there was a need to consider how MHPs could maintain and build their subjective well-being, and, critically, how organisations could address low levels of subjective well-being among MHPs.

Building on previous work, Oates, Drey and Jones, (2018) used a survey to quantify responses from 237 MHPs and supplemented this with 12 semi-structured interviews to understand the essence of their experiences. Oates and colleagues concluded that well-being was related to the enjoyment of work-life balance, availability of access to clinical supervision and, interestingly, a translation of work-based learning into learning in a home setting; that is, to develop the self at home and at work and therefore to develop the whole self. This is in line with the researcher's thoughts regarding the convergence between well-being at work and well-being in all aspects

of life, since skills and knowledge are readily transferable (Chapter One, section 1:4). It was therefore prudent to adopt for this study an approach such as AR, which encouraged both personal and professional development. This positive emphasis on coping and managing was in line with the prominence of influencing well-being through the encouragement of MHPs to offer insights and to self-determine interventions that would be of value, based on their positive experiences of enjoyment of what they did.

2:6.5 Sub theme: therapeutic optimism

A study of 70 recently qualified nurses (Morrissy, Boman and Mergler, 2013) explored the correlation between factors of mood, optimism, anxiety and well-being at work. The findings suggested that all factors were directly related to affective well-being and that mood made a significant contribution to well-being. This study provided some understanding of the value of perception and the significance of a sense of optimism at work, although it was not of direct relevance to MHPs in this AR study, in which variables such as experience, role and burnout might be more significant.

Positive psychological capital at work as suggested by Avey et al. (2011) consists of the positive psychological properties of hope, optimism and resilience, and it relates to employee attitude, behaviour and performance. Creation of a positive working culture, as suggested by Sergent and Laws-Chapman (2012), builds on resilience. In part this is related to care about self, which leads to a greater ability to care for others. Wong and Laschinger (2013) suggest that increased understanding of the

ways in which resilient MHPs can draw on their experiences and psychological capital can foster a greater sense of hope and optimism in the workplace.

Malinowski and Lim (2015) suggest that, in the workplace, such understanding and building upon features of psychological capital such as hope and optimism may be directly linked to the understanding and predictions of staff attitudes, performances and behaviours. Optimism and an ability to cope, or being proactive, are important qualities that enhance a positive position when MHPs face challenges in the workplace. Cruz (2017) used quality-of-life measures to find that nurses who were "coping" were those with increased scores in the social relationship domain (being in a team). Optimism and pro-active coping with work-related stress had positive impacts on staff. This finding further reinforced the researcher's thought (Chapter One, section 1:5) that the perception of the practitioner themselves was influential in their sense of optimism in the workplace and that this placed importance on the team in which they worked.

The literature therefore suggests that there is a complex interplay of hope and optimism with a sense of well-being at work. There are gaps in the understanding of how MHPs can promote and govern their positive experiences at work. Involvement of MHPs in the determination of strategies that capitalise on optimism and hope will directly correlate with enhanced well-being. Therefore, to promote a sense of hope and optimism in the workplace and to understand their impact on role perception amongst MHPs, it is imperative to have some understanding of the part that the

organisation and teamwork plays in the fostering of positive traits amongst staff. This is considered next.

2:6.6 Sub theme: teamwork

It appears that stress and poor well-being at work can result if the team climate is not managed effectively. In a literature critique, Cleary et al. (2020) suggest that attitudes of colleagues and the set-up of teams may influence MHPs' levels of well-being. They found that there were clear links between the environment and the well-being and satisfaction of MHPs.

Teamwork can refer to countless behaviours and emergent outcomes, but published literature suggests that there is no conclusive account of what constitutes an effective team. Evidence suggests that effective teamwork is directly correlated with improved clinical outcomes and decision making, integrated care and consensus of approach (Grumbach and Bodenheimer; 2004; Lemieux-Charles and McGuire, 2006 and McInnes et al., 2015).

Teamwork can also impact on staff and experiences at work. McCann et al. (2013) explored the formal and informal relationships that were set up within teams and the impact that these had on outcomes such as job satisfaction. McCann and colleagues (2013) suggested that the development of nurturing work environments acted as a preventative factor to reduce negative impacts of stress among healthcare professionals. For this AR study, working in a supportive team was viewed as

important to ensure well-being and to manage the potential impact that stress could have on care delivery (Maben et al., 2012; McTierman and McDonald, 2015 and Salyers et al., 2015).

There have been attempts to understand the value of teamwork through examination of the evidence from the outcomes of interventions to improve teamwork. McCulloch, Rathbone and Catchpole (2011) found only a modest correlation between effective teamwork and fewer problems in care delivery. However, positive links between task and performance have been explored and these suggest that there is a link between the way in which team workloads are co-ordinated and the behaviour of teams (McInnes et al., 2015; Schmutz, Meier and Manser, 2019).

The culture of a team in which MHPs operate can moderate the impact of stress and burnout. In a study of 201 registered nurses, Cheng et al. (2016) explored the concepts of team climate (that is, the environment in which the nurses worked) and emotional labour and the links to the quality of the care that was delivered. The findings suggested that team climate could temper the relationship between burnout and the masking of emotions, which, in turn, could influence staff retention in a positive way.

In a comparison study of job satisfaction amongst different professional groups in mental health teams, Fleury et al. (2018) highlighted clear professional group influence on perceptions of teamwork. Mental health nurses in particular were found to link a sense of job satisfaction directly with less team conflict and with their

involvement in decision making. Fleury et al. (2018) concluded that support should be given to involve staff in decision-making and that training for team working was important.

The perception among MHPs of their work experiences can be critical, and therefore it was important that this AR study should gain insights into teamwork and performance. In a study of 244 in-patient nurses, Welp et al. (2018) explored how personal and professional activities affected practitioner perception of both teamwork and performance. This study showed that personal and professional development activities led to higher levels of perception related to quality of care and to a sense of positive teamwork.

In line with this, in a review of literature that was related to teamwork in healthcare settings, Rosen et al. (2018) highlighted gaps in the understanding of the complexities of teamwork and performance. Rosen and colleagues (2018) concluded that there were gaps in empirical knowledge and understanding and that further consideration was required of the transferability of empirical evidence across healthcare settings. Further clarification was required of professional ‘fault lines’ in multidisciplinary teams and understanding of what competencies were pertinent in each setting and finally to understand that there was limited evidence or understanding of what team resilience was needed to manage the challenges that were faced.

It is important to understand teamwork and the pivotal role that teams can play in the ways in which care is delivered within health and social care settings. In a systematic review and meta-analysis on the impact of teams on clinical performance, Schmutz, Meier and Manser (2019) highlighted that teamwork could have a moderate impact on clinical performance. There was an indication that teamwork was important to improve performance and that this was regardless of the team member's role or tasks. Schmutz and colleagues (2019) concluded that healthcare organisations should recognise and address the development and maintenance of teamwork due to its value in patient care.

Teamwork therefore is multi-dimensional and is linked inextricably to the care that is delivered, to the experiences at work of practitioners and to their well-being. In this AR study, the experience of MHPs within teams would underpin empowerment to reduce limitations of process and performance to develop innovative ways to improve experiences. Understanding the team in which MHPs work is critical to link the work environment to satisfaction and well-being.

The studies that have been discussed provide an understanding of the factors that can influence practitioner well-being at work. Levels of well-being can be influenced by a complex interplay of factors and there is no definitive account of what influences well-being. In consideration of the current AR study, the decision to take into account factors such as teamwork, practitioners' levels of satisfaction and their ability to manage workplace stressors and adversity was in keeping with MHPs' initial thoughts at the outset of this study and added value to the adoption of a collaborative approach. Well-being is a complex concept and there are gaps in evidence of its effects, particularly during attempts to understand practitioner

experiences of well-being. To build on this theme further, consideration of a separate theme that explores well-being from an organisational perspective gives an insight into broader examination of workforce well-being. This is presented in the following section.

2:7 Organisational factors that influence well-being of the workforce

The papers (n=14) that were included in this final themed section of the review provided wider understanding to the background of practitioner well-being at work. This section of the review provides a backdrop to understand the climate in which practitioners work and how NHS organisations respond in order to meet the well-being needs of employees. The studies that were included were made up of empirical studies (n=6) and critical literature reviews (n=5) and editorial papers (n=3). The studies explored interventions and strategies that could improve well-being in the workforce. The quality of the studies was good but there were gaps in the evidence and the examples of approaches that were either transferable or open to widespread adoption remained limited. However, the following discussion demonstrates the value of encouraging and engaging the workforce in opportunities to cope with and manage the many challenges that they may face during work in the NHS.

Boorman (2009) and Chana, Kennedy and Chessell (2015) found that the challenges that faced organisations in their development of the well-being of their staff included ways in which they should develop the workforce and gaining an understanding of managerial and leadership styles and the influence these had on staff well-being.

2:7.1 Sub theme: leadership

Wong and Laschinger (2013) explored the positive impact of 'authentic leadership', which was defined as the development of valid leadership through honest relationships with employees that placed significance on their input, and the mediating role of staff who were empowered through this process. The limitations of the study, however, were that factors such as psychological capital and psychological empowerment were not explored, so the study fell short of providing further evidence of the mediating role that these factors could play. However, Wong and Laschinger (2013) highlight an important viewpoint, which is that it is essential for organisations to understand the stress that is faced by staff as they enter the nursing profession if they are to ensure the retention of nurses. This remains a consideration. The encouragement and engagement of MHPs to self-determine strategies to build well-being is one method by which to empower them and promote their contributions to a positive work culture and to stress management, and this finding supports the choice of an AR study for this thesis.

In a systematic review of studies in healthcare, Bronkhorst and colleagues (2015) considered the impact that organisational climate can have in relation to the well-being of employees. Conclusions that were drawn suggested that development of an environment that fostered support amongst co-workers alongside development of a leadership style that was relational improved the organisational climate. As a result, staff well-being was improved and levels of burnout, depression and anxiety were lowered. Similar to relational leadership approaches, which involve working together

to accomplish change, it was decided that the current AR study would involve MHPs working together to make changes with a common goal of improved well-being.

For that reason, as suggested by Utriainen, Ala-Mursula and Kyngas (2015), leaders should have a clear view on ways to build and enhance the positive aspects of well-being at work. The study proposed a theoretical model that suggested the development of a sense of togetherness in the workplace and enabling nurses to implement their ideas and to promote meaningfulness (a sense of value) and purpose. This report reinforced the researcher's thoughts regarding self-determination by MHPs to implement strategies that were in keeping with their experiences.

With an emphasis on transformational leadership and increased well-being at work, Arnold (2017) suggested that an organisational emphasis on transformational leadership could influence well-being. Arnold's review of literature concluded that there were gaps in the understanding of positive and negative correlations between this type of leadership and staff well-being. However, the study's findings suggest that well-being can be influenced by acceptance of shared goals, and this became an important factor in the determination of how best to ensure a shared focus within the AR study.

The relationships between healthcare managers and employees were explored further by Schon et al. (2018) as an important resource for the enhancement of employee well-being. Exploration of the relationship experiences of both managers and employees suggested that improvement of the relationships could be linked to

improved workplace environments. Improvement of these relationships was found to contribute to well-being and subsequently to care delivery. It is envisaged that adopting an AR will improve the working environment for MHPs.

There were few studies that sought to explore the experiences of MHPs in relation to the managerial and organisational factors that influenced well-being. Gillet et al. (2019) investigated the psychological processes that inform relationships between perception of managerial style and well-being of the MHPs. Using a prospective questionnaire (*n=294),* French MHPs answered questions regarding measures of perceived support (supervisors' behaviours that supported autonomy) and a year later, gave measures of satisfaction of psychological needs, engagement and job satisfaction. The findings suggested that managerial style was directly related to vigour, dedication and job satisfaction. However, the study focused purely on positive psychological processes and managerial styles and did not explore perceptions of negative or less supportive managerial styles. For the researcher, the engagement of influential stakeholders (Chapter Four, section 4:2) to support the AR study was imperative to override any negative perceptions that MHPs might have had of managerial and leadership styles. Linked to this is the development of the workforce to maintain well-being, and this is explored next.

2:7.2 Sub theme: development of the workforce

It is necessary to employ a workforce that is equipped to cope with the demands that are placed upon them to meet competing agendas (Foster, Cuzzillo and Furness, 2018; Johnson et al., 2018). Building on the study previously discussed that

investigated subjective well-being in mental health nurses (Oates, Drey and Jones, 2018), Oates (2018) explored what keeps nurses happy?, and suggested that staff well-being strategies should be informed by nurses' experiences in terms of what interventions would be useful to them. This finding was in parallel with the adoption of an AR approach to promote collaboration and self-determination of strategies to improve well-being in MHPs.

There are several themes that underpin current national and organisational responses to ensure that MHPs can embrace the many challenges that they face. As has been previously highlighted and with broader relevance than healthcare, Avey et al. (2011) explored in a meta-analysis the impact of positive psychological capital on behaviour, attitudes and performance in the workplace. The findings suggested that optimism and hope, alongside resilience and self-efficacy, were essential to human resource development. This concurred with the researcher's belief (Chapter One, section 1:5) that the inspiration of optimism would safeguard the well-being of MHPs.

There have been attempts to understand how healthcare organisations can equip the workforce to manage the challenges that they face. These have been highlighted by Williams et al.(2018) in a systematic review of staff well-being interventions in healthcare. The findings were that some studies had found evidence to support the use of certain interventions to improve well-being and to manage workplace experiences. These interventions included mindfulness, cognitive behavioural therapy, and skills sessions in the management of stress and training in the physiological responses to stress. However, Williams and colleagues suggested that

there were methodological issues in the studies, and these included the study designs, weak evaluation of the efficacy of interventions and no benchmark or measure. To the researcher, these concerns suggested a lack of clarity in the study of which interventions might be best placed to be adopted within healthcare organisations.

Interestingly, there are few intervention studies that have sought to promote the well-being of staff through stress management and prevention of burnout (Alenzi, McAndrew and Fallon, 2019). Some studies have sought to explore the effect of professional identity development programmes on burnout and job satisfaction and have demonstrated a decrease in burnout levels and increased professional identity amongst nurses (Sabanciogullari and Dogan, 2015). In a study by Salyers et al. (2017), it was found that, after a one-day workshop on prevention of burnout, MHPs were found to have reduced levels of emotional exhaustion and depersonalisation. Therefore, these findings suggest that even small changes can facilitate a change in experiences at work and, as in this AR study, changes in practice may be key to the improvement of well-being of MHPs.

Back and colleagues (2016) found that resilience training in palliative care nurses facilitated their well-being by mitigating the impact of workplace stress. Dow (2019) reported that practitioner well-being could be relational, whereby the practitioner was able to share both success and failure with peers. Dow and colleagues suggested that inter-professional perspectives were best placed to understand this phenomenon in the workforce.

In contrast, to improve the well-being of nurses exclusively, Kim et al. (2019) found that both work and personal features should be considered in depth. The researchers explored factors that influenced well-being in nurses to propose individualised interventions that were aimed at well-being and which influenced resilience, job satisfaction and burnout alongside compassion satisfaction and gratitude disposition (responding with positive emotion). These findings draw important links between well-being and resilience and mediators of burnout, compassion and satisfaction.

Yu and colleagues (2019) performed a systematic review of the literature (published between 2000 and 2018) that considered workplace and personal factors that were linked to resilience in nurses (*n=38).* They suggested that understanding of resilience could lead to the identification and prevention of potential issues in personal and professional development. This finding was in parallel with the intention of this AR study to build and develop well-being and, critically, to provide co-researchers with a sense of being able to exert control over their experiences at work. Gaps that were discovered in the available evidence could be filled through encouraging MHPs to advance thoughts about how to improve well-being and to capitalise on ideas about what interventions were best placed to build strengths.

Together, these studies highlight the importance that organisations play in the maintenance of the well-being of staff who work within the NHS. Studies suggest that even the smallest of opportunities to manage well-being at work can result in both

personal and professional development. There is little question that work in the NHS can be demanding. However, the adoption of an AR approach to the study, which was supported by the managerial hierarchy and leadership team, would produce engagement in work and increase positivity among MHPs. This would engender increased well-being, as has been demonstrated throughout this review. How the findings of this review informed the methods of this study is now discussed.

2:8 Development of the initial conceptual framework and use of AR

The literature review and discussion that has been delivered above demonstrates how the literature informed the changes that were proposed to the initial conceptual framework, which was developed originally for the AR study (Chapter One, section 1:5). The researcher's reflections on how the literature informed the chosen methodology are also detailed. Within healthcare settings, attempts are being made to facilitate a greater sense of ownership of performance. Quality improvement work provides an interactive process that involves agents of change (Casey, O'Leary and Coghlan, 2018). This motivated the researcher to use an AR approach.

Much of the current empirical literature relates to studies that have explored factors that impact on stress and well-being at work, but which are often quantitative in nature and are not representative of experiences. Attempts that have been made to investigate and measure well-being in quantitative studies highlight the complex interplay of many variables alongside the dynamic nature of MHPs' resilience, the teams in which MHPs work and job satisfaction. Studies have been developed that measure teamwork, resilience and job satisfaction but, again, the results are

dependent on the context of the research and an understanding of the variables alongside the researcher's viewpoint and theoretical positioning.

There is a lack of qualitative studies that have focused on the empowerment of MHPs to contribute to the improvement of optimism in the workplace and consequently to improve well-being. The studies that do exist provide valuable insights into the experiences of MHPs but fall short of establishing what MHPs can do in practical terms to enhance well-being at work. For the researcher, this conclusion reinforced the value of this AR study as a means to facilitate MHPs to self-determine methods that they could use to enhance well-being.

In contrast with studies that have been performed previously, this AR study will develop under the influence of practitioner experience and empowerment. In support of this stance, growing evidence of stress and burnout in the workplace amongst MHPs suggests a need to develop interventions that promote optimism and well-being in the workplace. The conceptual framework that was developed after completion of this literature review was built on initial thoughts that were detailed in Chapter One and highlighted the position of the research in terms of both researcher values and conceptual positioning (Figure 3).

The conceptual framework highlighted and articulated the development of the research questions for this study (Ravitch and Riggan, 2016). A conceptual framework that is developed at the beginning of a study evolves as research progresses (Astalin, 2013). In this case, the literature review helped to form arguments and included topical research and literature that were used to inform a

theoretical framework (Ravitch and Riggan, 2016). As can be seen in Figure 3, the conceptual framework was developed to draw together the key themes from the literature review and to inform research questions that addressed well-being at work. Significant changes that were incorporated into the conceptual framework after completion of the literature review were: a sharpened focus on job satisfaction, teamwork and resilience as the three main factors that were important in the determination of well-being at work; and emphasis on the experiences and perceptions of MHPs of these concepts and how MHPs could develop them to improve well-being.

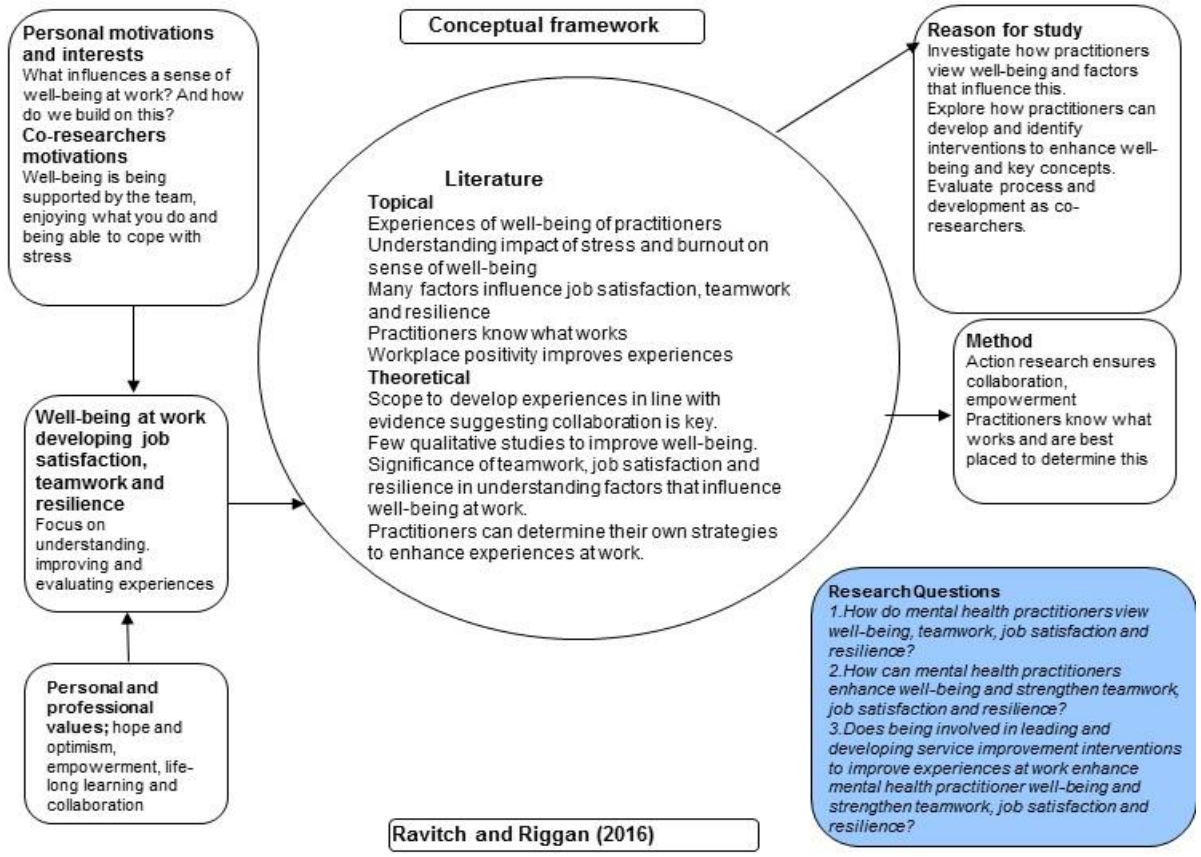

Figure 3 Conceptual framework

2:9 Research Questions

The conclusions that were drawn from the literature review suggested that there were gaps in the understanding of how MHPs could build and develop well-being at work. Well-being at work is complex and is dependent on many variables. For the researcher, questions arose about how MHPs perceived well-being and the links to a sense of job satisfaction, teamwork and being resilient. There are other factors that impact on well-being, such as issues around training and organisational approaches to enhance well-being. There are studies that have been discussed in the review that have adopted different methods to improve well-being but, largely, they precluded any contribution from MHPs themselves to determine what would work for them. This was an important point for the researcher. Finally, use of an AR and incorporation of a participatory approach would determine whether active involvement in the improvement of experiences at work would enhance well-being, as there was no evidence in the literature that was reviewed that this had been explored.

AR typically addresses questions such as ‘what am I doing?’ and ‘how do I improve?’ Hence, it was decided that the study would address the following three key questions:

1. How do mental health practitioners view well-being, teamwork, job satisfaction and resilience?
2. How can mental health practitioners enhance well-being and strengthen teamwork, job satisfaction and resilience?
3. Does being involved by mental health practitioners in leadership and development of service improvement interventions to improve experiences at

work enhance their well-being and strengthen teamwork, job satisfaction and resilience?

These research questions provide an overall goal which will underpin the AR cycles in each stage of the AR. As each cycle begins the questions will focus on the action and outcome (Riel, 2019). It is important to note at this stage, these research questions are consultative as it is this that demonstrates adherence to principles of AR. As highlighted by Stajduhar, Lindsey and McGuinness (2002), empowerment is an important outcome of this type of research and requires intentionality throughout, and in this case affords dialogue with stakeholders to determine the research development and the action and outcome within each cycle as the AR study evolves.

2:10 Broad aim and objectives of the study

The purpose of the exploration of this area of research is to widen knowledge and to develop practice that builds and strengthens well-being. Following the findings that were gathered from the literature review and to address gaps in current evidence, the focus of the AR study was to engender well-being through development of teamwork, job satisfaction and resilience amongst MHPs. In line with AR approaches, the study was designed to operate within the boundaries of professional and organisational intention and in line with local service delivery.

The intention of the study was to explore and question within a position that took into account the context (the CMHT) and incorporated a sense of accountability and transformation as a MHP and as a researcher. The purpose was to create change opportunities both at the CMHT (team) level and for individual MHPs who were

involved in the study. Terms such as collaboration, participation and empowerment can be value laden; whether the study is collaborative or participatory requires reflexivity on the part of the researcher to understand and explore who is likely to benefit from the study. One aim was to form a consensus between MHPs and the researcher regarding the central aim and objectives of the study, in order to guard against unequal power balance within the research group and to counteract debate about who would benefit (Heron and Reason, 2006).

The broad aim of the study was to enhance well-being at work through improved teamwork, personal resilience and job satisfaction.

The objectives of the project were in line with a three-stage iterative methodology:

1. To understand experiences – to engage mental health practitioners to enhance well-being and explore teamwork, job satisfaction and resilience and to identify and conceptualise how they could improve/build upon this (Stage 1).
2. To improve experiences - to develop implementation strategies that improve well-being, teamwork, job satisfaction and resilience through use of an action research approach (Stage 2).
3. To evaluate experiences – a) to evaluate and reflect on the effectiveness of the implemented strategies (Stage 3); and b) to evaluate and reflect on the experiences of mental health practitioners acting as change agents and co-researchers.

2:11 Summary

Although empirical studies of well-being at work are plentiful, studies that explore the experiences of MHPs are few and critically there are very few that have considered how MHPs can influence well-being at work from their perspective. This study will address that gap. This is important because it is widely recognised that mental health services in the UK and worldwide currently struggle under the pressures of lack of funding, staff shortages and increased patient demand. A healthy, functioning workforce is needed to cope in this environment if patients are to receive the care they deserve (McTierman and McDonald, 2015; Salyers et al., 2015; Johnson et al., 2018; Oates, 2018 and Tracy et al., 2019).

As an MHP herself, the researcher recognises that MHPs have clear ideas about what works in practice. Yet the literature review has shown that, although empowerment of staff is recognised as important for well-being, MHPs have rarely led on well-being initiatives (Hoert, Herd and Hambrick, 2018; Oates, Drey and Jones, 2018). This work addresses this by employing AR and PAR methodology, through the use of which MHPs are utilised as co-researchers. The following chapter describes the chosen methodology in detail.

Chapter Three - Methodology

3:1 Introduction

In this chapter, the methodological and theoretical perspectives of the study are considered. The theoretical and philosophical stance of the study is explored initially by review of research paradigms, with attention given to ontological, epistemological and methodological considerations. Positivist and interpretivist paradigms, alongside critical inquiry, are highlighted, and the development of an action-based research approach is explored. The rationale for use of an AR methodology is discussed in terms of the expectations that are placed on studies in health and social care and in line with a more practical approach that is necessary within these settings. Ethical considerations are addressed, in the context of AR methodology, and in line with the principles of AR, communication, relationships, participation and inclusion that underpin the development of the study are also considered (Stringer, 2013).

3:2 Methodological and theoretical considerations

A starting point for any research is to understand to what frameworks, theoretically and conceptually, the author subscribes, both as a researcher and a MHP. From a philosophical standpoint and in contention is whether philosophical frameworks can and should be mixed (McNiff, 2017). In relation to social research, questions arise as to the role of paradigm assumptions. For this study, a stance was taken that historical inadequacies of traditional paradigms could be resolved through use of emergent paradigms such as pragmatism, scientific realism and transformational emancipation (McNiff, 2017).

Broadly speaking, research paradigms position research within distinct domains through which the world is viewed. The world can be seen through universal, absolute knowing methods (quantitative), or through multiple relative truths (qualitative) (Bryman, 2015). When the study is explored from a purely quantitative perspective, a hypothesis can be tested to prove that a given intervention can improve well-being through use of established, validated measures to test the theory. This approach falls short of getting to the heart of human experience and the uniqueness within this. From a purely qualitative perspective, this current study could be developed to explore the well-being experiences of using an intervention. However, this approach falls short of involvement of MHPs to develop and explore their own interventions/actions and to be actively involved in the process. Although both perspectives may yield valuable data, a more practical approach that sees the value in the measurement of outcomes alongside human experience may provide a more comprehensive understanding.

As stated, AR is an established and feasible approach in health and social research (Teddlie and Tashakkori, 2009; Creswell, 2013) that enables consideration of multiple perspectives. Within the current study, AR methodology underpins issues that are related to data collection and methods alongside philosophical issues. The rationale for using AR is to integrate dissimilar data to explore their contributions to possible ‘changes’ in the workplace. As suggested by Creswell et al. (2009), it is this combination of data in AR studies that safeguards the measurement of more rigorous and cohesive outcomes and the drawing of meaningful conclusions. For this study, an AR approach was viewed as a practical approach that could be used to merge the experiences of MHPs with the development of well-being at work through

collaboration and empowerment. As previously stated the AR incorporates a PAR approach to move beyond empowerment of MHPs toward the emancipation of MHPs to make changes within the CMHT. The basic elements of PAR are participation of MHPs in all stages of research. It is not merely about new knowledge but equally focused on the value of action through empowerment. It is fundamentally about the researcher facilitating the whole process as shown by Collet et al. (2014) who employed PAR to engage clinical staff in successful improvements within a paediatric intensive care unit (PICU). Collett and colleagues highlight that engagement in PAR ensured learning, development and engagement in research for participants and that this resulted in strengthened teamwork.

Consideration was given to the researcher's perspective, as both a researcher and MHP, and to both MHPs' and co-researchers' experiences. The mixing of research paradigms that is involved in AR therefore necessitates investigation of philosophical perspectives to ensure alignment with research design and process.

3:3 Philosophical underpinnings

In order to develop the study, a consideration of research paradigms was essential to consider the most appropriate methods of research to be used within the context of health and social care settings. Critical to this was an exploration of the researcher's personal philosophical stance in relation to the study. It was also important to bring to the fore explicit personal viewpoints on the human condition, which could influence the conduct and analysis of the research. To facilitate this

process, philosophical stances are best considered in terms of ontological perspective (the nature of reality), epistemological perspective (how we know what we know) and methodological perspective (how we gather the data) (Scotland, 2012).

When exploring ontological perspectives, it is imperative that there is an understanding of how one's personal perception of human nature directly impacts on the choices that are made. It is this worldview that will underpin the pursuit of knowledge on the part of the researcher (David and Sutton, 2004). In simple terms, ontology is the perceived nature of reality (Hudson and Ozanne, 1988). Therefore, the examination of ontological perspectives ensures justification of the research process that has been chosen (Bracken, 2010).

An epistemological position relates to the nature and forms of knowledge. Central to this are the researcher's personal perspectives on how knowledge is created, what is known and can be known (Guba and Lincoln, 1994; Scotland, 2012). A research paradigm is based on ontological and epistemological assumptions and, therefore, can neither be proven nor disproven (Scotland, 2012).

The researcher's personal perspective forms the basis of decisions and is reflected in the choice of methodology and approach. The chosen methodological position, in principle, drives decisions about how, why, when and where the data are collected and analysed (Guba and Lincoln, 1994; Silverman, 2013 and Bryman, 2015).

Decisions that are made about the pursuit of knowledge are supported by the approaches (methods) that will be used to collect the data, which will be either qualitative or quantitative. Therefore, commitment to an ontological, epistemological position is essential. However, within different research paradigms the same phenomena can be explored. To this end, development of a clear rationale by exploring positivist, interpretivist and critical paradigms is imperative (Lincoln, Lynham and Guba, 2011).

3:4 Positivist paradigm

The scientific paradigm came to the fore in the Enlightenment period. The term 'positivist' was used to explain the application of the scientific paradigm to study the natural world (Cohen, Manion and Morrison, 2013). From a positivist ontological perspective, the world is seen as external and, regardless of the researcher's position/belief, it is taken that there is an objective reality (Hudson and Ozanne, 1988; Carson et al., 2001). Pursuit of facts over value judgements is seen to offer direct access to a real world and to a single external reality. The epistemological belief that underpins positivism is that the researcher is a separate entity and therefore objective. There is an assumption that these parameters ensure that an accurate explanation or account of reality can be given (Guba and Lincoln, 1994; Gray, 2013).

The methodological underpinnings of the positivist paradigm are that hypotheses and theories are tested using a supported formulation with well-grounded and proven data collection methods (Collis and Hussey, 2013). Tentative, untried hypotheses are identified beforehand and are tested empirically to find out if they can be

disproved (Johnstone, 2004; Stangor, 2004; Gray, 2013 and Hawkins, 2014). Influence or manipulation is specified to prevent the tainting of the process by confusing or compounding influences, namely ‘confounding variables’. By the act of manipulation or by influence, the researcher can investigate whether this alters or has bearing on the explanation of the reality that is sought.

However, as positivist researchers attempt to reduce the complex to the simple, they can find variables hard to manage. Variables can be hidden from the researcher, only to be discovered when the effect is evident (House, 1991). Whether any research can ever be value-free is questionable. Salomon (1991) highlights that the whole positivist research process, from the selection of variables through to the interpretation of findings, is underpinned by value-laden decisions. Deductions that are made from empirical evidence that is understood to be generalisable are rarely illustrative of all settings and variables (Ary et al., 2013). Research ignores the intentions of an individual and therefore the actions of individuals are not understood within a given context.

3:5 Interpretivist paradigm

An Interpretivist ontological perspective conflicts with the positivist stance and its pursuit of truths. The interpretivist approach suggests that there is no single external reality and no direct access to a ‘real world’ (Bracken, 2010). Reality is seen as relative and dependent on many variables (Guba and Lincoln, 2000); that is, reality is subjective and differs from person to person (Lincoln, Lyman and Guba, 2011).

Therefore, there are many realities (Scotland, 2012). As opposed to positivism, an interpretivist seeks to uncover truth in a contextual sense (Guba and Lincoln, 2000). There is acceptance that knowledge is generated through interactions between humans and their world and is transmitted in a social context (Crotty, 1998). The world does not exist independently of our knowledge of it (Denzin and Lincoln, 1994). The epistemological position is that the researcher interacts with the research subject and that this process assists in the uncovering of truth and meaning.

As with the positivist paradigm, there are limitations of which the researcher needs to be mindful. Primarily, interpretivist research is not unified and can rely on generic criteria against which to judge findings, rather than criteria that are relevant to the approach that is used (Cohen, Manion and Morrison, 2013). If reality is subjective, then its interpretation by researchers is likely to differ from that of the participants, raising questions around meaning (Winter, 2000; Flick, 2009 and Holloway and Wheeler, 2013). The data that are generated through this approach are highly contextualised and are therefore less likely to be used to underpin policy (Corbin and Strauss, 2014). In the case of this AR study, findings may not be generalisable to other CMHTs. Therefore, the process by which 'truth' will be generated through the interpretivist approach should be made explicit at the outset, so that considerations can be given to whether 'truths' are a true representation of the given context.

3:6 Critical Inquiry

Critical inquiry serves as a challenge to the assumptions of both the positivist and the interpretivist paradigms. Realities are entities that are socially constructed and are subject to continual influence (Guba and Lincoln, 2000). Ontologically, historical

realism is based on the view that reality has been shaped by many dynamics such as political, social, cultural and economic factors. As time has evolved, these influences have been accepted as reality; however, they may not be representative of reality in its true form. Central to this is the premise that language shapes and moulds reality (Ritchie et al., 2013). The critical theorist's viewpoint is that language is power and can be used to either empower or to weaken (Deetz, 2005).

The epistemological view of critical theory is that the researcher plays an elementary role in influencing the researched in a subjective way. There is an understanding that we are born into certain cultures, as the world has already been given meaning (Crotty, 1998). Within communities that claim knowledge, this in itself can feed oppression; if theory has been generated by those of a certain gender, culture or other such entity, surely the discovery of 'truth' should necessitate exploration of discrimination and oppression (Ceci, Limacher and McLeod, 2002).

Subjectivism is based on real-world phenomena and is linked to societal ideology (Scotland, 2012). Knowledge is socially constructed and power relations within society exert influence (Cohen, Manion and Morrison, 2007). Reality, therefore, can be altered by human action. Knowledge is not value-free; the emancipatory nature of knowledge can be embraced. Participants and researchers alike explore and analyse reality and recreate knowledge. Critical inquiry therefore acknowledges context and promotes equality. The methodology is aimed at transformation of the subject area through engagement, inclusion and emancipation.

Due to its subjective and dynamic nature, knowledge that is generated through critical inquiry may not be favoured to underpin policy in the same way as that which is generated from positivist approaches. It is important to note that knowledge production is often politically driven; since emancipation and empowerment are at the core of critical inquiry, this method of knowledge generation may not meet politically driven research intentions (Nealon and Giroux, 2011). It is not always possible to create 'equality,' as power imbalance is a reality that may need to be recognised at the outset to ensure transparency. In relation to the current AR study, the aim was collaboration and involvement of MHPs, and this would be dependent upon organisational parameters and demands that were placed on MHPs to meet different agendas, as highlighted in Chapter One.

Mindful of the complexity of undertaking research in healthcare settings, there are research approaches that warrant consideration alongside AR that adopt methods of inquiry that seek to understand the context and experience of participants. For instance, ethnography enables a researcher to explore the culture and values of the group and provide detailed description of the nature of the phenomenon that is being investigated (Belgrave and Seide, 2019) whereas in this AR study wellbeing had been conceptualised a *priori* from the published literature. The goal of ethnography is in-depth understanding of culture and lives of, in this case, MHPs at work. Immersion of the researcher, engaged in observation means that there can be an issue of influence, there is difficulty of observing without influencing the context of the research. In contrast, an AR approach adopts a collaborative approach to problem solving with a goal of improving understanding and improved practice and this is appealing as MHPs themselves can influence and determine the course of the

research (McNiff, 2017). Conversely, a grounded theory approach to well-being of MHPs would generate a theory grounded in data from the field (Belgrave and Seide, 2019). Although an attractive alternative, there is a focus at the outset to explain an action or theory that does not afford opportunity throughout for participants to determine the direction that the research takes toward actioning change, as in te case of this AR study.

3:7 Action research

AR has its origins in work by Lewin (1944), which explored the management of change and the development of strategies to understand adoption of new ways of being as part of a change process. This mirrors the researcher's perspective to create change in the CMHT. Lewin's work emanated from a perspective that sought to address social change in society with use of AR as a means to apply psychology and social psychology to practical effort (Adleman, 1993). Work that was based on change theory was later developed by Heron (1996). Examples followed of work that adopted an AR approach to research and of practice-based studies that had strong, practical, solution-driven foci and involved groups alongside organisational stances (Adelman, 1993). As a more practical and realistic way of generating change and knowledge in social settings, AR's emergence as a valid research methodology is clear (Heron, 1971; Heron and Reason, 1997; Stringer, 2013 and McNiff, 2017).

AR methodology with an emphasis on cycles of evaluation and reflection that adopt a practical approach to research builds on these original ideas from Lewin (MacDonald, 2012). The origins of contemporary approaches to the empowerment of

participants and the collaborative nature of AR can be traced to work by Paulo Freire. He believed that social change was underpinned by critical reflection and social justice through emancipation of the oppressed (MacDonald, 2012). His work became known as participatory action research (PAR), which afforded emancipation to marginalised groups. In the instance of this AR, and in response to research question 2, PAR provides an opportunity of emancipation in which MHPs can be liberated to self-determine strategies to improve their experiences at work.

It has been suggested that, perhaps in response to differences rather than to similarities between research studies, some AR has become termed as participatory (Lykes and Mallona, 2008). In the first instance, considering that MHPs can feel disempowered within their roles and in line with the transformational leadership that is widely advocated in both health and social care, the idea of an AR study was engaging. The word participatory suggests a political commitment to collaboration and a more participatory world view and is therefore an important element within this AR (Reason and Bradbury, 2005).

Upon debate and consideration within this study, it was decided that the term AR referred to working in collaboration throughout the study. To shape the AR further, a component of the AR would incorporate a PAR approach to promote an expectation of an increased level of participation and emancipation of MHPs to determine and instigate changes. Appreciative enquiry methodology, as was used in this study, has greater emphasis placed on action through engagement of stakeholders to self-determine change (Mishra and Bhatnagnar, 2012). The knowledge and subsequent

understanding are generated through action and are gathered in cycles to be shared amongst participants (Koshy, Koshy and Waterman, 2010). As suggested by Heron and Reason (1997), PAR, although built on the same principles as AR, takes the approach further and specifically is related to the development and improvisation of dialogue and collaboration and this is an important component of this AR in the action of change.

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Therefore, AR consists of a process of cycles of that are composed of planning action and leading to evaluation of the results of action/s (Kemmis, McTaggert and Nixon, 2013; Stringer, 2013). Distinguished from other forms of research, AR has several features that are inherent in the approach: collaboration, problem solving, change in practice, and development of theory (Stringer, 2013; McNiff, 2016). The AR develops as a collaborative relationship between the researcher and the practitioners (MHPs), and, as in this AR, this determines a continuous collaboration throughout (McNiff, 2017). This collaboration informs and clarifies improvement strategies and throughout the AR cycle informs: planning, action, observation and reflection to inform further critical action and continuation of the cycle (Kemmis, McTaggert and Nixon, 2013; McNiff, 2016).

AR is therefore a systematic approach to data collection and analysis with intention to make change through application of practical knowledge to the process (Gillis and Jackson, 2002). PAR is considered a subset of AR and despite the confusion of terms used, the intention in this AR is to impart change at the CMHT, taking specific actions as the central focus (McNiff & Whitehead, 2006 and McNiff, 2017). Incorporating PAR within this AR the central focus on action will be driven by empowerment and emancipation of MHPs to improve their well-being at work through action.

3:7.1 Participatory action research

The methodology of participatory action research (PAR) is incorporated in this study to empower mental health practitioners to develop strategies that develop well-being, team working, job satisfaction and personal resilience. The epistemological assumption of PAR being that, when achieved through action, greater power is given to knowledge borne out of social understanding (Fine et al., 2004).

Relatively new as a research methodology in healthcare settings, PAR has its roots in work developed by Dewy (1933) and then subsequently developed further by Heron (1971) and Reason (1988). The origins of this approach have been developed from ‘co-operative enquiry’ and this essentially translates to doing research “with” and not “on”. The idea is that those who actively participate are co-researchers and do so with awareness of the topic of interest (Reason, 1994). Overlapping co-operative enquiry, this type of methodology is appreciative enquiry (action research), with greater emphasis placed on the action phase. Cyclical in nature, the knowledge

and subsequent understanding are generated through action and are shared amongst participants (Action Research and Action Learning Association (ARALA), 2010).

The distinction between AR and PAR is centred upon a political distinction of the process, namely collaboration alongside emancipation and empowerment of all those involved in the process (Kindon, Pain and Kesby, 2007 and Armstrong and Banks, 2011). Incorporating a participatory approach can promote a greater sense of control for MHPs in light of pressures and demands placed on them as previously discussed. Working as a researcher amongst a group of co-researchers will necessitate an understanding of how groups are formed and sustained. A research partnership such as co-enquiry participation, will require the researcher using PAR as a participatory method to understand principles of interpersonal theory and the dynamics and interplay of how groups operate (Wicks and Reason, 2009). By putting MHPs at the heart of engagement and meaningful collaboration, PAR will enable and empower co-production of understanding.

In this study, the use of AR and incorporated PAR approach, focuses on 'knowledge in action' (O'Leary, 2004). It is research that is conducted through use of this action-based approach to generate knowledge that is situational and specific. The action researcher is immersed in the research setting, while the process and attention to the AR cycle ensures validity. Data are therefore contextually interpreted. AR adopts several approaches to share the power to seek knowledge. The epistemological position is that it is not enough to merely describe, understand and explain the world.

From this epistemological world view, it is essential to change the world (Reason and Torbert, 2001). Critical to this assumption are the questions: who decides the research agenda in the first place and who is the most likely to gain from it? It is in response to this question that the researcher explored issues of consensus within this AR in order to determine how MHPs could benefit from the AR study. It is this that underpins a PAR approach incorporated within the AR, as ultimately this is about the lives of MHPs working at the CMHT and how they can improve their experiences.

With consideration of the research questions and the above research paradigms, it was apparent that an AR-based paradigm position would be best placed to represent the researcher's personal position and philosophical stance. This sat with an epistemological position of intention to make change and to interact with what was being researched. Ontologically, an AR approach and perspective posits that reality is knowable through interaction within a given context. In the case of this AR study, the context was the CMHT, while the researcher and participants contributed to the process and this system supported the views of the researcher throughout this study. These views were imposed through open attempts to influence change.

AR methodology is particularly useful during exploration of work-related issues such as stress. Evidence suggests that individuals struggle to manage aspects of well-being when they must manage competing demands in healthcare (Chapter Two). This demonstrates commitment to the use of a research approach that reflects both a personal philosophical stance and a commitment to conducting rigorous research

within the context of healthcare. The use of an AR approach in the design of the study enhanced value and demonstrated commitment, while it created a democratic, inclusive study.

3:8 Action research methodologies

AR strives to engage and collaborate - in this case with MHPs from multiple knowledge points (Rahman, 1993). AR promotes a culture of inquiry; it is a model of research and work. Critically for this study, it is a form of inquiry that actively engages those who are not traditionally regarded as researchers. In the instance that MHPs can feel disempowered within their role, the idea of an AR study is engaging (Casey, O'Leary and Coghlan, 2018).

The use of AR, a realistic and pertinent approach, promotes a greater sense of control for MHPs to consider the pressures and demands that are placed on them during a period of massive national and local change. Working as a researcher amongst a group of co-researchers necessitates an understanding of how groups are formed and sustained. A research partnership such as that required in AR requires the researcher who applies the AR to understand principles of interpersonal theory and the dynamics and interplay of how groups operate (Wicks and Reason, 2009). By putting MHPs at the heart of engagement and meaningful collaboration, use of AR enables and empowers co-production of understanding.

AR is a qualitative research method that involves an epistemological assumption that knowledge that is born out of social understanding and gathered through action

gains power (Koch and Kralik, 2009). Three basic elements of AR made up the research methodology that was chosen here (Greenwood and Levin, 1998). The first element was the involvement of multiple stakeholders in the research (Collett et al., 2014). Secondly, the research did not merely aim to gain knowledge but was equally focused on the value of action (Wicks, Reason and Bradbury, 2008; McNiff, 2017). The final element was that the research was focused on locally defined perspectives, a sense of sharing power and decisions regarding focus and direction (Wicks, Reason and Bradbury, 2008; McNiff, 2017).

The rationale and benefits of using AR and incorporating a PAR approach for this study have been made clear above. However, there were also challenges to be faced; there is a lack of accepted general understanding of the key terms of AR and PAR and this can lead to misunderstanding. With reference to this study, careful consideration was given to ensure that a comprehensive and balanced approach was taken to the process in order to avoid potential pitfalls of confusion of terms and methods. McNiff (2013) states that the terms that are used in AR are central to the challenges that are faced and their misuse loses the meaning of AR. It is essential to remember that the intention is to change ideas, and that this involves a process of critical, reflexive evaluation and articulation. As suggested by Knight et al. (2017) following adoption of PAR in their study, using a PAR approach in healthcare can prove useful but organisation-wide approaches to change can heighten challenges faced in implementation. They suggest that a range of methods within the research process and a flexible research design that actively engages all stakeholders can mitigate this. Within this AR study, the researcher has been mindful to understand potential challenges and importantly the viewpoints of all stakeholders.

As a starting point, and in the spirit of commitment and collaboration, the choice of methods to be employed was explored with MHPs and these included interviews, surveys, focus groups and questionnaires, alongside workshops and other interactive methods to gather data as the AR progressed and were considered most appropriate. As AR adopts a problem solving approach it enables various methods to be employed as the AR develops. Reaching agreement on methods to be used included open dialogue with stakeholders about which methods could be adopted to ensure that data would be collected that was most suited to begin the process of understanding, developing and evaluating well-being of MHPs. To ensure MHPs were able to fully participate in making informed choices about the methods to be used, an overview of AR and PAR and how and why this could empower MHPs as active participants in the research was included (Wicks, Reason and Bradbury, 2008; McNiff, 2017).

A further challenge of the research is that the retention of the commitment of the participants over time is potentially difficult (Gillis and Jackson, 2002; Kemmis, McTaggart and Nixon, 2013). In this AR study, this challenge was navigated successfully. The study was underpinned by a clear understanding that work-related stress could have impacts on senses of well-being and therefore could impact negatively on MHPs' sense of being able to exert influence and control over how to develop and improve work-related experiences (Bliese, Edwards and Sonnentag, 2017). The project's focus on how staff could develop and strengthen teamwork to improve job satisfaction and personal resilience began a process of empowering staff to meet both organisational demands and to re-establish a sense of well-being

in the workplace. Consequently, participants' motivation and commitment were never under- or overestimated by the researcher and sensitivity to the participants' agenda throughout was essential to avoid misinterpretation (Gillis and Jackson, 2002; Young et al., 2006 and McNiff, 2016).

Within any community there are differences in values and abilities. There may likewise be issues with consensus on what the priorities are for change, and in a highly pressured environment, what the realistic timeframe commitment will be to ensure change (Gillis and Jackson, 2002; McNiff and Whitehead, 2011). These concerns required that careful consideration be given to the demands that were placed on MHPs to meet organisational targets, while different values and levels of expertise were managed in light of the impact that the work could have on each individual MHP (Chen et al., 2016). To manage this, the focus of the study remained at the forefront throughout and MHPs were actively encouraged to engage in the reflection process to explore the challenges they faced as co-researchers and MHPs.

Finally, the researcher had previously worked as a senior practitioner at the CMHT under study and therefore, attention was required throughout the research to ensure that she did not unduly influence the process. As the author of the study, engagement in the process could have inadvertently led to the researcher overstepping her role and influencing the research (McVicar, Munn-Giddings and Seebohm, 2013). It was essential that issues around power and the establishment of equal relationships had been considered from the outset. This prevented

misunderstanding of participants' perspectives and subsequent interpretations of the research. Lack of certainty and agreement at the outset could lead to the wrong questions being asked, which would result in the gathering of irrelevant data. Throughout the process, sensitivity and attention was paid to different leadership requirements (Gillis and Jackson, 2002). The researcher took a lead role in the analysis of data whilst participants took a lead role in the implementation of strategies to introduce and manage change. Attention to these challenges ensured that the AR methodology and the incorporation of PAR approach that was adopted was authentic and that the data that were gathered represented the real, everyday experiences and voices of MHPs.

3:9 Research design

Within AR methodology, there is an acceptance of a "methodological pluralism" (Midgley,2011). This study's methods included both engagement of participants, through the use of interviews and focus groups to understand experiences and thoughts about key concepts of the study, and a survey that sought to explore and measure responses to questions that were related to key concepts. An iterative three-stage approach was used, and a continuous cycle of evaluation and reflection on interventions underpinned all stages of this process. These stages of the process are shown in Figure 4 and highlights how the PAR has been incorporated in this AR study design.

The research design, data collection and analysis were primarily driven by the three-stage design and the types of data that were collected were varied in order to answer research questions and to meet the overall aim and objectives of the study. The choice and methods deemed appropriate by the researcher ad co-researchers

for the AR were; semi-structured interviews, focus groups, surveys and additional data related to functioning of the CMHT against NHS performance targets and a stakeholder analysis. Continuous evaluation and reflection were essential to all stages of data collection.

3:9.1 Overall sample

Sampling is the process by which individuals are selected from within a given group or population. At the outset, all stakeholders would be involved in the process and this included MHPs, locality leads and managers. This stage also included the identification of MHPs who were keen to take active roles as co-researchers.

3:9.2 Participants and setting

All participants were MHPs who were based at the CMHT. Participants in this study included a group of co-researchers who worked in collaboration to share information and to offer insights and feedback. Participants in the study were representative of those in the wider CMHT. Consideration was likewise given to avoid MHPs feeling under pressure to be involved in the study. McNiff (2016) recommends that the intention of the study to generate ideas should remain at the heart of the process, and McNiff states that research participants must be willing to engage and work as co-researchers in the study. MHPs who acted as co-researchers also contributed to the research by offering trustworthiness to the results and to the standing of the research within the CMHT. This involvement of co-researchers can garner enthusiasm among peers towards their participation and contribution to the research process (McNiff, 2016).

3:9.3 Stage 1 - research design

The preliminary stage of AR is to establish a baseline in order to understand the culture of the workplace and the variables within it. The initial stage of any improvement cycle is to understand the experiences of those in the research setting. As a concept, this appears relatively straightforward and an approach that can be readily adopted. For the researcher, however, time and consideration needed to be given to the capture of data that provided an accurate understanding of the experiences of those involved in the study.

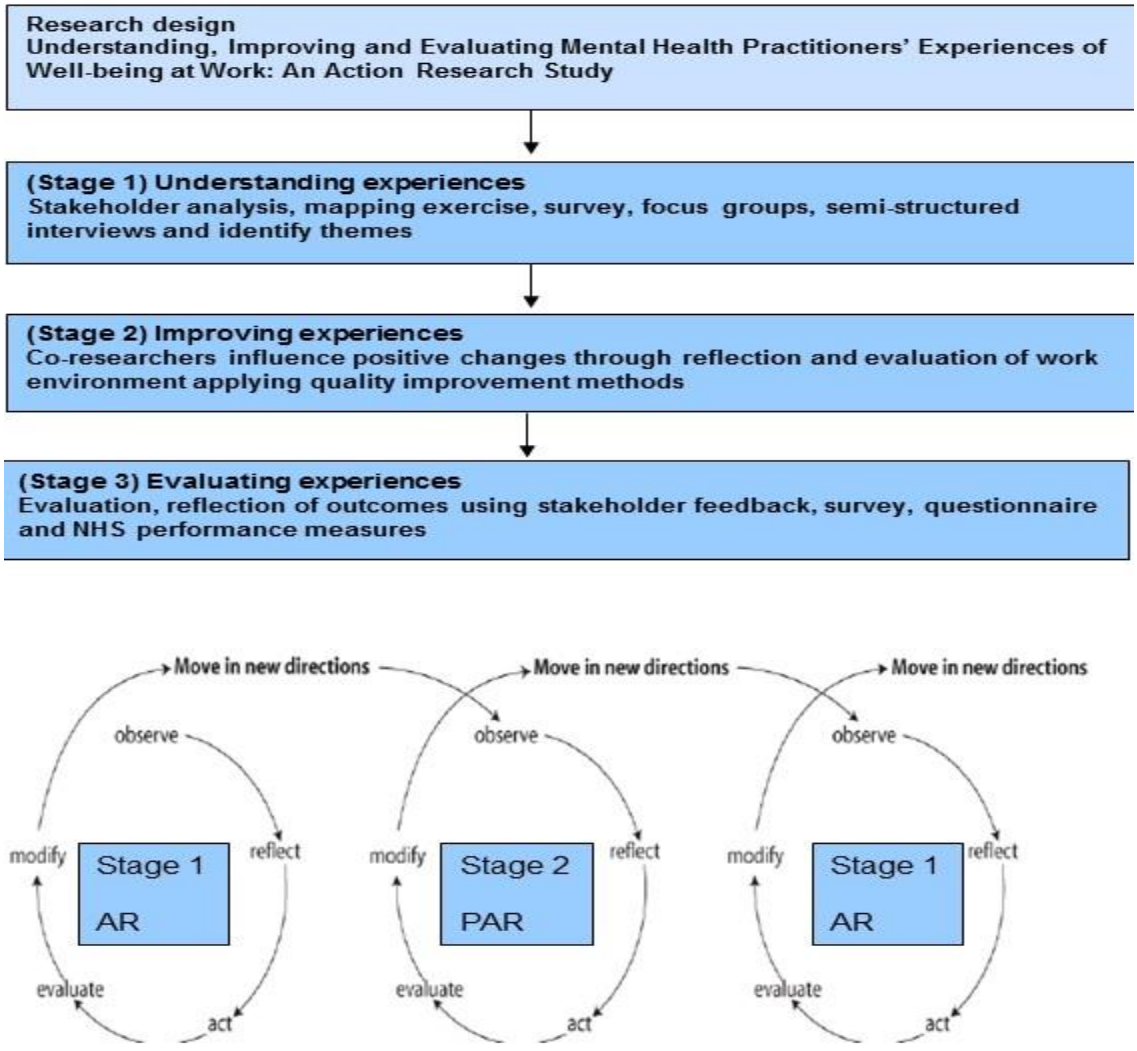


Figure 4 Research design

3:9.3.1 Mapping exercise and stakeholder analysis

A cognitive dissonance can be created by thinking more critically about the services we offer and taking time to explore them in-depth. The dissonance may include inconsistent thoughts, beliefs, or attitudes, which relate to attitude change (Kirchner et al., 2012). There is a contradiction between driving through change, being perceived as productive and taking adequate time to plan changes that are more likely to become embedded. Attempts to understand cognitive responses to learning and acquiring a more pragmatic and considered approach to improvement can supplement learning and relate to ongoing practice development. Therefore, the process of assimilation of new knowledge can ensure formative reflection that can be subsequently translated into practice (Hammond and Cooper, 2016).

Within healthcare, a stakeholder analysis should reflect meaningful engagement, reflection and a respect-based relationship with those that have an investment in the service and potential outcomes of the study. Thus, the stakeholder analysis reframes concepts and generates ideas and support. To use a stakeholder analysis, there should be an understanding of the nature of the interplay between individuals and organisations alongside both intentions and behaviours (Bourne, 2016). There was keen interest in this study amongst key influential stakeholders; for the researcher, this interest necessitated consideration of the different perspectives of both well-being at work of MHPs and of the organisation.

3:9.3.2 Data collection and analysis

Data collection and analysis from Stage 1 of the study would inform the themes that underpinned Stage 2 (as highlighted in Figure 4). The data that were to be collected at Stage 1 would consist of both quantitative and qualitative data, which would be reviewed together to provide a complete picture of MHPs' perspectives to inform the themes that supported Stage 2 (making changes). The purpose of this approach was twofold; firstly, to gain insight into MHPs' thoughts about well-being and their sense of job satisfaction, teamwork and resilience; and secondly, to gain critical insights into MHPs' views on how they could develop well-being and build job satisfaction, teamwork and resilience. These insights would help to inform the development of Stage 2 of the study.

3:9.3.3 Stage 1: data collection methods

Various methods for data collection were used in the study and data were collected in all three stages of the iterative process. Therefore, during the process, as specific issues or situations arose, both the researcher and the co-researchers worked together to make a shared decision on which data collection methods were most appropriate (McNiff and Whitehead, 2011; McDonald, 2012 and McNiff, 2016). Different methods of data collection were used to counteract the limitations of each and to give multiple viewpoints to inform solutions that would be adopted by the service (Ritchie et al., 2013). Figure 5 shows the data collection and analysis methods that were used throughout the three-stage design in response to the research questions that were posed and in light of the project focus on the understanding, improvement and evaluation of MHPs' experiences of well-being.

3:9.3.4 Survey

In line with survey methods that were permissible within the NHS Trust, Survey Monkey was used to survey staff at the CMHT. The researcher developed the staff survey with direct reference to existing evidence on the concepts that underpinned each of the key study areas: well-being, teamwork, job satisfaction and resilience at work. The survey and results from Stage 1 are detailed in the next chapter (Chapter Four).

A survey at this point (Stage1) provided a useful means to perform evaluation before the study was conducted and after it was finished as data collection could be extended as the AR progressed through to Stage 3 (Chapter Six) and the consideration of potential outcomes (Stringer, 2007). The initial survey generated participant responses to a set of specific questions that were related to the core components of the study. Descriptive statistical analysis was used to highlight important concepts and to provide a backdrop to other data that were yielded in the initial stage. At Stage 3, the survey provided a comparison between Stages 1 and 3 and could be used to gain an insight into subsequent findings. Therefore it acted as an outcome measure (as highlighted in Figure 5). The focus of this early stage was to explore and understand the culture of the team. This included developing an understanding of the roles and functions of teams within teams and to influence the future interventions and the cyclical process of Stage 2, as MHPs investigated interventions to develop well-being.

Research Questions /Stage	Data Collection	Data Analysis
Stage 1 Research question 1 Understand MHPs' experiences (January –May 2018)	Mapping exercise Stakeholder analysis Semi-structured interview Focus groups Survey NHS performance data	Field notes Survey Qualitative data-thematic analysis Performance indicators
Stage 2 Research question 2 Improve MHPs' experiences (June 2018-February 2019)	Stakeholder workshops Meetings with co-researchers Discussion with stakeholders Validation group feedback	Field notes Reflections and evaluations Co-researchers Performance indicators
Stage 3 Research question 3 Evaluate MHPs' experiences (February –April 2019)	Stages 1&2 Final Survey NHS performance targets Questionnaire Evaluation with stakeholders Co-researcher feedback	Field notes Qualitative data Survey comparison (Stage 1 and 3) NHS trust performance data (Stage 1 and 3) Co-researchers
RQ1- How do mental health practitioners view well-being, teamwork, job satisfaction and resilience? **RQ2- How can mental health practitioners enhance well-being and strengthen teamwork, job satisfaction and resilience?** **RQ3 -Does being involved in leading and developing service improvement interventions to improve experiences at work enhance mental health practitioner well-being and strengthen teamwork, job satisfaction and resilience?**		

Figure 5 Data collection and analysis stages 1-3

3:9.3.5 Stage 1: Semi-structured interviews and focus groups

For the researcher, the challenges of executing this phase of data collection were due to her position as an insider, then outsider, action researcher. Although she was no longer acting as an insider researcher, issues remained regarding unintentional bias (pre-understanding) and the perceptions among MHPs of her role as a colleague and peer (Coghlan, 2019). These issues warranted consideration to encourage participants and the researcher to affirm their positions on the collection of data (to avoid potential bias and offer a 'true' account). There were opportunities throughout for participants to revisit and amend their contribution accordingly. An example of which is a participant who amended their responses to each question. The participant felt that their initial contribution had not been reflective of 'true' experiences but more so an account which portrayed a practitioner who was managing the demands faced, and who was maintaining their well-being, which was not the case. It is interesting that following amendments to the data the MHP stated that peers had suggested a revisiting of contribution to interview data and this signified investment in the AR by MHPs.

The process of collecting qualitative data in semi-structured interviews and focus groups ensured that the researcher could capture the overall context of interviews. The interviews were face-to face, verbal interactions that prompted the supply of information in the form of answers to questions that the researcher asked (Gillis and Jackson, 2002). This type of interaction ensures a reciprocal learning and sharing throughout. Questions also explored MHPs' readiness to introduce change and to be involved in the process as co-researchers. A copy of the interview schedule is included as Appendix 2.

A semi-structured, one-to-one interview explores and contextualises thoughts on the subject and, critically, how the research questions can be addressed. Interviews are often used in AR at the outset, since they provide an opportunity for participants to share experiences. This process offers a theoretical approach to data collection and ensures that the researcher provides opportunities for participants to articulate their experiences (Stringer, 2007; McNiff, 2016). Interviews therefore provide an opportunity for interviewees to express thoughts and ideas in personal language based on experiences. The researcher can therefore explore general topics to uncover perspectives, whilst respecting the ways in which participants structure their contributions (Marshall and Rossman, 2011).

The use of semi-structured interviews enabled the researcher to explore in a private space some personal and sensitive themes that were related to well-being, job satisfaction, teamwork and resilience (Tong, Sainsbury and Craig, 2007). To supplement these data, focus groups were used to collect further data that were related to experiences of well-being, resilience, job satisfaction and teamwork by maximising on the dynamic between participants as co-researchers. An understanding of the value of sharing personal experience may yield richer data (Stewart and Shamdasani, 2014).

The use of focus groups ensured that participants were given the opportunity to explore issues that were specific to the study amongst their peers. Focus groups provide a tested method to generate data amongst research participants and

researchers that capitalises on communication in a group setting (Parker and Tritter, 2006). The focus groups consisted of those who shared similar experiences and characteristics to ensure that there was opportunity for them to share their perspectives with others who understood their position (Marshall and Rossman, 2011). At the outset, it was envisaged that the size of the focus groups (four to eight participants) would encourage contributions and sharing of ideas and garner optimal communication and potential for useful data to be generated. The researcher was mindful that a supportive environment should be fostered in which the sharing of different perspectives would be assured (Marshall and Rossman, 2011). To ensure that data collected within the focus groups was accurate and a true reflection of experiences, participants were encouraged to review a summary and amend or add additional data that they deemed important.

In line with AR and the collaborative nature of the study, all viewpoints were regarded as valid and all participants were encouraged to take the opportunity to communicate openly. The dynamic aspect of group-work encouraged the discovery of possible solutions to the development of well-being, teamwork, job satisfaction and resilience amongst the MHPs. The researcher provided structure to the focus group and therefore could check out tentative solutions and conclusions, alongside possible plans (McNiff and Whitehead, 2011).

Despite the many positive aspects of focus groups, the researcher was mindful of challenges and ensured that adequate consideration was given to issues such as: recruitment and inclusion of those who were less confident in speaking out; her

inability to ensure confidentiality in full as information was shared by group members; and her requirement to keep the sessions focused (Bloor, 2001). A copy of the schedule for the focus groups is included as Appendix 3.

3:9.3.6 Stage 1: data analysis

The purpose of data analysis is to make sense of data and to offer insights. The purpose of data analysis in AR is very much a process and throughout there is a general commitment to four threads: reading and scrutinising data, selecting data and exploring what is important, presenting data and, finally, interpreting and drawing conclusions (Altrichter et al., 2013). As in this case, the process followed a three-stage iterative approach, change was evaluated throughout the study.

This process meant that weakness in one type of data would be offset by strength in another (Creswell, 2009). Emphasis and careful attention was given throughout the analysis to ensure that all the data types that were gathered were adequately explored. The data that were generated warranted careful consideration, interpretation and discussion to resolve any discrepancy. To support this approach, NVivo 11 (Edlund and McDougall, 2016) was used initially as a software package to assist in the organisation of the data, to analyse, to make links and to develop insights. The thematic framework that has been described by Braun and Clark (2006) was then used to review critically the data and to develop themes.

For this study, the process of coding data was not enough to understand fully the MHPs' experiences. The degree of analysis of the data took the form of ongoing

critical reflection. This process included questioning interpretations and happenings, then sharing this appraisal and comparing interpretations and questions to capitalise on the potential for mutual learning (Munn-Giddings and Winter, 2013). Robust analysis of data ensured that the study remained credible and that the data could be used to inform and develop the evidence base for the subsequent service improvements.

3:9.4 Stage 2: interventions stage

Incorporating PAR as an element of the AR in this stage afforded opportunity to embrace the principles of emancipation as MHPs were able to instigate change as they deemed appropriate without constraints imposed to influence the course of improvements made. This phase of the AR made up the interventions phase in which the MHPs could lead and develop interventions that were aimed at improving their well-being at work. This was in line with understanding the factors that influenced well-being: job satisfaction, resilience and teamwork, as highlighted previously (Chapter Two). PAR in this phase is important as MHPs have the skills and knowledge and indeed the right to determine solutions and this affords meaningful engagement in leading change that is sustainable (McNiff, 2016).

Therefore, as PAR, stage 2 focuses on planning and implementing interventions based on findings from stage 1. MHPs are involved in establishing what changes are felt to be essential and then achieving this. Co-researchers will actively engage with findings from stage 1 to determine potential obstacles and challenges and to design and manage the process of implementation of change. Active engagement as

leaders of change begins the operationalisation of the principles of PAR and ensures that MHPs can reflect, evaluate and make changes in line with evidence.

The intention is that MHPs acting as co-researchers engage all stakeholders to review, reflect and evaluate the proposed changes. As the intervention phase develops it is this engagement of stakeholders and peers by co-researchers that will engender meaningful and sustainable changes to be made. The feasibility and acceptability of changes made will be evaluated throughout and as part of a subsequent AR cycle in stage 3. There is opportunity for feedback from peers and stakeholders and this includes seeking feedback and experiences of adopting a particular change in the CMHT. This is an important element of the process and ensures that amendments can be made to support those interventions that had most meaning to MHPs.

To do this, in line with PAR and the practical approach adopted in the AR study, the service improvement element (action and change) was underpinned through use of Plan-Do-Study-Act (PDSA) cycles (Taylor, 2014). It is envisaged that there will be a minimum of three PDSA cycles within each identified theme (Stage 1) but as the evolving nature cannot be determined prior to the PAR approach this was advisory rather than essential. When these cycles are used with a PAR approach and there is commitment to the principles that underpin all stages of a PDSA, their value is shown as their use ensures the ongoing participatory nature of the study.

Improvement and iterative development underpin the process. In order to ensure that the true value of this PAR approach was realised, the process reflected the principles that underpinned this type of approach and the cycles offered a measured way to ensure that all stages were adhered to (Taylor et al., 2013). By understanding the dynamic nature of a PDSA cycle and the evolving nature of multi-PDSA cycles, the process ensured that an ongoing participatory, reflective study was developed.

This systematic approach to testing and hypothesising informs decision making by clarifying what is happening from multiple perspectives. Therefore it influences the process of developing strategies to build well-being and to strengthen teamwork, job satisfaction and resilience. Communication at this stage involved all stakeholders; this is a key aspect of PAR as without such communication there would be limited success (Kirchner et al., 2012). It is important to note that the process of completing multi-PDSA cycles means that the amount of data that are yielded can be vast. It was imperative that all data were tracked and documented accurately. It was not adequate to report merely themes of the cycles but all stages within each cycle had to be reported to ensure consistency (Taylor et al., 2015 and 2013).

However, there are understandable issues in determining the success of PAR and using PDSA due to the variables that exist within a practice setting (Bradbury, 2015; Reed and Card, 2016). Evaluating PAR and AR is not just about change but more so an approach toward change with outcomes in context, knowledge and in those involved in the process (McNiff, 2017).

Lastly, ongoing considerations of the manner of reflection underpinned all stages of the process. Reflection was not performed in isolation but in a systematic and deliberate way, with assumptions being underpinned by evidence to support them. The underpinning PAR approach and use of PDSA in Stage 2 (Figure 6) helped to support MHPs to make improvements through iterative cycles of action and reflectivity. This iterative process ensured that there were opportunities to improve well-being and explore potential challenges and obstacles.

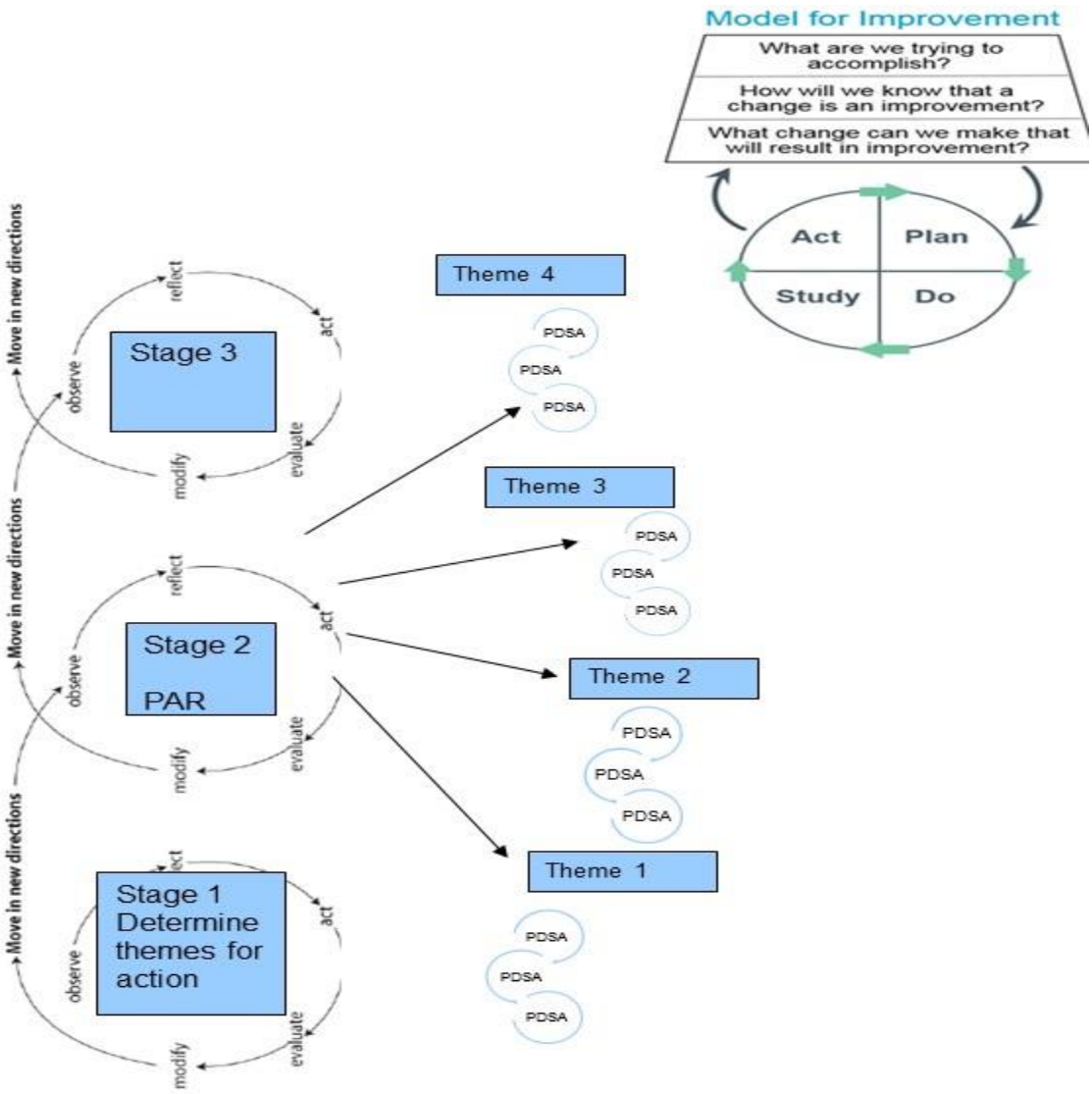


Figure 6 PDSA iterative cycles

3:9.5 Stage 3: evaluation, reflection and outcomes

The process of AR was evaluated to draw together key themes and outcomes from Stages 1 and 2 of the study. This evaluation was performed in addition to the ongoing evaluative and reflective nature of AR that was intrinsic within Stages 1 and 2. This stage included a repeat of the survey that was completed as part of the baseline data that were collected in Stage 1. Further qualitative data was gathered in this final stage through use of opportunities for stakeholder feedback (group exercises and anonymous feedback) and a simple questionnaire that was structured to build consensus by asking pre-determined questions of stakeholders and co-researchers. This method ensured that comparison and feedback was given by all stakeholders and it could be used to explore the impact of the interventions in relation to the data that were collected in Stage 1. This stage also included an exploration of the impact of the AR through critical reflection by the researcher and co-researchers.

3:10 Validity and trustworthiness

The trustworthiness of this study was in line with ensuring commitment to the principles that underpin valid research methodology and methods. Decision making throughout the study, which was demonstrated by the choice of data collection and analysis methods, ensured that study results would be relevant and reliable. The principle of AR is that knowledge exists in a state of flux and therefore is open to challenge. It is influenced by future events and a process of continuous engagement and negotiation between different perspectives and positions (Munn-Giddings and Winter, 2013). Consequently, in this AR it was essential that differences of opinion

could be shown and it could be demonstrated that the communicative processes that underpinned the study were open for debate and scrutiny.

To enhance the validity of this study, a validation group (McNiff, 2017) offered comments on the findings and analysis and reviewed the study critically as it progressed. The validation group consisted of a group of MHPs who were like those who were participants/co-researchers but who were working in a different CMHT setting, and organisational stakeholders from within the wider locality management structure of the CMHT. Fundamentally, the validity, as with all AR, was confirmed through a combination of personal and social validation and ongoing public legitimation (McNiff, 2017). This validation process required the continual consideration of both the interpersonal skills and organisational issues that could impact on the AR study. A critical aspect of engaging a validation group throughout this AR was to afford third party critical review and scrutiny of all stages of the AR as it developed. This presents an ongoing challenge to both the researcher and co-researchers to articulate and give account of judgments made and conclusion drawn. Involving a validation group can present a challenge when researchers are invested in the research and this necessitates preparedness for a critique of work which requires appreciation of this value of this type of feedback to ensure validity.

3:11 Ethical considerations

Throughout the study, attention was given to possible ethical implications. The rights of all those who were involved were paramount (Wisker, 2007). According to the University of West London (UWL) Code of Conduct for carrying out research, ethical

approval is required when human beings are used as participants and if the research is conducted within an NHS setting. Ethical approval was therefore sought, and a favourable opinion was gained from the UWL Research Ethics committee (Ethical Approval No. UWL/REC/CNMH-00066). Following a review, the research and development department of the NHS Trust in which the study was based approved the project as a 'quality improvement project' (“through the use of PDSA cycles, and information gathering”) and the study was placed on the department database (code 2887) (Appendix 4).

This study has been designed after taking into account human rights legislation, the World Medical Association’s Declaration of Helsinki (2000) (Salako, 2006) and codes of ethics and professional practice with regard to undertaking ethically sound research and ensuring that participants or any persons involved were not put at risk at any time (Nursing and Midwifery Council (NMC), 2018). Consideration of the principles of AR underpinned the research (Coghlan, 2019). It is important to note that there are unique ethical challenges that may arise when using AR. For example, in this study, participants lacked anonymity as peers acted as co-researchers. This situation was managed by the anonymising of data in Stage 1 and co-researcher roles were clearly highlighted and identified at the outset (Manzo and Brightbill, 2007). It was also important to take care that, due to the flexible nature of AR, emergent issues and questions that arose as the study developed were afforded the same consideration of ethics as was given to issues and questions at the start of the study. An expansive consideration of key issues is included as Appendix 5. To support this, participant consent forms are included as Appendix 6.

3:12 Summary

AR methodology was a viable option to ensure active involvement from the MHPs to influence aspects of practice in order to enhance well-being. Therefore, the methods that were chosen formed an important element in the deconstruction of dominant discourse (an accepted way of looking at /and /or doing by those in positions of power). The use of AR methodology in practice settings can be useful to promote change from within. AR is not a rigid approach but one that applies general principles and is designed to take account of the unpredictability of human nature (Stringer et al., 2014). Reed et al. (2019) highlight the complexity of the NHS and its services, which are interconnected, so that a context specific approach could be useful (hence the choice of AR) to ensure that there was engagement on the ground, and to embed practices with sustainability in the context (Lennox, Maher and Reed, 2018). AR offers a systematic approach to look at everyday solutions; it involves cycles of investigation to reveal solutions, with understanding that specific dynamics of a given context mean that there is variation in what works well. Fundamentally, AR is about the researcher facilitating the whole process. Incorporating PAR within AR enables the study to afford greater empowerment and emancipation towards determining a course of action.

This collaborative approach to research is akin to improvement methods that are often used in healthcare organisations to meet the quality agenda. Improvement methods ensure that quality initiatives are achieved through application of research methods to interpret and understand the process of quality improvement. To ensure that the true value of this AR approach is realised, the process should reflect the

principles that underpin this type of approach and the commitment to quality improvement (Taylor et al., 2013).

This exploration of ways to understand and research the world has helped the researcher to develop a research methodology that reflects her core values and world view and makes them explicit. These are: working in collaboration with others; pursuit of lifelong learning; belief in personal and professional growth and the development of hope and optimism in self and others; and democracy, honesty and trust. AR aligns with these values because of its emphasis on participation, empowerment and collaboration. AR provides MHPs with an understanding of how and why actions can meet with intentions and knowledge generation. This understanding underpins personal and professional growth, as is highlighted in the researcher's field notes.

Researcher field note extract - Growing like Topsy! (April 2018)

> *The more I find out the less I know! Really worried that the study has potential to be too big. One of my peers has said I am making it too hard on myself. Perhaps it needs to be difficult, but will AR prove too much? Need enough time to ensure changes become embedded - need to be brave and start? I will need to plan out a minimum of six months and possibly nine months for the action stage of the study. Realise as I investigate methods and literature that I could probably write 100,000 words and be no nearer to feeling confident as a researcher or as a doctoral student. Imposter syndrome!*

Chapter Four –Understanding Experiences and Development of Themes for Action (Findings, Data Collection and Analysis Stage 1)

Research Question 1- How do mental health practitioners view well-being, teamwork, job satisfaction and resilience?

4:1 Introduction

This and the following chapters (Five and Six) are aligned to the research questions that are shown in Figure 7. This chapter details the findings for Stage 1 of the study, which involved the collection of data to inform action plans for Stage 2. The exercise highlighted the involvement of key stakeholders, their engagement in the study development and their contribution to the evolving nature of the study. This underpinned the ongoing commitment to collaboration and shared decision-making between the researcher, co-researchers and wider stakeholders. Data that were included in the mapping exercise were linked to the performance of the team and they provided direct comparison with NHS Trust performance targets. These performance data set the context for this research by providing an overview of how the team functioned at the outset and end point of the study.

Data were collected via a survey, semi-structured interviews and focus groups to provide a picture of MHPs' perception of well-being at work. Participants' responses and a thematic analysis of this data are discussed in this chapter in detail along with how identified themes informed Stage 2 of the study (development of strategies to enhance well-being). Finally, the ways in which this stage of the research contributed to changes in practice and the evaluation of the process is discussed. All stages (1-

3) were underpinned by cycles of reflection and evaluation, in line with the AR (and PAR that was incorporated in Stage 2) approach that was adopted.

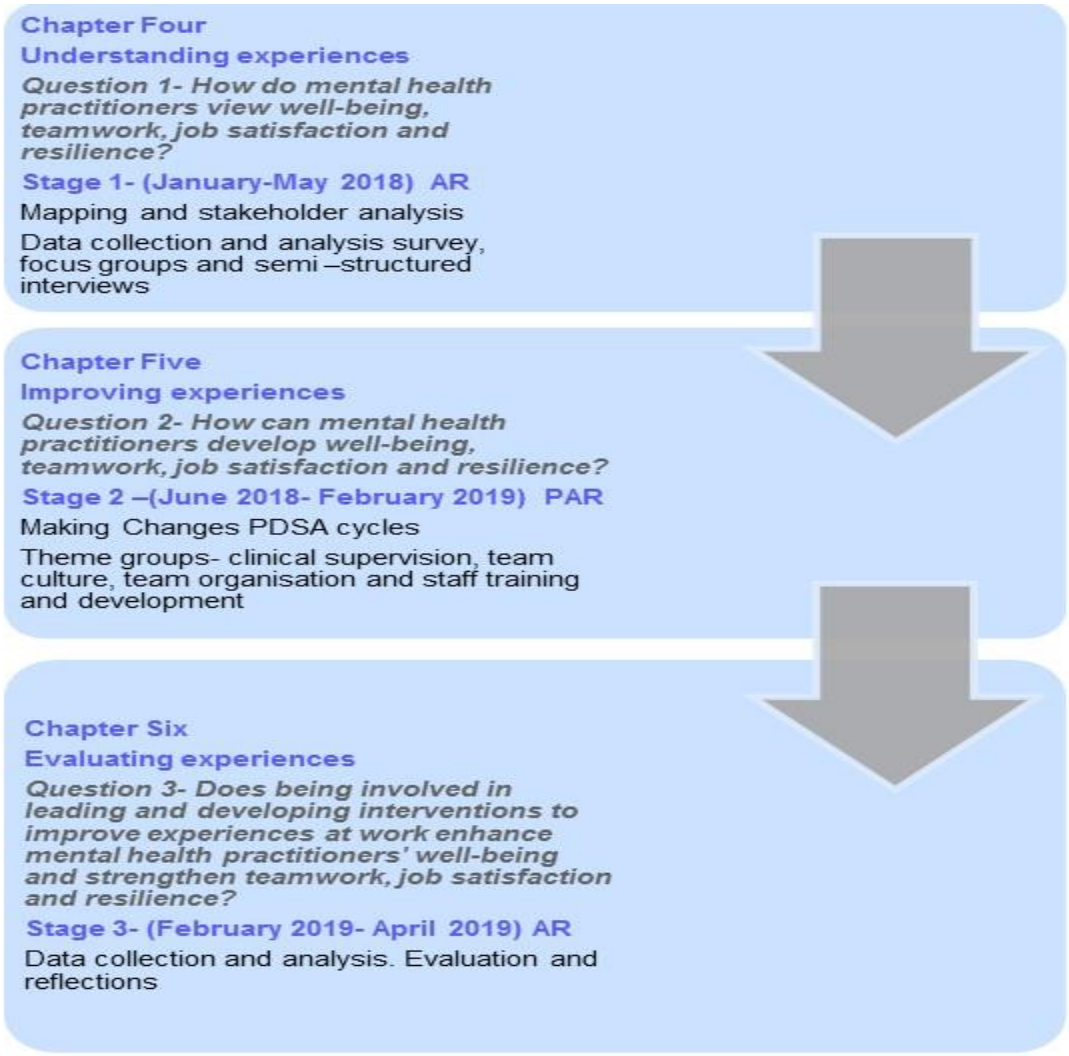


Figure 7 Linking findings to research questions

4:2 Mapping exercise and stakeholder analysis

The purpose of the mapping exercise and stakeholder analysis was to develop a clear picture of the challenges that were faced by the CMHT members as stakeholders. Information that was gathered routinely for NHS Trust monitoring purposes and which reflected performance of the team was reviewed. This included: recruitment and retention rates, absence figures, and measurement of the team

against performance targets and indicators (Table 3). This data provided a pre-study overview of team functioning and performance (for the corresponding post-study overview, see Chapter Six, section 6:5).

These data highlighted key areas with which the CMHT was struggling. The team faced challenges such as a high number of patients with complex needs, difficulties with meeting performance targets, periods of high rates of absence due to sickness plus high staff turnover. The CMHT was failing to meet trust-wide targets, which was indicative of the pressure that the team experienced. The team was regarded as underperforming and therefore as a cause for concern by the Trust. When this team was compared through Trust-wide data collection with other local CMHTs, it was apparent that the team's effectiveness was low, and this finding reinforced the motivation for the study. There appeared to be a disconnection between organisational expectations and the experiences of the MHPs.

To supplement these data, an analysis of stakeholders provided an understanding of which individuals were most likely to have an impact on the success of this study; that is, those individuals who were likely to have influence, those who were most interested in being involved in the promotion of well-being, and those who were most likely to benefit from team success (Varvasovszky and Brugha, 2000). Involvement of co-researchers in the stakeholder analysis was the first step in the empowerment of the MHPs to take ownership of the intervention.

Table 3 Performance Data as part of Trust-wide monitoring

Data March 2017-March 2018

Delayed transfer of care Trust target 7.5%

APR 17	MAY 17	JUN 17	JULY 17	AUG 17	SEPT 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18
6.2%	2.8%	2.7%	7.4%	7.0%	6.6%	**8.0%**	**15.9%**	**8.2%**	0.0%	3.2%	3.6%

Mental Health CPA review Trust target 95%

APR 17	MAY 17	JUN 17	JULY 17	AUG 17	SEPT 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18
94.3%	95.4%	**91.4%**	**93.2%**	**94.7%**	97.3%	**93.4%**	**92.0%**	**88.0%**	**93.2%**	**91.5%**	95.0%

DNA rate (red/high more than 6%) – Trust-wide data comparison

APR 17	MAY 17	JUN 17	JULY 17	AUG 17	SEPT 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18
9.66%	**6.45%**	**8.53%**	**9.07%**	4.37%	4.53%	4.28%	4.42%	4.14%	**7.62%**	**7.67%**	4.12%

Mental health: acute occupancy rate (red/ high more than 85%) – Trust-wide data comparison

APR 17	MAY 17	JUN 17	JULY 17	AUG 17	SEPT 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18
98%	**94%**	**102%**	**107%**	**114%**	**114%**	**107%**	**95%**	**98%**	**109%**	**108%**	**93%**

Staff turnover rate (red /high more than 15.2%) – Trust-wide data comparison

APR 17	MAY 17	JUN 17	JULY 17	AUG 17	SEPT 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18
12.9%	11.0%	9.4%	10.9%	13.2%	**20.7%**	**16.7%**	**16.7%**	**18.6%**	13.2%	**20.7%**	**22.3%**

Staff sickness rate (red/high more than 3.5%) Trust target

APR 17	MAY 17	JUN 17	JULY 17	AUG 17	SEPT 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18
4.20%	3.48%	3.48%	3.48%	0.60%	0.60%	**4.06%**	**21.46%**	0.41%	0.41%	0.60%	**4.06**

Mental health within clustering target (red/high lower than 95%) Trust target

APR 17	MAY 17	JUN 17	JULY 17	AUG 17	SEPT 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18
87%	**87%**	**87%**	**86%**	**85%**	**84%**	**85%**	**83%**	**83%**	**84%**	**83%**	**81%**

Comment

This falls below expectations of performance and could be an indicator that staff are struggling to manage competing demands

This is indicative of the high level of complex need amongst the CMHT caseload

Highlights that retention of staff is an area of concern. It may be linked to organisational and service changes as discussed in Chapter One.

Indicative of staff struggling to manage competing demands and prioritising other aspects of their roles

Mandatory training March 2017-March 2018
Clinical Risk - 3 Year - Green > 85%, **Amber 70 - 85%, Red < 70%**
Information Governance - 1 Year - Green >95%, **Amber 80 - 95%, Red < 80%**
Mental Capacity Act - 3 Years - ≥75%
Safeguarding Adults Level 1 - 3 Years - Green > 85%, **Amber 70 - 85%, Red < 70%**
Safeguarding Children - Green >95%, **Amber 80 - 95%, Red < 80%**
Infection Control - Green > 85%, **Amber 70 - 85%, Red < 70%**

	Last 12 mths	APR 17	MAY 17	JUN 17	JULY 17	AUG 17	SEPT 17	OCT 17	NOV 17	DEC 17	JAN 18	FEB 18	MAR 18
Clinical Risk (3yr)	84%	87%	87%	**84%**	**84%**	85%	85%	**77%**	**81%**	**80%**	**85%**	85%	**82%**
Information Governance (1yr)	89%	**86%**	**87%**	**94%**	**87%**	**89%**	**86%**	**87%**	**89%**	**89%**	**89%**	**86%**	**94%**
Mental Health Capacity (3yr)	84%	84%	85%	83%	84%	83%	85%	83%	86%	85%	83%	85%	86%
Safeguarding (1-3yr)	82%	95%	95%	**76%**	**78%**	**68%**	**80%**	**79%**	**84%**	86%	**68%**	**80%**	91%
Safeguarding Children (3yr)	89%	88%	89%	90%	88%	89%	88%	85%	87%	89%	89%	88%	93%
Infection Control	87%	89%	87%	86%	89%	88%	85%	**84%**	86%	86%	88%	85%	90%

Complaints
April to Sept 2018- 8 complaints

Clinical/Managerial Supervision
During 2018 the average % who received managerial supervision was 28%. It was identified that managerial supervision was placed as low on the stakeholders' priorities as they did not feel any benefit from the existing format.

Mandatory training is essential and expectation of required by all in line with safe and competent practice. Despite this, the CMHT performance is a cause for concern.

The discussions of the stakeholder analysis emphasised to co-researchers that they had a key role in the maintenance or improvement of team well-being through a direct influence on the development of initiatives. Ways in which the co-researchers could work with peers who did not initially wish to be involved in the study (as co-researchers) were also highlighted. As can be seen in Figure 8, the stakeholder analysis provided a good understanding of how best to ensure ongoing support and engagement in the study. This also indicated to co-researchers who from among them was best equipped to exploit relationships with significant stakeholder individuals and particularly with those individuals who were most likely to support and contribute to the study as it developed.

Working with stakeholders in the early stages of the study provided the less involved practitioners with opportunities to contribute their ideas and for their contributions as stakeholders to be validated. This validation of stakeholder contributions became an important element of the study (Chapter Five, section 5:3), as feedback often led to the imposition of corrective actions, which helped the whole team to feel involved.

The process therefore opened a dialogue about the study with influential individuals. Co-researchers' thoughts about how best to engage peers who were deemed hard to engage were also crucial. Ongoing discussions with co-researchers confirmed the researcher's intuition that team members felt that there were underlying issues of poor communication and fragmented relationships within the CMHT. This confirmation acted as a motivating factor for co-researchers to engage with stakeholders who had little or no interest in the study, and this enthusiasm to engage

these stakeholders appeared to be driven by the co-researchers' belief in the value of the study, which was encouraging to the researcher.

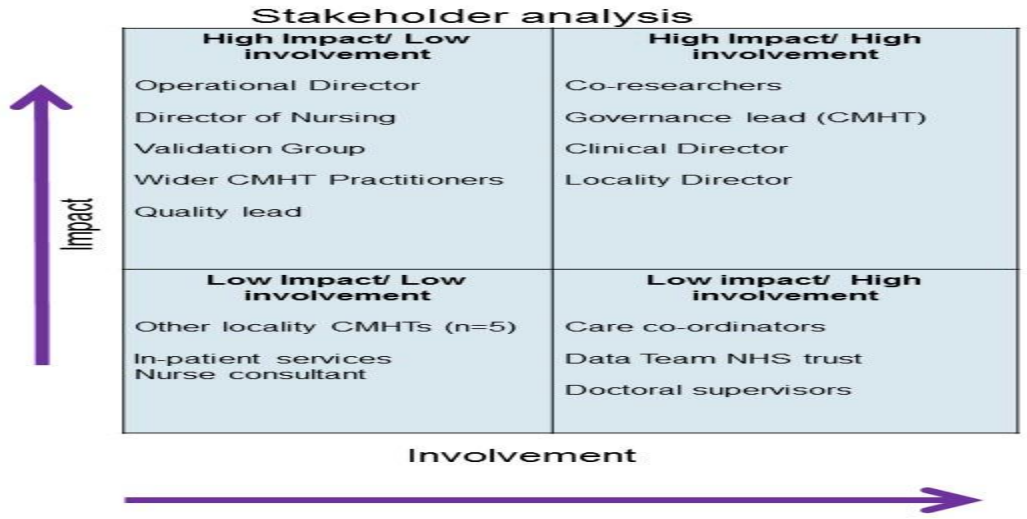


Figure 8 Stakeholder analysis grid

The stakeholder analysis led to discussions about the existing state of team working. Some MHPs said that they felt isolated and unable to share positive thoughts about the intended study. This partial disinterest acted as a motivational factor for the researcher and co-researchers and it became critical to the pro-active approach that was adopted to engage with those who were most likely to be impacted by the study. These conversations highlighted the importance of involving all stakeholders in the project. They informed an in-depth analysis of the inter-relationships within the team (Bourne, 2016) and of how MHPs' feelings would impact on the study, including how best to foster enthusiasm within the CMHT.

The mapping exercise and stakeholder analysis underpinned the initial phase of the data collection and analysis section of the study. They were followed by use of the

survey, semi-structured interviews and focus groups to gain an in-depth understanding of MHPs' perceptions and experiences. The results of this part of the study are reported next.

4:3 Initial survey quantitative data analysis

The purpose of this survey was to provide a baseline assessment of MHPs' perceptions of well-being. The survey was repeated during Stage 3 (Chapter Six, section 6:2).

4:3.1 Participants

To avoid bias, the intention was that all staff who worked at the CMHT as MHPs would complete the survey. Completion by all staff would offer the 'truest' picture of staff perceptions of the key concepts that were to be investigated in the study and therefore would be representative of the population (McPeake, Bateson and O'Neill, 2014). MHPs who were invited to respond to the survey numbered 16. Six posts in the CMHT were unfilled and 14 staff were no longer in the team following the changes to the team structure that have been previously outlined (Chapter One, section 1:2). These figures indicated a need for the study, as they showed the recruitment and retention issues that the team faced.

4:3.2 Survey instrument

Since there is no universally agreed, validated and reliable measure of well-being at work, job satisfaction, teamwork, or resilience that is designed for use in healthcare settings, the survey was developed following the literature review and questions were generated from measures of key study concepts. The survey was designed to ensure that: the researcher's assumptions did not unduly influence the questions that

were posited; questions were simple to answer; participants would be willing to take part; and the results could be objectively interpreted (Evans and Mathur, 2018).

The survey was drawn up with no questions that could lead to identification of participants. This was to ensure that respondents would answer questions honestly without fear of judgement (Coghlan, 2019). Although it might have been useful to understand the composition of the respondent sample, the potential loss of confidentiality was felt to pose too great a risk to include questions that would have delivered this information, and an overview of the whole team was deemed satisfactory to meet the aims of the study.

4:3.3 Survey findings

Responses were supplied by 11 (68.7%) CMHT practitioners and all questions were answered by all respondents. Simple descriptive statistics were used to analyse and interpret findings. This enabled the calculation of the percentage distributions of responses to questions. The survey, enabled the identification of significant issues to inform Stage 2 (the service improvement). The full survey results are included in Appendix 7. Although the data were not sufficient to detect statistically significant differences between participants, the survey proved a useful tool to identify the unique factors that influenced the experiences of MHPs in order to interpret a wide range of factors that may have impacted on their well-being. The survey findings as percentages provided an indication of variability in responses to questions.

4:3.3.1 Questions related to job satisfaction

The literature review highlighted that there is a widely held perception that those who work in care settings enjoy their roles and that this enjoyment motivates them to work in such areas. There are various definitions of job satisfaction that suggest it is affected by emotional responses to various components of the job. A relationship exists between a sense of achievement at work and a greater sense of well-being; this warrants consideration in terms of the reverse of this, that is, does well-being impact directly on job performance?

Participants' responses to questions that covered domains of job satisfaction are detailed in Table 4 and are interpreted in the sections below.

Table 4 Job satisfaction - responses to questions

	1. Strongly agree	2. Agree	3. Somewhat agree	4. Neither agree nor disagree	5. Somewhat disagree	6. Disagree	7. Strongly disagree
Autonomy *I feel able to make decisions independently and I am encouraged to do so*	9.09%	36.3%	27.2%	0%	0%	9.09%	18.1%
Respect *I feel that I am respected in my role*	9.09%	45.4%	9.09%	0.0%	9.09%	9.09%	18.1%
Relationships *I have good relationships with my colleagues and others that I have contact with*	18.1%	36.3%	9.09%	9.09%	0%	27.2%	0%
Environment *This is a healthy place to work*	0%	9.09%	27.2%	18.1%	18.1%	0%	27.2%
Justice *I feel that I am always treated fairly*	9.09%	36.3%	9.09%	9.09%	9.09%	18.1%	9.09%
Leadership *I am encouraged to make a contribution to developing the team as a whole*	9.09%	36.3%	27.2%	0%	0%	9.09%	18.1%

4:3.3.1.1 Autonomy

(Q1: I feel able to make decisions independently and I am encouraged to do so)

Of note is that 30% of the respondents indicated that they did not feel able to act autonomously, neither did they feel supported to do so, and a further 27% only felt somewhat able to make decisions independently. This is important as working autonomously is considered to be an attractive feature of working in a community setting. Failure to address this perceived lack of autonomy may impact on both job satisfaction of the staff and staff retention figures.

4:3.3.1.2 Environment

(Q4: This is a healthy place to work)

A positive, healthy work environment is essential for high job satisfaction. Overall, respondents to the survey did not agree that the CMHT was a healthy place to work. In fact, more than 90% of the survey participants were either equivocal in their opinion (they somewhat agreed or were neutral) or disagreed that the work environment was healthy. This issue therefore clearly required attention in this study. It is interesting to note that stress at work may have influenced respondents' answers. As shown in question 3, in the resilience section of the survey, staff responses suggested that they found it difficult to maintain good work-life balance, and this opinion may have led to perceptions that the workplace was not a healthy place to work.

4:3.3.1.3 Leadership

(Q6: I am encouraged to make a contribution to developing the team)

Opportunity for development is linked to job satisfaction. However, practice initiatives are often driven by a set of pre-determined outcomes that give higher priority to the organisation than to the individual staff member. Therefore, fostering a sense of empowerment within the organisation can be important to ensure an increased sense of job satisfaction for MHPs.

More than 25% of respondents did not feel they were encouraged to contribute to team development; only 9% strongly agreed with this statement. Involvement in personal and professional activities (such as this AR) can have an impact on the practitioners' perceptions of the quality of care that they offer. Involvement of MHPs in the development and management of the implementation phase of the project was important to shift respondent viewpoints and to ensure that MHPs could contribute to team development.

4:3.3.2 Questions related to resilience

Resilience involves caring about oneself and others. In regard to this study, it was relevant to understand that in a health context, levels of resilience could impact on the quality of care that was delivered. Creation of a positive culture at work could build the resilience of MHPs, which in turn could translate into better care delivery. Engagement and encouragement of MHPs to determine what strategies might work best for them could begin a process of empowerment and articulation of the contributions that they made. Participants' responses to questions on resilience are detailed in Table 5 and each domain is discussed below.

Table 5 Resilience - responses to questions

	1. Strongly agree	2. Agree	3. Somewhat agree	4. Neither agree nor disagree	5.Somewhat disagree	6.Disagree	7. Strongly disagree
Expectations *I feel positive about my role and anticipate that I will continue to achieve my goals*	9.09%	36.3%	27.2%	0%	0%	18.1%	9.09%
Motivation *I feel excited by my role and I am keen to develop*	36.3%	18.1%	18.1%	0%	0%	18.1%	9.09%
Work-life balance *I am able to keep my personal and professional lives separate*	9.09%	27.2%	9.09%	0%	18.1%	18.1%	18.1%
Resilience *I feel that I cope well with stress and adversity at work and adapt well*	0%	36.3%	36.3%	0%	0%	9.09%	18.1%
Coping with stress *I feel that I have effective strategies to manage work stress*	9.09%	36.3%	27.2%	0%	0%	9.09%	18.1%

4:3.3.2.1 Work-life balance

(Q3: I am able to keep my personal and professional lives separate)

The responses suggested that only 39% of staff felt that they had a clear work-life balance. This finding suggests that there is a widespread concern among staff regarding work-life balance (54% disagreed with this question).

However, the responses to questions that were related to coping with stress and adapting to adversity in the workplace showed that 28% of respondents felt that they did not have effective strategies to handle these challenges. This is important to understand the cost of managing competing demands and the potential impact that this cost can have on well-being at work. These answers suggested that MHPs were more likely to express their concerns with work-life balance than to acknowledge that they had issues with coping with stress.

4:3.3.2.2 Resilience, stress and adversity

(Q4: I feel that I can cope well with stress and adversity at work and adapt well)

Workplace stress can have a negative impact on well-being as it reduces an individual's sense of control over their situation.

It was found that 28% of the respondents did not agree with the premise that they coped and adapted well in the face of stress and adversity. It was hoped that this study would encourage practitioners to develop strategies that promoted resilience in the workplace. On reflection, however, the wording of the question may have influenced responses; *"I feel that I cope well…"* suggests at the outset that there is an expectation that the respondents should be able to cope.

4:3.3.2.3 Coping with stress

(Q5: I feel that I have effective strategies to manage work stress)

Again, the data suggested that most respondents considered that they had coping strategies. However, there was a contrast between the answers that were offered to this question and some responses that were made to the question that was related to coping with stress and adversity. Responses to both these questions showed that,

although no respondents strongly agreed that they coped well with stress and adversity, when they answered a question that was specific to their self-management, the staff showed more indication that they had strategies they could use. This perception would be important as the study developed, since the AR methodology would underpin a sense of building on the strengths of each practitioner and capitalising on their hope and optimism.

4:3.3.3 Questions related to teamwork

An understanding of teamwork and how teams function can play a role in understanding the concepts that underpin care delivery in healthcare settings. As discussed previously, there has been a suggestion that effective teamwork leads to fewer work-based difficulties. In this study, knowledge of the perceptions and behaviours of MHPs was critical to garner insights into teamwork. MHPs' responses to questions on teamwork are detailed in Table 6 and are discussed below.

Table 6 Teamwork - responses to questions

	1. Strongly agree	2. Agree	3. Somewhat agree	4. Neither agree nor disagree	5. Somewhat disagree	6. Disagree	7. Strongly disagree
Working with others *I enjoy working in my team and feel very supported*	9.09%	18.1%	36.3%	9.09%	0%	0%	27.2%
Communication *As a team member I am kept up to date and always know what is happening*	18.1%	9.09%	36.3%	0%	9.09%	9.09%	18.1%
Optimism *I feel very positive about my work*	9.09%	45.4%	18.1%	0%	0%	18.1%	9.09%
Caring *I have concern and empathy for my colleagues*	27.2%	54.5%	9.09%	9.09%	0%	0%	0%

Caring *My colleagues have concern and empathy for me*	0%	27.2%	45.4%	0%	9.09%	9.09%	9.09%
Sharing *I share my ideas and concerns with colleagues*	9.09%	45.4%	9.09%	9.09%	18.1%	9.09%	0%
Sharing *My colleagues share ideas and concerns with me*	9.09%	45.4%	9.09%	9.09%	0%	27.2%	0%
Hopefulness *When I think about my team, I feel excited; I know we are successful and have great promise for the future*	18.1%	18.1%	27.2%	9.09%	0%	9.09%	18.1%
Hopefulness *When I think about my job, I feel excited; I feel that I am successful at what I do and know that I have promise for the future*	27.2%	27.2%	9.09%	9.09%	0%	18.1%	9.09%

4:3.3.3.1 Caring about self and others

(Q4: I have concern and empathy for my colleagues; Q5: My colleagues have concern and empathy for me)

There were interesting responses to the questions that were related to caring: over 80% of respondents thought that they felt concern and empathy for colleagues. Conversely, only 27% of respondents agreed that their colleagues felt concern and empathy for them, and none strongly agreed. If resilience among practitioners is considered to include care for themselves and each other, then this mixture of feelings is significant. It would correlate directly with the well-being of the workforce and needed to be considered as the study progressed.

4:3.3.3.2 Hopefulness

(Q9: When I think about my job, I feel excited; I feel that I am successful at what I do and know that I have promise for the future)

Replies to questions about working in the team at the CMHT suggested that many MHPs were positive about development as part of a team. More than 50% of the

MHPs were hopeful about their own promise for the future; however, fewer MHPs (36%) were hopeful about the promise of the team as a whole. For the researcher, this result showed that, as individuals, the MHPs in the CMHT felt optimism and hopefulness. This would be an important factor in the success of this AR.

4:3.3.4 Summary

The findings from this baseline survey (Stage 1) suggested that the MHPs had enjoyed some positive experiences of well-being, job satisfaction, resilience and teamwork. However, the survey also highlighted some of the more negative experiences of MHPs from a subjective viewpoint, which could be addressed through this study to improve their overall well-being. For example, although autonomy is integral to the role of MHPs who work in a CMHT, several practitioners reported that they did not experience autonomy.

Some factors that were related to the overall focus of the study warranted consideration in Stage 2 (which is discussed in Chapter Five). MHPs had a sense that they cared about others but that this was not reciprocated. This would be important for the next stages of the study, in which the MHPs would need to work together as co-researchers in order to orchestrate changes.

4:4 Qualitative data analysis – semi structured interviews and focus groups

The survey provided an indication of concerns that were related to the domains of well-being that had been identified in the literature review. However, qualitative data was needed to provide a richer, in-depth insight into MHPs' experiences of well-being. Semi-structured interviews and focus groups were used to explore how MHPs

developed strategies to enhance their experiences at work in order to inform Stage 2.

4:4.1 Participants

All MHPs were given an opportunity to be involved in either a semi-structured interview or a focus group according to their preference. Invitations and an outline of the study were presented at a team meeting; prospective participants were able to express interest to be involved outside the meeting. Table 7 provides details of the participants (*n*=5 in semi-structured interviews; and in two focus groups, *n*=11 participants; group1, *n=7,* and group 2*, n=4*). Interviews lasted for an average of 50 minutes and focus groups approximately 90mins. In the case of individual interviews, additional information that was collected included age and period as a qualified MHP. All MHPs agreed to participate, which indicated the value that they placed on improving well-being at work.

Table 7 Participants, focus groups and semi-structured interviews

Semi-structured interviews					
Age	Gender	Role/band	Years qualified	Time at CMHT	Participant
28	M	Nurse, Band 6	3 years	1 year	P1
43	F	Social worker, Mental health practitioner	20 years	17 years	P2
40	F	Nurse, Band 6	16 years	9 months	P3
28	F	Nurse, Team leader, Band 7	5 years	2 years	P4
53	F	Service manager	10 years	1 year	P5
Focus groups					
Gender		Role/band	Time at CMHT		Participant
Group 1					
F		Care co-coordinator, Band 6	8 months		F1

F	Care coordinator, Band 6	1 year	F2
F	Social worker	7 years	F3
F	Social worker	2 years	F4
M	Care coordinator, Band 6	1 year	F5
M	Social worker	2 years	F6
F	Care coordinator, Band 6	6 months	F7
Group 2			
F	Care coordinator, Band 6	10 years	F8
F	Social worker	8 months	F9
M	Care coordinator, Band 6	1 year	F10
F	Care coordinator, Band 6	4 months	F11

4:4.2 Findings

The data collected in interviews and focus groups yielded rich data and is explored next. The findings are explored to link respondents' responses to their perception of well-being at the CMHT and to the key concepts in this AR study. It is this narrative account that adds weight to the themes that were developed in the subsequent thematic analysis. These findings and themes developed, underpin the incorporation of PAR in the subsequent stage of this AR study, as MHPs lead and develop changes at the CMHT.

4:4.2.1 Experiences of well-being

When discussing experiences of well-being at work participants felt that it was related to a number of factors and that maintaining well-being was linked to being able to say if you were struggling and that support should be readily available. As

shown in the quote below, there is implied reluctance for MHPs to “be completely honest” and this can relate to feeling judged if not deemed by others to coping and this links to survey findings previously discussed.

> *“I think it should be a space where you're able to say, 'This is going on, I don't feel comfortable, I'm struggling, I need some support here'. You should be able to be completely honest about everything, and then once you've identified the areas where you feel you need some support, that support should be available”* **P3**

Associated with well-being at work, MHPs reported feeling isolated. This is an important finding which links to the environment. Well-being in this instance is adversely affected by perceptions of isolation and a culture that perpetuates a need to focus on the immediacy of workloads.

> *“Again, opening up, people have got certain skill sets, making people aware of who is in the team, and reducing that isolation that people often feel, I think it's kind of heads down, just getting on with what we have to do in the here and now”.***F8**

Many participants made links between well-being and the relationship with peers, and feeling valued. As shown in the quote below, there are connections made between well-being and the key concepts in this study. This MHP quote highlights the importance of: peers (teamwork), acknowledgment of the challenges that are faced (resilience) and the nature of the job (job satisfaction).

> *“I think it's definitely about - for me, it's being able to be at work where I can be really honest about a) the challenges we face, and that's from a practical point of view; but also in terms of the complexity of the cases that we're dealing with, and being able to share that in a way that doesn't feel threatening and really feels productive and to be in a team that values that”.* **P1**

Many MHPs acknowledged that well-being as a professional was important when managing the stress faced, they felt a sense of professional responsibility to ensure that they maintained wellness and capitalised on the moments when they felt excited

about going to work and this is important to understand the value of motivation and this links closely to job satisfaction as discussed previously.

> *"Obviously we're professionals and we recognise that if it's having significant impact on our work, it may have to be escalated. There are times where I love, and almost skipping to the job, and there's days where on a Sunday I'm thinking, oh my goodness, what am I doing? I suppose it's at those times where I'm really questioning what I'm doing, that it becomes even more important to keep well".* **F3**

4:4.2.2 Experiences of Job satisfaction

The perception toward job satisfaction among MHP participants was largely related to feeling appreciated and valued as highlighted in the quote below. There are links between job satisfaction and motivation and communication. The importance of communication was a consideration in this AR study, specifically in the PAR approach that was to be incorporated into stage 2 of the study. MHPs' communication skills were deemed essential to underpin successful engagement with all stakeholders in the participatory and empowering approach adopted.

> *"Feeling that you're valued, feeling that you're supported and there is somewhere that you can go and feel able to have the communication makes a big difference in, again, job satisfaction, more than anything. If you wake up and you say, 'Yes, I'm going to work.'"* **P4**

Several MHPs suggest that motivation to come to work was not enough and that job satisfaction could be related to understanding your role and also to managing competing demands. As shown in the quote below there is contention between wanting to make a difference to both peers and service users, but also to manage competing demands.

> *"Yes, wanting to come to work, wanting to make a difference, wanting to be a role model for others in how good practice should look like and what the role is. The less good things is when you're trying to balance the interventions that you're offering the client and doing the right thing by the client versus all these other demands which can make your morale poor."* **F9**

The result of managing the conflict of expectation of role versus organisation need could lead to poor morale. This would be commanding within the PAR element of the study, as morale was essential to ensure ongoing motivation and engagement but also linked to increased feelings of pride toward work and achievements made. This connected to perceptions of working within a team and as shown in quote below, links are made to preventing burnout and to 'letting people thrive and not just survive'.

> *"We are in a pressurised job, so I do think that we need to bring some of that knowledge into what we do every day, so that we are supporting staff, we don't have to wait until it gets to crisis point, that we can actually be preventing people from staff burnout, and beyond that actually letting people thrive, not just survive".* **F11**

4:4.2.3 Experiences of Teamwork

MHPs responses to questions about teamwork were most notably linked to and compounded by feelings of isolation and needing support from peers. As can be seen in the quote below, there is a sense that individuals are focused on their own perspective and therefore are less aware of the experience of others. This was important, as it replicates the findings from the survey which suggested that although MHPs care about colleagues, they believe their colleagues do not care about them. This further strengthened the position of PAR incorporated within this study to encourage and support MHPs to work together in collaboration and to share experiences.

> *"I'd say team working isn't something that we do very well within our team. Well, we share an office and I think everyone is working at completely different levels and doing very different things with people and I think, to some extent, it's quite isolated. I think really when we do have the team meeting, everyone brings their different agenda to it. I don't think we rely on each other; we don't use each other in support as much as we could I think"* **F1**

For MHPs their experiences of teamwork were connected to the idea of being able to share experiences with each other and that often the pressure of work and stress experienced impacted on opportunities for team members to use each other as a support network. As can be seen in quotes below, there is a notion that MHPs attempts to support each other within the team are thwarted by work pressures and stress. There is acceptance that this would be an important element of teamwork: being able to share feelings and support one another.

> *"If you look at our team, sharing emotions, I think it's probably something that is lacking a little bit because it can lead to all sorts of anxieties and everything and people cannot be as effective as they might be because they're worrying about this or they're worrying about that."***F3**

> *"I think staff try their best to support each other, so colleagues, they support each other; however, in my opinion, because everybody's extremely stressed and extremely busy, don't have the time to support colleagues as much as perhaps is needed or as much as you would like, for me, for myself, here, if it's about myself"* **P5**

Participants, therefore, suggested that having opportunities to work together and being afforded opportunities to share experiences, to reflect with a peer, was important. Many MHPs responded to questions about teamwork with a positive value placed on those occasions when they worked together. This opportunity was felt to be important to improve skills and confidence as seen in the quote below. In this AR study this is linked to developing skills to manage challenges faced and becoming resilient.

> *"From my own experience, joint visits, without a doubt. I think, like I said, being able to go out and to look at a situation from different perspectives, to get feedback on the situation - that is like a peer supervision really, because you can come away from the situation and really reflect on your practice, good, bad and otherwise. Sort of highlight their confidence and maybe areas that they could improve upon, to help build their confidence and their own self-esteem."* **F8**

4:4.2.4 Resilience and coping

Managing the challenges faced at work for MHPs was connected to feeling able to cope and having and awareness of maintaining a good work/life balance and ongoing wellness. Managing stress at work was a commonality in experiences of respondents, MHPs recognised the value of developing strategies to manage stress and that focusing on the caring role can ameliorate the impact of stress as seen in quote below.

> *"I would say my stress fluctuates! It changes from time to time. I think every now and again, I have a difficult time - something happens, do you know what I mean, and it's quite challenging and I get a bit frustrated and upset but then I look for positive experience with the patients, something like that, and that, for me, outweighs some of the negative stuff I think."* **F7**

MHPs also related resilience with managing the emotional nature of their work and having care and support from others. There was an expectation that peers should notice when a peer was struggling and support them. As highlighted in the quote below, there is understanding that being supportive of others can foster good relationships, in which MHPs can build confidence in a non-judgemental relationship which in turn impacts on resilience.

> *"Which in turn sort of builds up an element of resilience in themselves, because, yes, there's just resilience in themselves. It also builds that relationship as well, so if they're more confident about coming back to me and to them particular people that have helped them and been non-judgemental."* **P1**

Participants also understand that positive feelings toward work were related to being afforded opportunity to develop and learn together and this is important to help individuals to learn and grow independently. As highlighted in the quote below, resilience is linked to coping and development of self and others, and critically linked to the motivations for doing the job in the first place and this was an important

element of engaging MHPs in this AR study as links between well-being and care delivered are explicit.

> *"It's also important to give staff the opportunity to be innovative and have ideas. Not everyone has all the answers, we've got different life experiences, different professional experiences and can learn different ways to cope from each other. I never lose that thought that the client should be at the centre of everything you're doing and I think the day I stop thinking in that way is the day I shouldn't be doing the job, it helps me be resilient and continue".* **F5**

This narrative account of MHPs' experiences provides a picture of the key factors that impact on well-being that are inter-related and correlate to perceptions of job satisfaction, teamwork and resilience. It is this data that details perceptions of MHPs experiences of the key concepts in this study, and highlights how MHPs' well-being is linked to influences that included: isolation, managing emotions, the environment, role, morale, stress, and working together and this informs the thematic analysis that is discussed next.

4:4.2.1 Experiences of well-being

A thematic analysis (Braun and Clark, 2006) was conducted, which included a reflection on the position of the researcher within the research process. This addition enhanced the trustworthiness of the study (Gale et al., 2013; Lewis, 2015; Silverman, 2015). Thematic analysis is not linked to an epistemological or theoretical position and in this case, its use enabled the study members to have some flexibility to identify and create themes that were of value to the study and to the experiences of MHPs (Braun et al., 2019).

4:4.3. Thematic analysis step 1: become familiar with the data

The initial stage of thematic analysis involved the reading and re-reading of the interview and focus group transcripts to begin a process of immersion in the data. Field notes that were made by the researcher during the interviews and focus groups were used to add detail that was not evident in transcripts. Active reading ensured that critical analysis could be undertaken to highlight initial patterns, themes and strategies (Braun and Clark, 2006). The reflective notes that were made by the researcher at this time demonstrate this:

Reflections from field notes, April 2018

> *A privilege and humbling; the attendees at the focus group seem to understand that working in a team is important but there is a sense that the team does not always function effectively. There is a sense that there are competing demands on time and this relates to feeling stressed. There is a clear picture of wanting to support one another and that as team members they want to feel involved. Some aspects of teamwork enjoyed, relate specifically to being able to work together. There is a real sense of valuing and appreciating one another.*

4:4.3.1 Thematic analysis step 2: generate initial codes

In this step, data were organised systematically (Braun and Clark, 2006) in order to highlight and articulate the themes within the data that were pertinent to the research questions. This required ongoing comparison of emergent themes and the associated extracts from focus groups and interviews.

The intention was to understand that the researcher's interpretations and perceptions, alongside views of the best way to proceed, might not be in line with those of her co-researchers. Open coding was used to capture segments of data. Codes were modified as ideas were generated. Identification of the themes that

captured and encompassed the data proved to be challenging due to the complex experiences of the participants. Each transcript was reviewed to highlight initial codes, and, throughout the process, codes were modified as themes became more apparent. The software NVivo11 (Edlund and McDougall, 2016) was used to review transcripts and develop themes, but much of the generation of initial codes was done by the researcher in an ongoing cycle of reading, highlighting and reviewing. This process required critical reflection and ongoing consideration of emergent themes (Nowell et al., 2017). During this step, key extracts were highlighted to begin the process of linking participants' data to categorised information that was aligned to and answered research questions (Nowell et al., 2017).

4:4.3.2 Thematic analysis step 3: search for themes

Themes at this stage of the analysis were defined as significant patterns that emerged during steps 1 and 2 of the thematic analysis (Braun and Clark, 2006). There was overlap between initial stages of coding and emergent themes and this related to the similar experiences that were shared by many of the participants (Maguire & Delahunt, 2017; Richards, Hemphill and Templin, 2018).

Themes were categorised by their significance, codes were clearly linked together, and repeated patterns of responses supported emerging ideas. This approach was beneficial in the management of a large amount of data and informed the process of streamlining the data as their relevance and significance to the research questions were considered. As shown in Table 8, preliminary themes were identified with the codes that were related to them specifically.

Table 8 Preliminary themes-thematic analysis

Theme – Support ***Codes*** *To develop support in practice* *Supported by management* *To have an opportunity to be supported* *Giving and receiving feedback* *Optimistic about practice* *Understanding of role* *Kindness to self and others*	**Theme - Team Structure** ***Codes*** *Understanding the role* *Structure of team* *Plan of work/ Duty system* *Manage expectations* *Demarcation of roles and responsibilities* *Caring and sharing* *Communication*
Theme - Working Together ***Codes*** *Standard approach* *Responsibilities* *Caring and sharing* *Managing conflict* *Giving and receiving feedback* *Communication* *Work-life balance*	**Theme - Staff Development and Training** ***Codes*** *Understanding the role* *Standard approach* *Knowledge and understanding* *Optimism* *Confidence* *Evidence of best practice*

4:4.3.3 Thematic analysis step 4: review of the themes

Themes were reviewed and modified to ensure that they were in line both with the study and with the perceptions of the co-researchers themselves (Braun and Clark, 2006). To accomplish this step, the researcher and co-researchers worked through each step of the process to ensure that MHPs' perceptions had been interpreted accurately. The process of reviewing themes facilitated the researcher to explore whether emergent themes were intrinsic to all participants or idiosyncratic to one. During this step, key questions (Braun and Clark, 2006) were: do themes accurately reflect the literature? Is there too much in a theme? Are there any overlaps? Are there subthemes? Is anything missing?

The purpose of this step was to make a clear distinction between the themes and to explore preliminary themes with further in-depth consideration and deliberation. Changes that were made at this stage were:

1) an initial theme, '*Support*', was not considered to reflect the data accurately and it was apparent that sub-themes were related to emotional well-being and the structure of supervision. Therefore, a theme of *Clinical Supervision* was introduced that captured the emotional needs of participants but also reflected a process that supported feelings and experiences in a cycle of reflective practice during clinical supervision;

2) during review of the initial theme '*Team Structure and Organisation'*, it became clear that there were not many data to support the term 'team structure' and that respondents had used the terms organisation and structure inter-changeably. Further analysis and refining of codes suggested that respondents were referring to organisation of the team and therefore a theme of '*Team Organisation'* was established;

3) the initial theme '*Working Together*' was not considered to be distinct enough and there was a clear sub-group that was related to the culture within the team. Many of the codes were related to respondents' thoughts on the ethos of the team, and this observation was supported by data on strategies that could improve the working environment. Therefore, two sub-themes were introduced that were specific to the environment and how to improve the experiences of being at work. The theme name was altered to '*Team Culture',* which reflected the values that were expressed and participants' views. These changes are shown in Table 9 below.

Table 9 Review of themes: thematic analysis

Reviewed theme – Clinical Supervision ***Sub-theme: Emotional well-being*** *Feeling supported in practice* *Supported by management* *To have an opportunity to be supported* *Feeling valued* *Confidence in practice* *Kindness to self and others* ***Sub-theme: Supervision process/framework*** *Receiving feedback* *Support to develop* *Opportunities to reflect* *To learn and grow as a practitioner* *Understanding of role* *No clear structure* *Skill of supervisor* *Not given priority*	**Reviewed theme - Team Organisation** *Understanding the role* *Structure of team* *Plan of work* *Manage expectations* *Demarcation of roles and responsibilities* *Caring and sharing* *Duty system* *Communication* *Business meetings* *Workloads* *Flexible work patterns* *Manager and team leaders*
Reviewed theme - Team Culture ***Sub-theme: Environment*** *Standard approach* *Responsibilities* *Team approach* *Compliments and feedback* ***Sub-theme: How to improve well-being at work*** *Managing conflict* *Caring and sharing* *Giving and receiving feedback* *Communication* *Work-life balance*	**Theme - Staff Development and Training** *Understanding the role* *Standard approach* *Knowledge and understanding* *Optimism* *Confidence* *Evidence of best practice* *Expert practitioners*

As demonstrated in the thematic map that is shown in Figure 9, there was distinct refinement of themes and a process of understanding their connectedness. The process of development of themes and sub-themes ensured a narrative that reflected the ongoing nature of the development and refinement of each theme and the content within it. Careful consideration prevented themes developing that did not accurately reflect the data in order to retain authenticity.

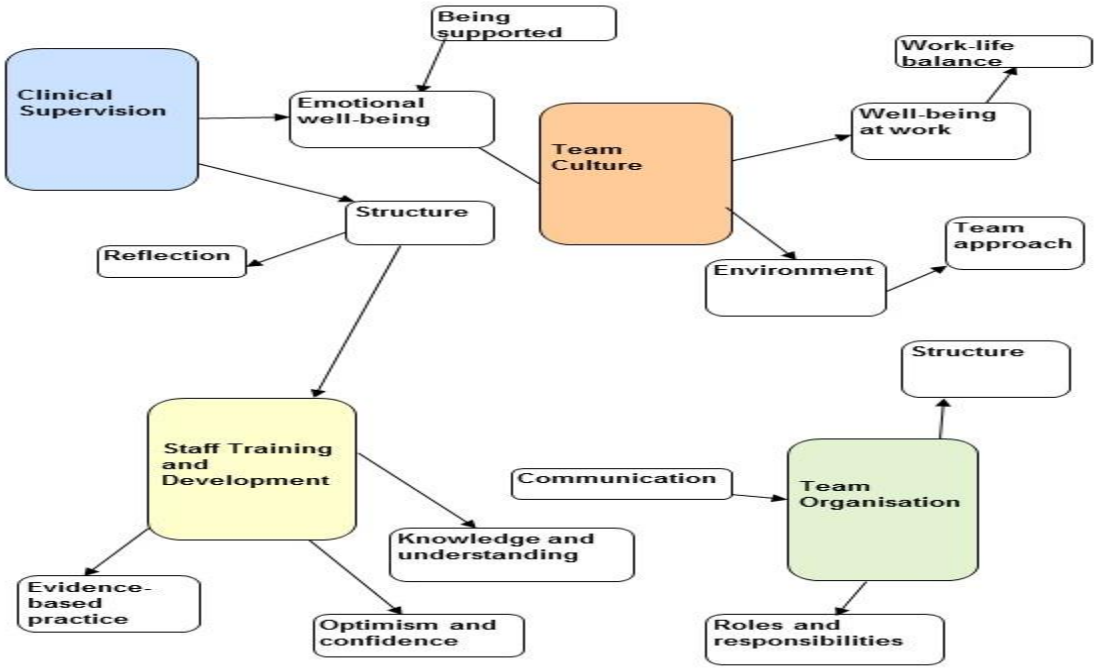


Figure 9 Thematic map

4:4.3.4 Thematic analysis step 5: definition of themes

In the penultimate step of the thematic analysis (Braun and Clark, 2006), attempts were made to redefine each theme further and to put together a comprehensive narrative of what each theme covered. Attention was given to the identification of the essence of each theme and the interactive nature of each with the others. A final thematic map, which is shown in Figure 10, highlights how themes were refined to reflect the broad nature of MHPs' experiences in relation to the key concepts of the study. This final thematic map provided unambiguous themes and sub-themes. To ensure the ongoing trustworthiness of the process (interpreting and developing themes) confirmation was sought from co-researchers, MHPs and the validation group at this point. The content of themes is discussed below.

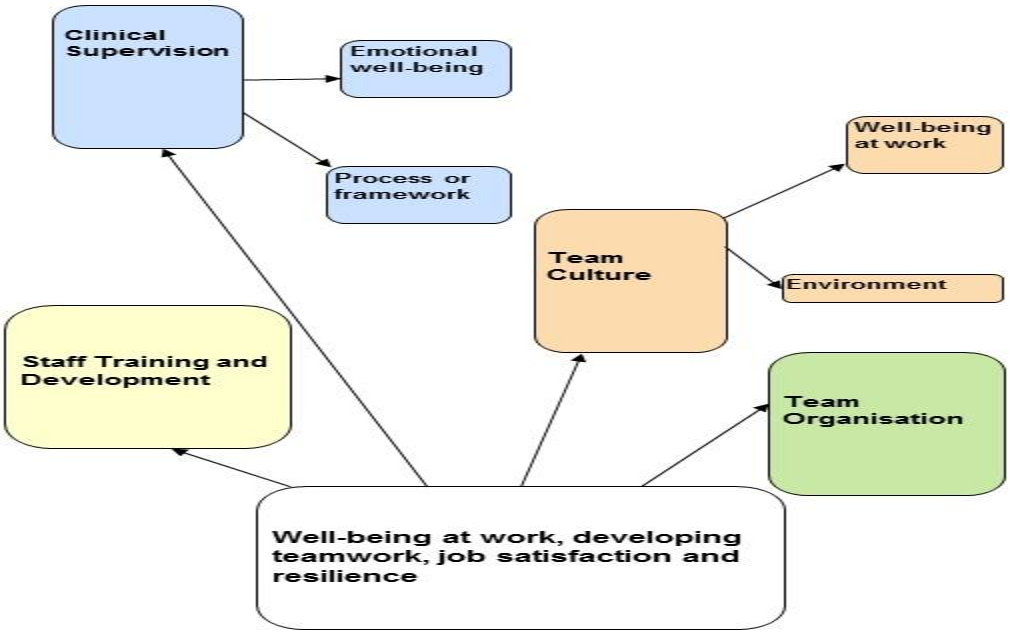


Figure 10 Final thematic map

4:4.3.4.1 Theme: clinical supervision

Throughout the data collection phase, questions that were related to how well-being, teamwork, job satisfaction and resilience could be developed, although taken individually, often led to discussions about well-being in general and in particular, the desire to have a safe space in which practitioners could share and develop their thoughts. This wish was linked to a sense among practitioners that they required space to be able to work safely and effectively. The collected data reflected the notion that participants needed space to think about clients and to reflect on practice. Respondents also commented on feelings of being contained, being able or not to accept feedback and their ability to manage the emotional aspects of their roles.

The theme of clinical supervision captured both emotional well-being and a need for the introduction of a process and framework to ensure that practitioners were equipped to develop both personally and professionally. Clinical supervision as an overall theme captured the notion of learning and attending to growth through reflective practice. This was clarified further by the use of the sub-themes of emotional well-being and the process or framework of supervision. The need for these is highlighted in quotes below, which account for the sub themes of 'emotional well-being' and 'process or framework'.

> *"I was about to go home, but I answered the phone anyway and there's a problem and it played on my mind. I was thinking about it waiting for me at nine o'clock the next morning, I was thinking, I'm not going to manage it now but it was still sitting there on my mind and I didn't have a good night's sleep"* ***P1*** *(Emotional well-being)*

> ***"****Supervision is really important, and I think informal supervision is as important as formal supervision because there must have been a whole build-up to that situation coming to a head between the staff, and I think there must have been a whole build-up to that person not being challenged on those thoughts, but a long time for it to come to a head, there is no structure here and so this can happen"* ***P3*** *(Process or framework)*

4:4.3.4.1.1 Sub-theme: emotional well-being

Participants referred to their need to talk through work-related experiences in an honest way. These comments reflected a sense of emotional well-being at work and how this could be impacted upon by conscious and unconscious dynamics. These comments showed that MHPs thought it was important not only to have the opportunity to discuss and reflect on practice, but also to be appreciated.

> ***"****Again, from my own perspective, I think it's definitely about - for me, it's being able to be in a forum where I can be really honest about a) the challenges we face, and that's from a practical point of view; but also in terms of the complexity of the cases that we're dealing with, and being able to share that in a way that doesn't feel threatening and really feels productive"* **P1**

As the participants discussed how they managed their emotionally difficult experiences, they made connections to the reasons why they were doing the job in the first place:

> *"Management, as well, [I'm not saying they should say] thank you, but bringing up the positives that someone can bring to the team, or if you're managing a very difficult caseload or something. I think it's worth [them] just saying that [they] appreciate what you do"* **F6**

Some MHPs alluded to the importance of building the confidence of peers, while some indicated that they sometimes wished for this for themselves:

> **"***If you're out with a colleague you tend to find yourself saying to them, 'you're good with people,' or whatever the thing is. If we had a bit more scope to do that sometimes, if people wanted to go out with a colleague with that kind of morale-boosting in mind, that might be nice"* **F9**

Some participants suggested that it could be difficult to 'keep in touch' with their original motivation for being a MHP, particularly when feedback was sometimes unhelpful:

> ***"****The way I see myself, I'm quite resilient, and I think that's why I try and spend so much time with people because, like I said, I'm quite positive and upbeat and I worry that I'm just projecting that on to people and that's not really how they feel"* **P1**

> *"I can safely say that we're all here doing this job because we want to be here, we want to be doing what we're doing, and we want to be doing well. We're trying our best, and when you get all these things being thrown at you, 'this is outstanding, that's outstanding,' it's not helpful. It can be quite demoralising. The times when your achievements are recognised are few and far between. To me there's not the balance that there needs to be"* **F10**

4:4.3.4.4.1.2 Sub theme: process or framework

In relation to clinical supervision, there was evidence of the importance that the MHPs placed on a clear process or framework for supervision:

> **"***Sort of having a supervision format structure, using it as an opportunity to not only discuss caseload management, but also, as I've said before, discussing personal aspects if they feel that it's relevant, career opportunities that they want. I think again going back to being quite focused on the individuals, bringing up their morale, their confidence boosts"* **P4**

Some participants thought that management (that is, the process of overseeing and management of practitioners in their roles) and clinical supervision (that is, a process that enhances growth and increases skills) had merged, despite them being very different processes with sometimes conflicting aims. This contributed to disillusion among MHPs and was alienating:

> *"It's not a particular time, [it's] where there might be someone coming in and out of the room as, they need help, or actually recording as a part of supervision not for me and my skills but what I haven't done"* **F7**

Clearly, practitioners value supervision, particularly if it is pertinent to their own needs and agenda. MHPs seemed to consider a lack of clinical supervision to create a gap in their working practices. It can be argued that clinical supervision directly and indirectly links to other key themes, since a framework of robust supervision can have an impact on all aspects of work experiences. However, it stands alone as an essential element of how practitioners perceive support to develop and reflect on practice in a safe space.

4:4.3.4.4.2 Theme: team organisation

Team organisation refers to MHPs' various experiences of how the team worked. Essentially, the findings suggested that there were three core threads that ran through MHPs' thoughts about working in an effective team. These threads related to: support (understanding each other), communication (being able to have meaningful engagement) and roles and responsibilities (acknowledgement that team members had diverse capabilities and could play various professional roles). Building on these core threads, there was a suggestion that MHPs wanted opportunities to manage expectations and to find different ways to manage the complex nature of their roles.

> "*I think if we had better levels of support to manage our work, that might possibly go towards making things somewhat better, but I think the bottom line is there are just so many pressures on the service, not enough staff*" **F11**

Regarding the management of expectations, MHPs were of the opinion that recent changes in the team structure had not been considered, and this view contributed to participants' feelings of not being supported. Further to this, MHPs suggested that there was no clear plan of work; daily tasks changed on a frequent basis in response to the organisation's management of a lack of staff and due to retention issues. MHPs acknowledged the pressure that the wider team was under but they felt isolated and suffered feelings of stress.

> ***"****Everyone's got their own caseload I think really and that keeps everybody busy, so then outside of that, we don't really have much knowledge of each other's caseloads necessarily. So, they end up not being able to cope, if someone's struggling with something, they probably feel that they're carrying it on their own because nobody else is aware of the issue"* **F1**

Participants suggested that having a shared vision and common goals was essential to support them in their roles. There was acknowledgement of the complex nature of the job and of the impact this had on well-being. MHPs felt that a fostering of meaningful engagement with work was valuable, not only in relation to outcomes but also due to a sense of sharing this experience with other members of the team.

> ***"****The different qualities that we have here are something special. We should take time to actually talk and support each other; that would be good"* **P4**

MHPs wanted to share honest, open communication with colleagues and to manage potential conflicts in a healthy manner. It is important to note that this theme was not centred on the development of clear job plans to meet organisational need (although this was important) but rather that the team built on core threads of support, communication and understanding of roles and responsibilities, as has been discussed previously. As can be seen from the quotes from MHP participants in interviews and focus groups, the need for effective communication amongst team members was felt to be of paramount importance:

> ***"****Protected time, if you actually implemented that, that could be something your colleagues - people have the space in the day to do that. Just difficult cases, people sharing it out a bit more and it's not just sitting with one person because they've got a sense of responsibility. There could be a way that we could actually - there might be one patient but there could be a few people involved together"* **F7**

Some participants in the discussions argued that there was a need for clearer demarcation of roles and an understanding that MHPs should complement one another's strengths and diverse capabilities:

> ***"****Some sort of away day that the wider team went on, with the focus on looking at roles, responsibilities, the different personalities, skills and interests that we have is something"* **P4**

As has been highlighted, there are links between resilience and teamwork and arguably job satisfaction, and these are important for MHPs' well-being.

> *"But actually, no, we do have a specific role, and that isn't part of my role, and sometimes it gets lost, and it's like we are the care plan for everything. So that can challenge your own resilience, and if you are resilient and you're able to say, 'Well, no, actually, that's not something I'm meant to do, I've done this, but then that decision is not my job"* **F4**

4:4.3.4.3 Theme: team culture

The theme of team culture represents practitioners' values, beliefs and attitudes in relation to working as part of a team. The responses to questions suggested that MHPs were mindful of the interplay between organisational influence and the immediate team. In essence, team culture relates to both the environment in which practitioners work and to personal experiences of well-being. This was highlighted in two sub-themes: environment and well-being at work.

> ***"****Unfortunately, over the last year and a half, say, things have changed significantly, and I don't feel that my team is actually functioning as a team at all really. I do personally feel a tremendous lack of support within my team, and it's quite interesting really that there are colleagues within the wider team who I do find are more supportive even though I'm not actually part of their team. I kind of really miss how things used to be"* ***F1*** *(Environment)*

> *"You come the next morning, nobody will go, 'Oh, yesterday you started an assessment at five. How did that go?' No. So it's... I don't feel that anybody cares about me, about my work, about us. As long as the job is done"* ***F6*** *(Well-being at work)*

4:4.3.4.3.1 Sub theme: environment

There was widespread acknowledgement of the pressures that MHPs faced, alongside suggestions regarding ways that staff might capitalise on the positive influences of work experiences:

> *"And I think that's quite unique to the CMHT; I don't think you have that richness of all these different professions in one building, it's quite unique to the CMHT, which I think helps us enormously in terms of doing the right thing by a client group because we then can have a completely holistic view of that patient"* **P5**

MHPs showed acceptance of the differences between experiences that colleagues underwent and they placed importance on the celebration of their practice. However, opportunities that were afforded to share experiences were dependent on an environment in which MHPs felt time pressures because they had to manage busy workloads:

> *"I think staff try their best to support each other, so colleagues, they support each other; however, in my opinion, because everybody's extremely stressed and extremely busy, [we] don't have the time to support colleagues as much as perhaps is needed or as much as you would like, for me, for myself, here, if it's about myself. In the last year, I haven't been able to support the team as much as I would have liked to because I never have time, even for a break or don't have time even to exchange ideas unless someone comes and approaches me and says, 'Oh, can you advise me on this?'"* **F3**

4:4.3.4.4.3.2 Sub theme: well-being at work

Team culture was found to be inextricably linked with MHPs' experiences at work and was underpinned by their sense of well-being. Well-being in this context related to and overlapped with the focus of each theme. Well-being in all themes could be taken to be indistinguishably linked on a superficial level; however, the essence of this theme was to develop and build experiences of well-being specifically:

> **"***I also think it's important to look at people's career prospects, aspirations and goals. Again, achieving what you want to in your career builds up your own self-worth, and again builds up your confidence and your resilience, because it helps people to realise that they're being recognised for the good work that they're doing. They are actually progressing in the area that they want to progress in"* **P4**

Findings from this data analysis suggest that there is a need to lessen isolation and stress and that there should be an emphasis on caring and sharing for oneself and others. Participants suggested that there were issues related to stress that, in part, were related to the establishment of a work-life balance, teamwork and well-being.

> **“** *I think more team social stuff, so recently we had a shared lunch where everybody cooked something and brought it in, and I just think those things are important because where you're stressed and you lone work, you need to feel like you have roots somewhere”* **P3**

There was also a sense that stress at work was compounded by difficulties with the management of conflict and that, for some, this meant adopting an approach to pre-empt any potential challenges. This can be seen in the quote below:

> *“I do always try not to be too confrontational with people sometimes, if someone tries to challenge me on something, I just try and let them say their piece and just give my answer in a way that they don't feel like I'm saying no to them and saying that they're wrong but just show quite a passive approach to it. Not to be argumentative or anything like that but just, yes, be diplomatic about things”* **P1**

These considerations show that team culture can involve a complex interplay of both environmental issues and well-being. It can be easily understood by MHPs and should not be confused with overall organisational culture, which was not the focus of this study and was not raised by participants:

4:4.3.4.4 Theme: staff development and training

The theme of staff training and development refers to the specific skills and knowledge that MHPs perceive as necessary to enable them to do their jobs. The MHPs who were involved in the study accepted that training and development would enhance individual performance and each worker’s ability to manage their

caseloads. Alongside this there was acceptance that both the MHPs and the organisation shared a responsibility to develop on an individual and professional basis:

> ***"****I think some of the support as well, there's additional training for people, things you can do to up-skill yourself as well and management recognise that and give the opportunity to go to courses, things like that, it makes a difference as well. That's quite a positive thing because you can feel that progression as well for yourself which can support [you]"* **F2**

MHPs thought that, within the team, there was a wealth of skills and knowledge that could be shared. There was a sense that care and practice would be enhanced if skills and knowledge were viewed as important in the wider context by the organisation. It is significant that some MHPs had ideas on ways to develop skills and knowledge through development of shared approaches to exploring and building skills:

> ***"****Yes, I mean I wish we had a module around solution-focused therapy or some sort of solution-focused groups within the building, I think that would help us enormously because I think we need to change people's thought processes around things, and I think when you automatically start thinking in a solution-focused way, it automatically makes you feel more positive about everything anyway"* **P5**

This theme was linked to skills and knowledge, but it was also indistinguishable from the experiences of MHPs themselves. There were links between well-being and the feelings that MHPs had that were related to their overall sense of job satisfaction, teamwork and resilience. Thoughts were expressed regarding how best to learn and grow, and thereby to engender a workforce that was equipped to meet the complex and dynamic nature of the work and the challenges that staff faced:

> ***"****There are a lot of things that are difficult, but I do actually like working for this trust, and I'm always very much aware that, as clinicians being out in the*

community, we are the face of the trust. I like hearing about our overall success, I like it when I see [that] areas where we're performing well are highlighted, and about that there's the satisfaction as well. Being able to talk about what we're achieving, the positive achievements that we're making as a trust but we need to be supported too." **F8**

Despite the interplay of many factors, there was a sense that MHPs sought to celebrate success and to build confidence. This theme was developed with the emotional experiences of MHPs in mind and the impression that strong skills and up-to-date knowledge were intrinsic to care delivery and MHPs' self-belief. Consequently, this theme was not exclusively about training and development, but included MHPs' experience of this at work and what motivates MHPs in their roles.

"That's what pulls me through every time I doubt myself in terms of whether it's ability, do I know what I'm doing? I just feel like I'm winging it sometimes, or am I made the right way to do this job? I do worry about people and all those sorts of things. In the end, the thing that I always come back to is, if I'm supporting people, and I just really focus on the patients whenever I get a bit bogged down with the other stuff. It's definitely the patients why we're here, isn't it?" **F9**

4:4.3.5 Thematic analysis step 6: discussion

The thematic analysis captured factors that were important to MHPs and their well-being at work. The themes are independent, but there is a complex interplay between them that links directly to the research questions and to MHPs' experiences. This interplay accounts for MHPs' perceptions of well-being at work and the factors that influence their perceptions and experiences.

Findings from the thematic analysis were critically appraised and discussed in the context of the published literature and current thinking on well-being and influences

on MHPs' well-being at work. This appraisal ensured that the next stage of the study developed in accordance with current thinking. Each of the four identified themes (which have been highlighted within this thematic analysis) were therefore appraised further to ensure that they also were representative of MHPs' experiences.

4:4.3.5.1 Theme one: clinical supervision

Clinical supervision as a theme drew together evidence and findings to articulate the focus of the theme and to guide Stage 2 of the study. Stress management was recognised to be a key factor in the experiences of practitioners (Bliese, Edwards and Sonnentag, 2017; Snowdon, Leggat and Taylor 2017 and Johnson et al., 2018). Having a safe space to explore experiences was thought to lead to development of positive attributes to maintain well-being at work (Hart, Brannan and De Chesney, 2014; White, 2017; Cutcliffe, Sloan and Bashaw, 2018 and Howard and Eddy-Imishue, 2020). MHPs felt that there was value in the recognition of the complexity of managing competing demands and that this could impact directly on psychological capital and work-based experiences (Van Bogaert et al., 2013; Stacey et al., 2017; Foster et al., 2019 and Renwick et al., 2019).

Workplace stress can be correlated inversely with a sense of being able to improve well-being experiences (McTierman and McDonald, 2015; Oates, Drey and Jones, 2018). Findings of the thematic analysis suggested that practitioners understood the dynamic nature of work and that clinical supervision connected and built upon experiences and positive outcomes by affording an opportunity to reflect both personally and professionally (Bronkhorst et al., 2015; Oates, Drey and Jones, 2018; Gillet et al.,2019 and Glassburn, McGuire and Lay, 2019). MHPs showed that they

considered it important to have the opportunity to build and develop care delivery, and it is known that such opportunities at work can influence subjective well-being (Oates, Jones and Drey, 2017; Oates, Drey and Jones, 2018). MHPs in this study thought that clinical supervision should offer a safe environment in which they could reflect and explore development within aspects of their role in a supported manner, but there was agreement that this was not the case. There has been acknowledgement that lack of, or deficient, clinical supervision frameworks are directly linked to stressors and burnout of practitioners (McTiernan and McDonald, 2015; Pollock et al., 2017).

As the study progressed, it was important to develop a range of clinical supervision opportunities. This aim was a priority of the study in order to enrich the experiences of MHPs. As was apparent in MHPs' responses and in performance data, clinical supervision was largely not available to MHPs in an accessible format, since it had been merged with management supervision. This theme represented MHPs' experiences and acted as a motivating factor to build positive work situations and it became a framework to ensure ongoing development of MHPs and of the wider team during Stage 2 of the study.

In summary, central issues for MHPs were concerns around having honest feedback that would enhance delivery of effective practice. The findings of this study suggested that MHPs wanted to re-connect with the feelings of why they were doing the job. This became an important motivation for the study and provided an inherent insight into the emotional investment that MHPs put into their work.

4:4.3.5.2 Theme two: team organisation

A theme of team organisation emerged from the thematic analysis and from the relevant literature. It represented both the environment in which practitioners worked and their experiences that were specifically related to roles and responsibilities. Evidence suggests that well-managed and co-ordinated tasks and performances can enhance positive experiences for practitioners (Kelly et al., 2016; Masum et al., 2016 and NHS, 2018). The findings of this AR study suggested that MHPs made clear links between effective team function and care delivery (Rosen et al., 2018). Schmutz, Meier and Manser, (2019) report that teamwork is a multidimensional concept and that it can have direct impacts on the care that team members deliver. Amid the MHPs who were involved in this study, clearly there were practitioners who understood that teamwork involved a combination of competencies and suggestions were made to develop decision-making, communication, conflict management and shared values.

Development of a theme that directly related to optimism (in each individual and in the team) by increasing understanding of the critical issues that were faced by MHPs was aligned to the study intentions. MHPs' contributions suggested that there were issues with the management of complex caseloads and the demands that they faced, and that these issues could make impacts on experiences at work (Clearly et al., 2016). It has been reported that work roles, caseload sizes and complexities are components that can impact on morale (Rosen et al., 2018; Schmutz, Meier and Manser 2019). If the impact of stress and burnout on the emotional labour of practitioners is understood, then this suggests that there are effective practices that

can ameliorate the negative impact of stress and improve well-being (Johnson et al., 2018).

The data that were collected in this study showed that many MHPs did not feel valued in their roles and that there was little acknowledgement of the demands they faced. Van Bogaert et al., (2017) and Li et al., (2018) have indicated that psychological empowerment of staff can be enhanced if there is an understanding of the roles and, critically, the contributions that practitioners make and that this links to job satisfaction. To encapsulate this theme, MHPs in this study suggested that core threads such as communication and feelings of being appreciated influenced their perceptions of the work experience and that this in part accounted for work organisation.

Various researchers have acknowledged the value of support, effective communication and appreciation of the diversity of the workforce (Xu et al., 2010; Bronkhorst et al., 2015). However, the MHPs' experiences were dependent on each of these areas having been attended to. There were clear examples throughout the findings that highlighted negative experiences that had resulted from inattention to influential factors, and these negative experiences may have led to isolation and stress. Therefore, development of a theme that was specific to both the environment and experiences of MHPs was important to underpin initiatives in Stage 2 that would build on well-being at work.

4:4.3.5.3 Theme three: team culture

The theme of team culture concerned both well-being at work and the environment in which MHPs worked, with a focus on togetherness and building a shared sense of purpose. MHPs struggled to contend with challenges that they faced, and this

directly and indirectly impacted on work-life balance (Baum and Kagan, 2015; Holland et al., 2019). It has been reported that organisational culture and the fostering of a supportive environment can develop physical and mental well-being in staff (Utriainen, Ala-Mursula and Kyngas, 2015; Kelly et al., 2016 and Garcia et al., 2017). The perceptions that MHPs shared suggested that they had mixed feelings towards their roles and that these mixed feelings resulted in both positive and negative viewpoints; contradiction centred on feelings towards colleagues and relationships. This issue required consideration in development of co-researchers (Shen et al., 2017; Schon et al., 2018). Good experiences and a perception that relationships at work are strong are critical for MHPs and are linked directly with a sense of wellness at work (Schon et al., 2018; Jarden et al., 2019). In contrast, the participants of this study were clear that the culture of their immediate team was not one of support.

It was important to develop a theme that accounted for the feelings with which MHPs viewed their roles. Engagement of practitioners to explore what motivated them would be critical to Stage 2 of the study. MHPs who can articulate strategies to manage and develop aspects of their work and who understand what motivates them play an important role as components of work engagement (Malinowski and Lim, 2015; Van Bogaert et al., 2013). It is clear from the data that were collected in this study that there was a need to build MHPs' feelings toward being part of a team.

This was evident in findings that suggested that MHPs faced challenges in their management of conflict with peers and within teams. These challenges existed

alongside an atmosphere of competitiveness, isolation and stress, which compounded the issue. Positive work cultures can build resilience amongst practitioners and enrich feelings of care about oneself and others (Sergeant and Laws-Chapman, 2012; Foster, Cuzzillo and Furness, 2018 and Foster et al., 2019).

This theme provided clear direction for the future work as it encapsulated the experiences of MHPs as they worked within this environment. The MHPs themselves indicated a desire for an improved team culture. There were clear examples of MHPs who experienced stress and this directly and indirectly impacted on their work-life balance and well-being, which led to a less positive work experience (Oates, Drey and Jones, 2018; Gillet et al., 2019).

4:4.3.5.4 Theme four: staff training and development

This theme of staff training and development was also aligned to the study intention. MHPs had a clear sense of the skills and knowledge that were necessary to enable them to deliver effective care. They also recognised that appreciation of others' skills and working with them was important.

As highlighted by Welp et al., (2018), personal and professional development and the perceptions of staff among their supervisors are related to both the quality of care that is delivered and to teamwork. It is important that the work of the MHP is viewed positively, since optimism is important for well-being (Malinowski and Lim, 2015; Cruz, 2017 and Cruz et al., 2018). To improve well-being in the team that was

the focus of the study, an emphasis on personal and professional development to build on enjoyment of the work roles would be important.

However, as one participant pointed out, training alone would be insufficient. Development of hope, optimism and resilience, alongside changes to team culture, would also be important to boost the self-efficacy that was needed for MHPs to carry out their roles well (Avey et al., 2011; Cleary et al., 2020). It was therefore essential, in the future work, to explore options that could build and develop knowledge and skills, enhance decision-making and performance and hence enhance MHPs' senses of optimism and job satisfaction (Happell and Koehn, 2011; Clearly et al., 2016). The service improvement approach to the study encouraged practitioners to discover and 'action' activities to build personal and professional development in order to transform their experiences (Foster et al., 2019) whilst also focusing on the impact of team culture.

To summarise, the themes that were identified both highlighted specific challenges and indicated the ways in which MHPs could address these challenges. The need for specific personal qualities, skills development and team working within the context of a supportive working culture were highlighted. MHPs clearly articulated how this could impact on well-being.

4:5 Summary: understanding experiences and development of themes for action (findings, data collection and analysis, stage 1)

Question 1- How do mental health practitioners view well-being, teamwork, job satisfaction and resilience?

The process of data collection and analysis of the findings that were made in Stage 1 reinforced the value of the study for the researcher and co-researchers. The use of

different methods ensured that the experiences of practitioners and the intention of the study could be aligned. Involvement of all key stakeholders was critical to this process and helped to ensure attention to and analysis of the findings within the context in which the study was placed.

The environment of the team required consideration as the study progressed. This was because the survey findings suggested that practitioners felt that, although they cared about their colleagues, they did not necessarily feel cared about, and this was related directly to resilience. As practitioners worked as co-researchers, they needed to develop a sense of sharing and working in collaboration to instigate changes. Therefore, the use of PAR incorporated in this AR study was essential to ensure not only empowerment and emancipation of MHPs, but to engage MHPs in a collaboration to improve experiences. Some findings suggested that practitioners did not feel that they were able to contribute to team development, and this issue was linked to the notion of job satisfaction. This reinforced the value of an AR approach, since the involvement of practitioners as co-researchers would be important to offer practitioners the experience of involvement in development of the team.

Feeling part of a team links directly to well-being at work and creation of this feeling was an intrinsic part of this study. Practitioners' accounts of their experiences at work suggested that there was interplay between factors that influenced delivery of care and a sense of well-being. Thematic analysis resulted in the development of the central themes of clinical supervision, team culture, staff development and training and team organisation; interventions that were built around these themes would

support practitioners to manage the complex interplay between their experiences and the challenges that they faced.

Practitioners were aware of what influenced their well-being and could identify ways to enhance their well-being. The environment in which practitioners work may be crucial in their self-identification in relation to: their enjoyment of and fulfilment in their role (job satisfaction), their ability to manage and cope with stress (resilience) and feeling as though they are part of a supportive and caring team (teamwork). The data that were collected highlighted the factors that were important to staff in the fulfilment of their role (access to clinical supervision, improved milieu, better work processes and personal and professional development) and demonstrated that, in order to function fully in their role and for the team to develop in line with expectations, it was necessary to address these influences in this study to enhance well-being.

It was important that MHPs had positive feelings toward the study. During the data collection and analysis, the findings suggested that MHPs were keen to explore ways in which to foster well-being in themselves and others. The role of co-researchers therefore included the management of the expectations of stakeholders and the garnering of ongoing support and involvement in the study from peers and this was important to ensure success of the subsequent PAR element of this study.

The collaborative nature of this study involved interactions between stakeholders and co-researchers; this ensured development of an internal perspective regarding both the context of the study and commonplace practices and how the action stage should develop to meet MHP need. The researcher subscribed to an insider/outsider perspective to facilitate this focus of collaboration.

Constant evaluation and reflection informed the researcher's development. This enabled a process of transformation and of reconceptualisation of the AR study as it progressed. Despite the researcher's anxieties related to a lack of research experience, the process of collection and analysis of data facilitated an opportunity to explore thoughts about the study and to add clarity about her development and learning as a researcher.

There were findings that related to the sense of isolation that MHPs experienced (e.g. perceptions that their own care about others was not reciprocated), and this was an important consideration for this study. Secondly, the organisation standpoint and practitioner experiences appeared at odds with each other. From the MHPs' point of view, emphasis on performance appeared to have negated any need to support, encourage or empower them to develop in order to be able to meet targets. Lastly, it was apparent that MHPs had a wealth of ideas about how to improve well-being and interventions that would be useful, but this was at odds with an organisational approach to quality improvement that did not embrace fully the concept of practitioner self-determination and empowerment. Therefore, the use of PAR approach to empower MHPs to self-determine change, challenged organisational approaches to implementing and managing change.

Ongoing involvement of stakeholders and the validation group (Stage 1, pp. 143) ensured the authenticity and trustworthiness of the study. A validation group judged each stage of the research and, although its members were sympathetic to the aims of the research, they were able to provide critical feedback based on the similarities between the experiences that were voiced by the participants and their own work experiences (CMHT demographics, caseload sizes, similar performance issues and staff mix).

Feedback from the validation group was as follows.

> *The lack of supervision is not surprising; we make sure that we prioritise supervision, but staff don't always get it, and some avoid it. I think we are all struggling, and morale is not always good. We try to keep motivated but there are too many changes. The areas shown are like our experiences here; staff are struggling to cope at times and feel stressed. Having a focus that staff should lead is a good idea - staff avoid the (quality improvement) approach and when we are asked to volunteer for projects, we struggle to find time and/or staff keen to do it.*

The work that is described in this chapter informed the work that followed and is described in the subsequent chapter. Chapter Five details how MHPs can improve experiences of well-being and improve teamwork, job satisfaction and levels of resilience and this is evidenced in the incorporation of PAR in this AR study.

Chapter Five: Improving Experiences and Finding Solutions through Action (Stage 2)

Question 2- How can mental health practitioners enhance well-being and strengthen teamwork, job satisfaction and resilience?

5:1 Introduction

This chapter considers the work that was performed to develop well-being at work through the fostering of an environment in which MHPs acting as co-researchers could influence positive changes at the CMHT through reflection and evaluation of the work environment. This action element of the AR study incorporates a PAR approach that built on themes that were identified as representative of MHPs' experiences of well-being at the CMHT (Chapter Four, section 4:4.3) and these themes were: clinical supervision, team culture, team organisation and staff development and training. To ensure that they were representative of MHPs' experiences, these themes were explored with all stakeholders to ensure that multiple perspectives influenced decisions that were made regarding the choice of priority areas for change. Incorporating PAR at this stage ensured that it was MHPs themselves who determined and dictated the course of action and the decisions made.

This process demonstrated how, with support, co-researchers could highlight specific insights that they had gained into the CMHT and the subsequent improvements to be made. This chapter presents the PAR approach and the use of PDSA cycles that were created and how these led to change and innovation. Changes that were made were deliberated within the wider context of the CMHT with

those who were likely to influence or have interest in these changes, such as those MHPs who did not wish to engage with the study as co-researchers. The discussion that is presented in this chapter includes an overview of the process by which changes were identified and implemented through the PAR process and adoption of PDSA method with contributions from stakeholders and co-researchers.

Throughout the performance of this stage of the study, continuous evaluation and reflection (integral to this AR study) ensured that changes that were made were refined and modified and then shared with all stakeholders. The outcomes and changes that were planned were structured to demonstrate that these changes reflected the focus of the study and were relatable to MHPs' experiences. Learning points and evaluation have considered whether the use of this PAR approach to make changes has resulted in front-line staff (who acted as co-researchers) who now feel empowered and emancipated to influence work experiences and whether this has strengthened the CMHT in terms of the perceptions of MHPs and performance of the team.

Throughout the explanation in this chapter, the researcher provides an account of the process with consideration of her motivations for this study and her ambitions for success of the AR study in order to understand the potential for and impact of bias. Finally, a review is offered of the lessons that have been learned and challenges that have been overcome. This review informs the evaluation and reflections that made up Stage 3 of this iterative AR (PAR) study and which are described in Chapter Six.

5:2 Quality improvement and the use of PDSA in healthcare

Methods of quality improvement (QI) that are used within healthcare settings support delivery of effective and efficient care (Reed and Card, 2016; Ross and Naylor, 2017 and Williams and Caley, 2020). The use of a systematic approach to the management of change and the improvement of systems can impact not only on care delivery but also on the culture within an organisation as the process itself can influence the work atmosphere (Foster, 2016; Reed and Card, 2016). The active engagement in QI method (PDSA) of the co-researchers in this PAR could support them to assimilate and develop skills in the management and leadership of change and help to address any concerns that they had about service delivery (Jones, Vaux and Olsson-Brown, 2019).

Engagement in QI projects creates challenges for the staff, such as finding time to be involved, use of methods in which staff are well rehearsed and employment of a considered design to assure quality (Ham, Berwick and Dixon, 2016). Reed and Card (2016) suggest that, of the many tools that are used to implement change, PDSA cycles can get to the heart of change and facilitate the transformation of ideas into action. The use of PDSA iterative cycles tests out change and continual improvement (Taylor et al., 2014; Knudsen et al., 2019).

PDSA is widely adopted in healthcare (Taylor et al., 2013; Sarre et al., 2019). It is a four-stage approach that involves: the planning of an intervention to address a problem, the implementation of the intervention, investigation of the outcome of the intervention and then action to ensure the improvement/continuation of the intervention (Taylor et al., 2014). The value of action learning using PDSA within this

PAR element of the AR, is that co-researchers can develop reflective skills throughout the process, and this can improve their understanding by developing and building their skills and knowledge through doing (Revans, 2011; Slootmans, 2018;).

Within the NHS trust in which this AR study was performed and specifically the PAR approach incorporated, PDSA is the preferred method for introduction of QI initiatives. The principles were therefore familiar to the MHPs who were involved in this study. Application of these principles to introduce changes in healthcare ensures that change is tested on a small scale and the impact of the change is assessed in a cycle of reflection and evaluation that builds on previous learning in order to introduce the change more widely (Improvement NHS, 2018; Williams and Caley, 2020). The researcher recognised that sustainability of this PAR was linked to a cyclical process that would be continuous and outcomes would become apparent over time, and therefore the changes would continue after this study period (Lennox, Maher and Reed, 2018). An important factor in this PAR approach was the empowerment of MHPs; therefore, the areas that were identified as potential causes for concern were self-determined by MHPs and not pre-determined by the organisation, as is common in quality assurance. It was hoped that this difference would lead to greater enthusiasm among MHPs and stakeholders to adopt the proposed changes.

To develop co-researchers as leaders of change and service improvement, there has been a focus on MHPs exploring and reflecting on the complex interplay of communication, relationships and team dynamics. This process has informed understanding of the emphasis that has been placed on work experiences by all

stakeholders, as shown in Stage 1 (Chapter Four, section 4:2). To engender the development and exploration of knowledge of practices and procedures, co-researchers were encouraged to adopt a systematic approach to service development: that is, the PAR approach and to use PDSA cycles and to embrace the concept of action learning through reflection in and on action (Williamson, Bellman and Webster, 2011; McNiff, 2017).

It was important for the researcher to understand fully the complexities of this QI method. This understanding involved acknowledgement of the consequences of adopting a QI method such as PDSA without comprehension of the potential difficulties (Reed and Card, 2016; McNicholas et al., 2019). Consensus is not required on the areas that may be targeted for change and this can influence the ways in which change is interpreted (Davidoff et al., 2015; Reed and Card, 2016). For the researcher, this meant appreciating that, first and foremost, PDSAs needed to 'make sense' to co-researchers and this was important as the process enabled them to 'try it out' and see what would work. Payment of this attention to challenges that might be faced was a means to revisit the motivation for the study (to empower MHPs to improve their well-being at work) and to ensure that a theoretical approach was adopted in order to manage change and QI in healthcare (Davidoff et al., 2015; McNicholas et al., 2019 and Williams and Caley, 2020). With careful consideration of the use of PDSA within this PAR, iterative cycles ensured that each stage within each cycle was led by co-researchers (supported by the researcher) as they actively learned and then made informed decisions about future changes.

5:3 Identification and implementation of changes

Stage 2 of this study involved an eight-month PAR approach and application of PDSAs in areas of the CMHT. This was led by co-researchers. The action elements were supported by the adoption of the themes (Stage 1, Chapter Four, section 4:4.3) that had been previously identified. Hence under the theme of clinical supervision, the element that required action was lack of access to clinical supervision; under staff training and development, the action element was that there were few opportunities for staff development and training to support them in their work; similarly, the theme of team organisation led to proposals to act to remedy the inadequate processes and structure that were in place to support the MHPs' work; and with regard to team culture, action was required since MHPs felt that the culture of the team required improvement to prevent the reported low morale and isolation of team members.

The PAR approach that was adopted ensured that MHPs could investigate practice at the CMHT to improve the quality of their understanding of well-being at work within context (McNiff, 2017). The researcher worked alongside co-researchers to support the planning and implementation of changes to improve well-being. To underpin this process and to structure this PAR approach, workshops were held with stakeholders at the commencement of Stage 2 (June 2018), mid-point (October 2018) and at the end of the action stage (February 2019). These workshops were an important element to ensure that there was reflection and evaluation of changes that were made (Stringer, 2007).

This pragmatic approach to support change (Figure 11) and to encourage dialogue among stakeholders helped to balance the aspirations of those who were involved in the study with the production of practical plans (Coghlan, 2019). Consequently, the first step in the PAR eight-month cycle of change was the evaluation of the initial findings from Stage 1 and an assessment process to discover whether the research team agreed with these findings (Chapter Four, 4:5). The process of seeking agreement on the potential areas in which to instigate the 'action' phase can be uncertain. In this case, this process necessitated the clear articulation of a concise and organised account of the data analysis and findings to all stakeholders (Deverka et al., 2012; Reed, 2016). This was important to ensure the ongoing engagement of key stakeholders.

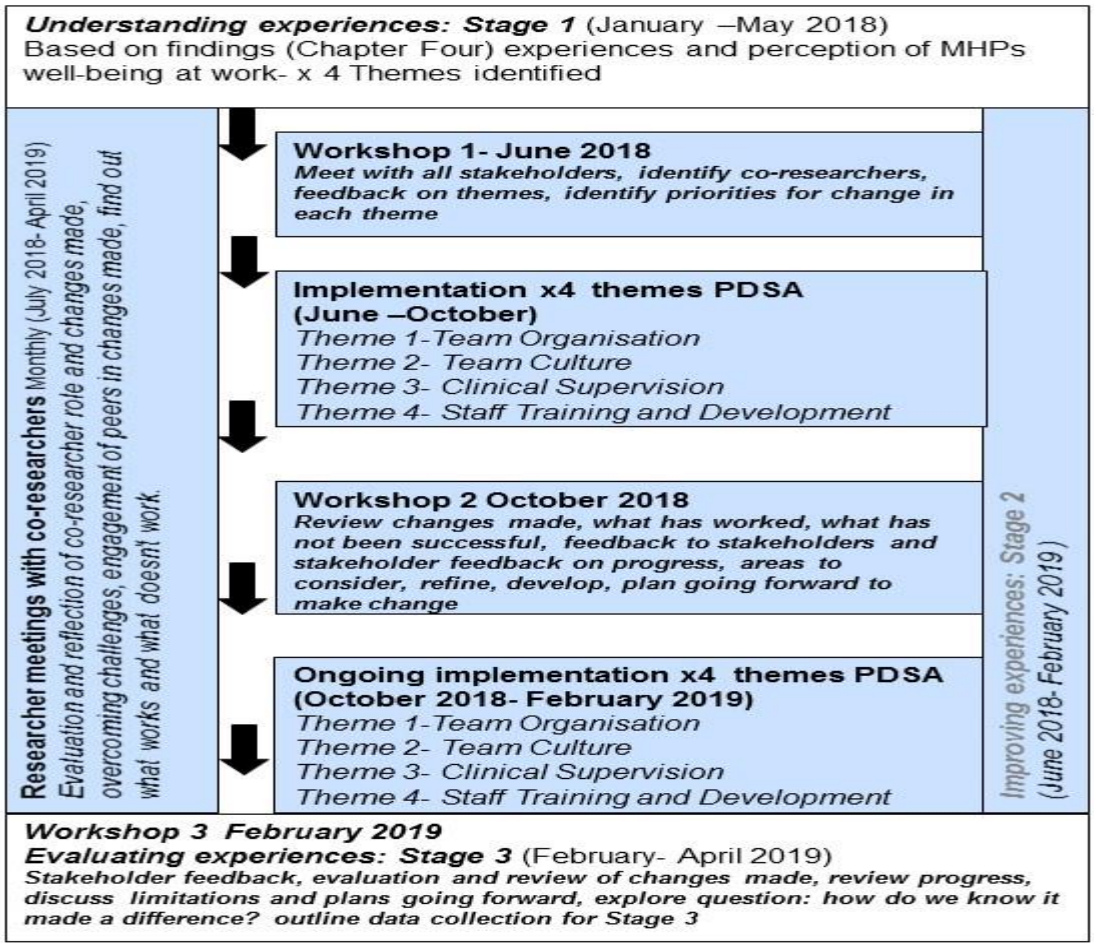


Figure 11 Overview of PAR approach to the identification of changes to be made

In June 2018, an initial workshop that involved all MHPs and key stakeholders (facilitated by the researcher) ensured that participants understood the proposed areas for improvement and aimed to manage the expectations of those involved by reaching agreement on priority areas (Casey, O'Leary and Coghlan, 2018). To ensure that attendees were not distracted by work issues, the workshop was held at a location away from the CMHT. Attendees are detailed below in Table 10.

Table 10 Participants in initial workshop, July 2018

Participants – Workshop July 2018	
Clinical Locality Director	X1
Mental health nurse	X 5 participants
Clinical Governance Lead	x1
Team leaders	X2 participants
Business manager	x1
Social worker	X 3 participants
Health care professional	x1
Occupational therapist	x1

MHPs were given the opportunity to explore each theme (clinical supervision, team culture, team organisation and staff development and training), to discuss and investigate whether the theme was reflective of their experiences and to explore their thoughts regarding whether they wished to be involved in the study as co-researchers. These central themes were considered important by MHPs (findings from Stage 1, January 2018 - May 2018) and were therefore felt to be priority areas on which to focus. This level of detail was deemed to be sufficient to ensure that changes made would be pertinent to participants in this study (for instance, if MHPs viewed something to be a problem, such as their lack of opportunity to receive clinical supervision), since there was evidence to suggest that this reflected MHPs' experiences. Table 11, lists each of the theme areas and highlights why they were considered important to MHPs' well-being, based on the findings from Stage 1.

To embrace the participatory nature of this PAR approach, and to be practical about how co-researchers could develop PDSAs, MHPs decided which theme they wanted to focus on and in which they wished to implement changes (Table, 12). Written consent was obtained from those who wished to engage actively as co-researchers to lead the action phase of the study (Appendix, 6). This consent was obtained in addition to consent for data collection that was obtained in Stage 1 of this study. This was to ensure that consent was obtained separately for data collection in Stage 1 and in Stage 2, as not all co-researchers were involved in Stage 1 data collection and it was necessary to define their contribution as co-researchers.

Table 11 Theme groups – findings, Stage 1

Well-being at work
Four Themes identified Stage 1
(findings from data collection and analysis)

1. Team Organisation
The concern is that;
The team struggle to manage the competing demands that they face
There is a sense of ineffective teamwork that impacts on well-being at work
Staff struggle to manage their workload and meet expectations such as performance targets
There is a perception of a lack of management support and communication
There is no sense of achievement and sharing good practice

2. Team Culture
The concern is that;
Morale at the CMHT is low and MHPs feel isolated
Staff are struggling to meet the demands that they face.
There is a concern that various factors influence the culture of the team in which they work, and this includes, low morale and low commitment to quality initiatives
There is no opportunity to share ideas and special interests
Management supervision is the only supervision available and is rarely offered
There is poor team communication and sometimes conflict with peers

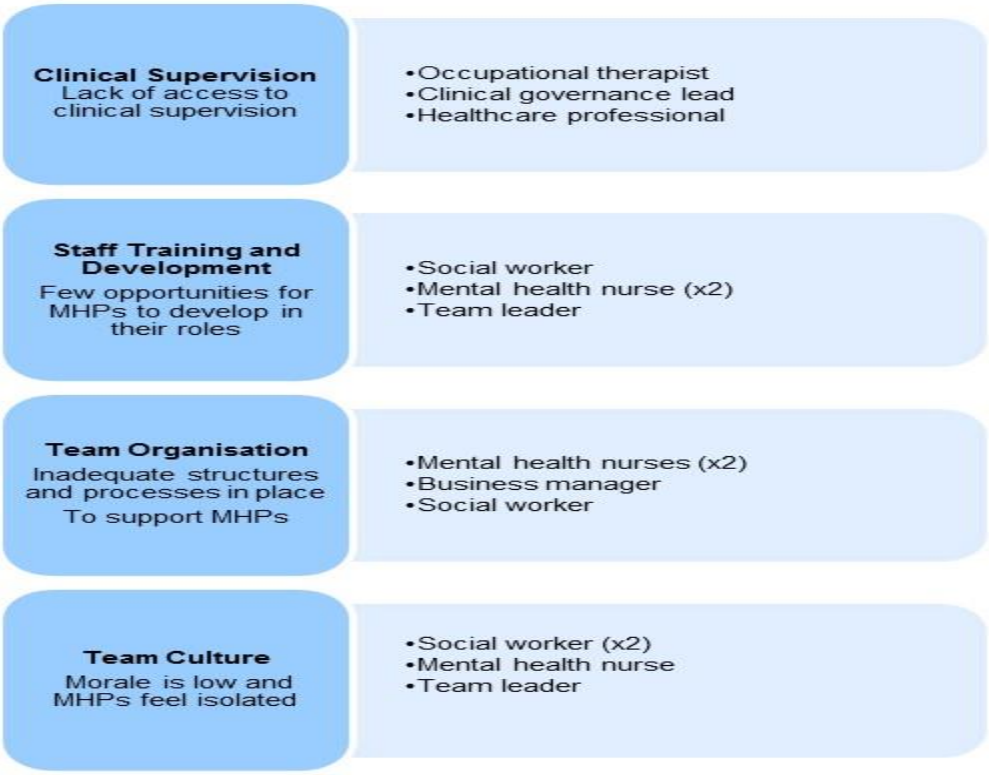
3. Clinical Supervision
The concern is that;
Few practitioners have access to clinical supervision and there is disparity in type and frequency of clinical supervision
There is no framework or process in place to support clinical supervision
Lack of clinical supervision has impacted on well-being of staff

4. Staff Training and Development
The concern is that;
Staff feel they lack skills to manage their role personally and professionally
Staff feel that they cannot manage parts of their role and feel unsupported or prepared to meet the many challenges that they face, and this includes;
maintaining staff well-being, issues with staff retention and feeling isolated
There are policies and procedures for personal development plans and appraisals but this is not adopted effectively
Staff would like opportunities of personal and professional development and this includes evidence-based practice to support clinical practice, stress management, self-awareness and resilience training

It is important to note that not all stakeholders wanted to engage in the study as co-researchers and that this sentiment was respected (that is, the right to decide and not feel unduly influenced by peers was respected) by the researcher and co-researchers. However, to ensure that everyone had the opportunity to be involved in shaping the changes that would be made, all stakeholders were included in all

workshops so that they could contribute and make suggestions based on their experiences as MHPs.

Table 12 Co-researchers and theme groups



Each theme was chosen by a self-selected group of co-researchers (with input from stakeholders) who then considered the perceived issues and needs and possible solutions or changes to be made. This process of identification, planning and implementation of change ensured that each co-researcher was engaged in the introduction of potential solutions or changes that would improve the work environment. Within this, each theme was discussed in regard to aims (that is, the goal of the change) and the primary drivers (that is, influential factors that needed to be addressed to achieve the goal). This process was designed to ensure that co-

researchers were able to make certain that the plans that they made were realistic and achievable.

At the conclusion of the initial workshop, each theme group of co-researchers made plans to verify that the changes could be made through adoption of a PAR approach and use of PDSAs. In line with a PAR approach, ongoing critical evaluation and reflection would be fundamental throughout the process (McNiff, 2016). Whilst MHPs were engaged in refining and modifying changes, they would be encouraged to reflect on and share their growth as co-researchers and their experiences as agents of change (Banks, Herrington and Carter, 2017).

The second workshop with all stakeholders, which was held at the mid-point of the action phase of the study (October 2018), enabled co-researchers to share and to feedback on the progress they had made and to seek support and to clarify amendments that needed consideration. The workshop at this stage made sure that there was active engagement and participation of the whole team and guaranteed the contribution of MHPs who did not wish to act as co-researchers (McNiff, 2016). Feedback that was given by co-researchers followed a structured format: achievements, plans going forward, challenges faced and things going well. Throughout the workshop, MHPs were also encouraged to add to commentary that was provided by co-researchers and amend accordingly. To do this, each theme group set up a flipchart outside the workshop venue, and throughout the course of the day, stakeholders could write anonymous comments on the flipchart. This method of supplying comments was felt to afford everyone the opportunity to provide

honest feedback; otherwise, stakeholders may have felt obliged to agree changes that were suggested by co-researchers.

Confirmation of the engagement of stakeholders was achieved through opportunities to give feedback and to offer insights into each theme. This was critical for the stakeholders to garner a sense of ownership of the interventions (McNiff, 2017; 2016). This encouragement of involvement built a sense of ownership of both the direction of the PAR in response to research questions and of the service improvement itself for all stakeholders. Ultimately, this mid-point workshop afforded an occasion to review, reflect and evaluate changes that had been made and to consider feedback from stakeholders and other co-researchers about how plans needed to be adapted.

The final workshop, which concluded the eight-month action element of this PAR approach, was held in February 2019. This evaluation and reflection workshop sought to engage all stakeholders in the evaluation and review of changes that had been made and to explore ways in which these changes could be sustained and further developed. This reflects the principles of PAR: collaboration and transformation through learning (McNiff and Whitehead, 2011), and highlights the iterative nature of the PDSA method itself. The final workshop was attended by 25 stakeholders, who were co-researchers and MHPs. This high level of attendance suggested that the impact of changes that had been made had been felt within the wider CMHT, and that the stakeholders accepted that the approach that had been adopted and the changes that had been made and which were led by their peers (as co-researchers) had been of value. The collection of data and analysis that was conducted at the workshop then informed the discussions/findings which are

described in the next chapter of this thesis (Chapter Six – Evaluation of Experiences and Action Interventions).

5:4 Data collection and analysis, Stage 2

Throughout the action phase of the study, the researcher worked alongside the co-researchers, who were leading on the PAR approach and PDSA cycles and planning the changes to be made. The researcher's role was to meet with each theme group on a monthly basis (Figure 12) to reflect on the PAR and the PDSA method and to evaluate the group members' experiences of acting as co-researchers. This regular opportunity to discuss and consider the experiences of those involved in the process afforded opportunities to explore challenges that co-researchers had encountered and to highlight areas that warranted further consideration. This systematic approach to inform decision-making through clarification of what was really happening influenced the cyclical nature of multiple, linked cycles of change (Taylor et al., 2013). This method demonstrated commitment to the scientific nature of PDSA (testing and hypothesising) as a method to evaluate, reflect and build upon practice (Taylor et al., 2013) and to the principles of PAR (McNiff, 2017).

The process of introducing change at the CMHT (and data gathering in Stage 2 to supplement data that had been collected in Stage 1) served to demonstrate the process of PAR and the method of PDSA cycles and to highlight outcomes that took into account changes that had been made. Therefore, the data consisted of a combination of field notes, reflection and evaluation (co-researchers and researcher) and observations of changes that had been made and communication within each theme group. Additional data from field notes that were made at each of the

workshops (June 2018, October 2018 and February 2019) provide an account of the progress that was made toward change in each of the theme groups and how this was shared with stakeholders. This process, which involved evaluation of the results together and analysis of the research, was aligned to principles of PAR (Greenwood, 2018) and demonstrated commitment to collaboration and participation.

5:5 Results

All four theme groups of co-researchers were able to identify and perform changes during the action phase of this study. Over the eight-month period (June 2018-February 2019), each theme group was able to manage the PAR approach and PDSA method to inform and instigate change. They were able to overcome issues regarding commitment of time to the process and their abilities to balance their aspirations with being realistic within time constraints and to learn and adapt as the process evolved and changes were made (McNicholas et al., 2019).

As shown in Figure 12, each theme group of co-researchers identified four potential interventions, except for the co-researchers who were involved with the theme of team organisation. These co-researchers decided that review of the structure of all meetings within the CMHT would be beneficial and would result in a clear indication of change being made to the wider team and stakeholders.

To demonstrate the findings from this action phase, each theme is discussed in the following overview of specific results. The discussion includes excerpts from field notes and co-researcher reflections. It also details lessons that were learned and

challenges that were overcome. Rather than describing the contents of each PDSA cycle, the account of the PAR approach is reflexive and gives meaning to the empowerment of MHPs to make changes to improve well-being.

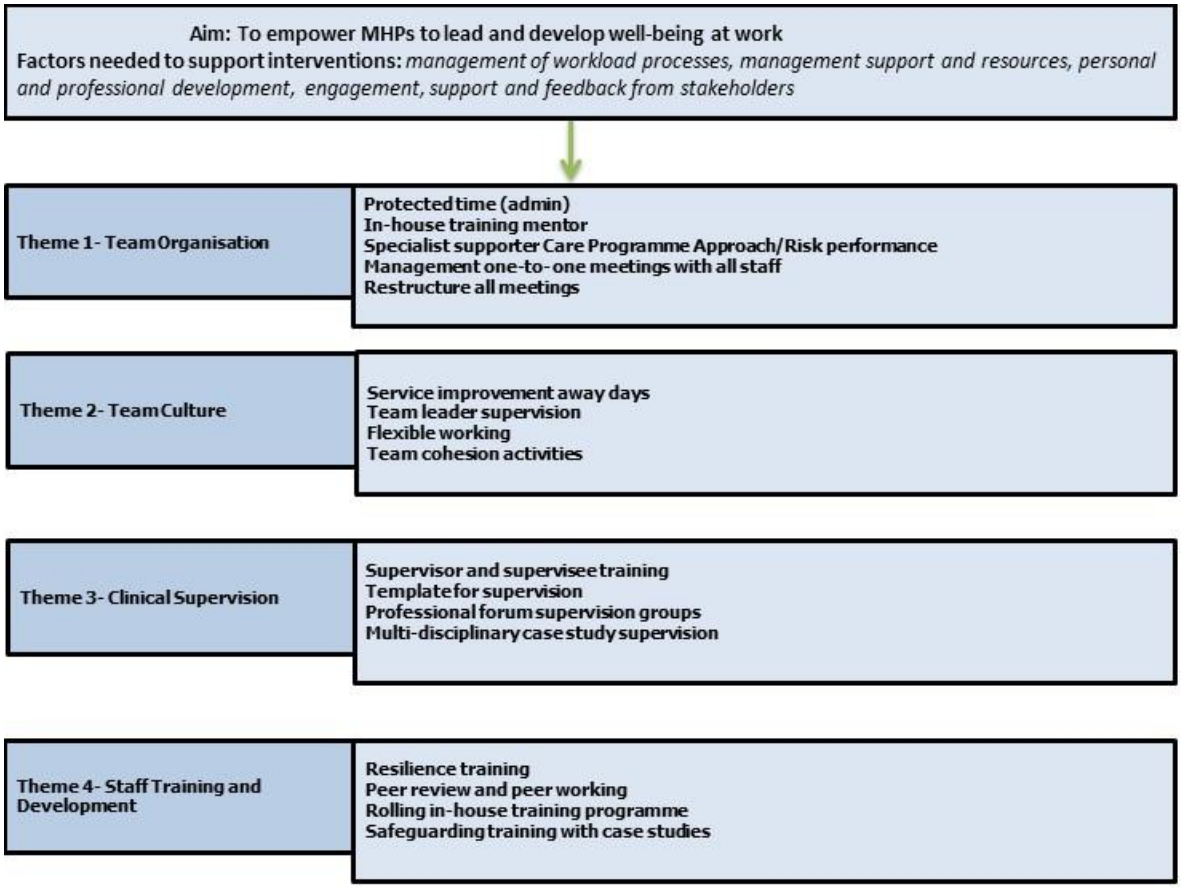


Figure 12 Changes proposed by theme groups 1-4

5:5.1 Theme 1 – Team Organisation

The primary drivers that were established by the group at the outset were focused on the intention of the study: the enhancement of well-being at work. This showed the sense of responsibility that the co-researchers felt toward enhancing the well-being

of peers. The primary drivers were associated with staff morale and improvement of communication alongside the formation of structures and processes that supported development of the CMHT.

Taken from field notes, August 2018: theme 1, Team Organisation

Co-researcher -"I will enjoy doing this and I am organised so I know that this is useful for others to see. Centralising our efforts will make sure we don't lose interest"

Co-researchers stated that they had a clear sense that the structure and set-up of the team required the expectations of the NHS trust to be more explicit (for instance, through development of an accessible Excel document, in-house training mentor) and the promotion of a positive and supportive work environment (good practice forum, positive feedback messages). These proposed areas of change supported the potential areas of change that had been determined at the initial stakeholder workshop (Table 12) and co-researchers considered that these were essential to support the requirements that had been highlighted by MHPs.

Whilst co-researchers agreed that better working processes and structures at the CMHT would result in positive outcomes for MHPs, there were mixed opinions on how to measure success and which plans were priorities. Co-researchers' understanding that the interventions would impact on relationships and experiences of MHPs acted as a challenge as the co-researchers struggled to establish a clear plan of how to measure outcomes that were important to them as MHPs. Co-researchers realised that imposition on MHPs of a requirement to use additional

formats (such as Excel documents) to support their work could add pressure and stress. Therefore they decided to seek additional support (that is, feedback from peers) to ensure that changes they made would be considered to be beneficial by MHPs themselves and not merely an outcome that was favoured by the organisation (for instance, to meet NHS performance targets).

Taken from field notes, September 2018: theme 1, Team Organisation

Co-researcher - "Lots of staff are worried about Excel and need support. We should not add to stress - we should focus on getting support for them"

Keen to foster enthusiasm, co-researchers collected data and feedback from stakeholders about the meetings they had attended and set about implementing a plan to revisit the terms of reference of each meeting. Alongside this, co-researchers investigated adherence to NHS Trust targets (completion of care programme approach (CPA) and risk assessments) and to mandatory training requirements. This drove through cycles of change as co-researchers moved towards the introduction of significant changes that would alter how MHPs managed competing demands and workloads; the aim was to bring in specialist support to meet the expectations that were placed upon them. This was achieved by introduction of an addendum to the role of a Band 7 professional, who would act as a specialist to support MHPs to meet organisational targets through one-to-one support and training.

Adoption of a creative way of engaging with data ensured the ongoing validity of the interventions that were under consideration. Evidence that the CMHT was not meeting expectations (that is, NHS performance targets) was used to support plans to introduce a guideline regarding protected time. A process to test possible changes

was introduced (for instance, to test whether MHPs used protected time) and to see whether positive outcomes were evident in performance data.

Taken from field notes, November 2018: Theme 1, Team Organisation

Co-researcher -"We booked the seminar room so that they [the MHPs] were away from the building - we must make sure that the team leaders are aware and they won't call them away [from the meeting]. I sat there last time as I think this sent a message that we value this" [protected time]

Co-researchers took a keen interest in the use of PDSAs and were able to ensure that each linked PDSA cycle demonstrated a considered approach. The driving force of the process was careful attention to making substantial changes to the processes and structures that were in place at the CMHT. There was a strong emphasis on reflection amongst co-researchers; honest accounts were requested that were in line with the potential challenges that were foreseen. There were vigorous discussions throughout the process of how the limitations of their chosen interventions could be overcome.

Taken from field notes, January 2019: Theme 1, Team Organisation

Co-researcher - "Not all change is good; sometimes we have got it wrong"

The co-researchers in this theme group showed a clear sense of achievement. They took a keen interest in the progress of all theme groups and introduced a change to the support that was offered to all MHPs by developing a systematic process for staff to be supported in one-to-one meetings with the service manager. The co-researchers sought to solve potential problems rather than to become despondent.

Taken from field notes, February 2019: Theme 1, Team Organisation

Co-researcher - "We have experience of managing change, we have influenced others and this is good; we can make meaningful change"

The MHPs who were involved as co-researchers and who were empowered to improve the service appeared to capitalise on their strengths (such as positivity and creativity), which were reinforced further by sharing their interest in the PAR approach and AR study with peers who showed similar qualities (such as confidence and leadership). There was a sense that their attraction to the theme in the first instance had been underpinned by the value they each placed on being organised in their own roles. During the process, the co-researchers and researcher realised the impact of the empowerment of MHPs to instigate improvements to their work experiences. This realisation brought its own rewards in terms of the co-researchers' improved job satisfaction, teamwork and resilience and ultimately their well-being at work.

5:5.2 Theme 2: Team Culture

From the outset, the pro-active, ongoing engagement of all stakeholders required concerted effort on the part of co-researchers to be mindful of maintaining their enthusiasm whilst not dismissing the concerns of their peers. The cause for concern in this theme, as articulated by this theme group of co-researchers, was influenced by factors that included few opportunities to develop and grow as professionals and ineffective communication within the wider team. Initial thoughts to underpin change that would improve the culture of the team were centred on a broad aim of fostering a positive culture within the team. The primary drivers were levels of staff well-being

and the need for professional and personal development through engagement with and knowing peers, in order to improve morale and increase the number of opportunities to work together.

Taken from field notes, August 2018: Theme 2, Team Culture

Co-researcher - "I think our group is important. We can make a difference and show that the CMHT doesn't need to sink"

Co-researchers felt that the team culture could be improved if there was attention to factors such as the need for positive feedback and to have opportunities to share, develop and grow together. These co-researchers began a process of developing cohesion activities at the CMHT. Understandably, the co-researchers were keen to instigate changes immediately. As they were committed to improving social interaction within the CMHT through team building activities, the co-researchers felt that they 'understood' that their plans would work and therefore wanted to move to implementation of changes. Within the PAR approach adopted this was a challenge and this is a common during application of any change method including PDSA; that is, it is tempting for those involved to try to drive through change without consideration of or adherence to the method (McNicholas et al., 2019). Therefore, the co-researchers organised some one-off events such as team lunches.

Taken from field notes, August 2018: Theme 2, Team Culture

Co-researcher - "We need to make sure there are some quick wins as everyone gets disinterested quickly"

Following feedback from stakeholders (through the workshop in October 2018), co-researchers sought to explore and revisit how best to proceed to improve the team

culture. The feedback from the stakeholders suggested that some useful changes had been made but they were largely felt to be singular events such as team lunches and organisation of the October workshop rather than deep-rooted changes that would lead to permanent change of the work culture.

> Taken from field notes, October 2018: Theme 2, Team Culture (workshop with stakeholders)
>
> *Co-researcher (theme, Clinical Supervision) - "This project is not just about coming up with ideas, it is about us all working hard to make changes that make a difference to work"*

The co-researchers explored how improvement of the team leaders' abilities to support staff would be beneficial and impact on MHPs' experiences at work. It was felt that this increased support would improve morale as team leaders would be able to develop their leadership and management skills. Co-researchers understood that team leaders would be in a better position to support and nurture their teams (by fostering a better working environment) if they themselves felt valued and supported. For the researcher, this highlighted that co-researchers were beginning to appreciate the value of looking beyond immediate gratification (social events) toward understanding the influential factors that directly impacted on staff morale.

> Taken from field notes, December 2018: Theme 2, Team Culture
>
> *Co-researcher - "If we are supported, then team leads need it as well. If they are able to develop the skills, they need to do the job, then morale will be improved"*

A focus on development of a flexible working policy engaged MHPs as they appreciated the attempts that were being made to improve their experiences at work. However, the co-researchers in this group faced a challenge as policies operated

Trust-wide and pertained to human resource management; therefore those who were most likely to be able to influence a decision about adoption of a new policy were remote from the team and hard to engage. There was consensus that local (CMHT) changes could be made and adapted to afford greater flexibility for MHPs who worked at the CMHT.

It proved challenging to involve MHPs to act as co-researchers to determine which strategies would be best to improve the culture of the team in which they worked. Given the impact of stress and burnout, it was perhaps unsurprising that, in the first instance, MHPs favoured fun, social activities over those that did not give immediate gratification. For both the researcher and the co-researchers, a concerted effort was made throughout to guard against pressure to act immediately and introduce instant interventions.

This group of co-researchers felt that the wider team wanted to see results more quickly than the chosen method would allow. However, by revisiting and discussing this problem with the wider team and reiterating the aims of the study, co-researchers were able to make significant impact on the working environment. Changes and solutions to team environment problems showcased a combination of changes that sought to lessen isolation, improve morale and encourage team-building. These changes were made in direct response to MHPs' experiences at the CMHT.

Taken from field notes, January 2019: Theme 2, Team Culture

Co-researcher - "Building a pro-active approach rather than a reactive approach [led to us gaining] a general respect throughout the building"

5:5.3 Theme 3: Clinical Supervision

The theme of clinical supervision highlighted to co-researchers the complex nature of the work environment for MHPs and the importance of feeling supported.

Taken from field notes, June 2018: Theme 3, Clinical Supervision (stakeholder initial workshop)

Co-researcher - "We have a wonderful opportunity to develop what we want from supervision and make sure that no-one has that sort of experience again"

Co-researchers placed importance on the development of effective supervision and this was highlighted in an update meeting with the researcher. At the planning stage of a PDSA, the co-researchers investigated what clinical supervision needed to be if it was to become embedded within CMHT practices. Their thoughts are highlighted below in researcher field notes.

Taken from field notes, July 2018: Theme 3, Clinical Supervision

Co-researcher - "We have been thinking about why clinical supervision is important and what needs to support its implementation and needed consideration. This included; a safe space to reflect and develop as a MHP, improved staff morale, a strategy to support the process, meet Trust expectations, maintained clinical competence and reflective practice and [we need] more than one option available"

The interview data that were taken from the Stage 1 findings showed that there were disparities in the experiences of MHPs and that many lacked access to clinical supervision. These findings acted as a motivating factor for co-researchers.

Taken from field notes, August 2018: Theme 3, Clinical Supervision

Co-researcher - "It [clinical supervision] is key for all staff, it is not acceptable that it has been ignored, making these changes will change our experiences and help us all to feel valued and supported"

Co-researchers in an initial PDSA developed a template of good practice for use in clinical supervision sessions. The production of this template led to the creation of further cycles of change that built upon small changes and enabled decisions to be made based on the data that were generated. To ensure wider participation outside the group of co-researchers, feedback was given to fellow MHPs in either via email or at stakeholder workshops.

Although co-researchers were clearly committed to the process of PAR, there was a temptation to drive through the PDSA cycles of change with limited reflection and analysis of data before moving back to 'doing'. This was unsurprising considering the emotional impact that work experiences had upon MHPs who were struggling to develop in their roles.

Taken from field notes, September 2018: Theme 3, Clinical Supervision

Co-researcher - "I don't go to the supervision group and haven't had supervision for years. It doesn't seem to be important in this team - that's shocking, isn't it!"

The researcher needed to develop a skill to ensure that co-researchers understood the true significance of PAR and a pragmatic approach to service improvement and, for this to be realised, the process needed to reflect the principles that underpinned this type of approach (Taylor et al., 2013).

This reflection of method principles was critical to ensure that sustainable improvements were made. For co-researchers, this enabled appreciation of their efforts towards enhancement of well-being at work. Co-researchers at times lacked confidence to change existing documents, and it became important that the researcher should make suggestions and encourage co-researchers to liaise with others outside their work environment to seek agreement and permission to change documentation. This acted as a motivating force for co-researchers who began to see themselves as able to influence change that could come from both within and without the CMHT.

Throughout the process the researcher supported the co-researchers to appreciate that they were able to develop their ideas and introduce professional forum groups and multi-disciplinary case conferences to share practice and explore areas for development. Within these reflexive discussions, a focus remained on how to appraise critically the changes that were made, how to ensure that any change was sustainable, and how to avoid becoming unrealistic about what was being achieved.

> Taken from field notes, November 2018: Theme 3, Clinical Supervision
>
> *Co-researcher - "I am unsure but the others are always helping me to see that we can make changes and I can't believe that I am being given support to influence supervision groups - we are amazing"*

With an emphasis on both corroboration and collaboration from the wider team, the limited clinical supervision options that were available to MHPs reinforced and affirmed the aim of the theme group at the outset. These showed the changes that were required in practice and the need for interventions to develop effective clinical

supervision processes. Changes that were implemented by co-researchers were an important feature in the maintenance and development of well-being and this success reinforces the notion that MHPs are best placed to determine what works for them and this reaffirms the PAR approach adopted. Confirmation that all stakeholders had either supervisor or supervisee training also supported MHPs to ensure that they were able to make the best use of the clinical supervision opportunities that were afforded to them.

Co-researchers faced challenges in managing these changes. The narrative they used with their peers was that clinical supervision was highly valued by directors and the service manager, so the leaders had agreed that MHPs would be encouraged and supported to find their preferred options for clinical supervision. Co-researchers acknowledged the difficulties that MHPs had experienced as a team and made sure that the value of taking time for personal and professional development was made explicit. This narrative, which was used by co-researchers to involve MHPs in the changes that were made, was critical to the engagement of staff in the process.

Clinical supervision is by no means a new concept. However, the introduction of a change of process to a team under substantial pressure to meet competing demands caused some issues. The co-researchers and researcher needed to make a concerted effort to appeal to the wider team and to persuade MHPs to participate actively. At times there was a sense that MHPs struggled with the concept of ownership of change and instead would have preferred that others take control to guide the theme development. This presented the researcher with an ongoing

challenge (which was not to intervene and to keep MHPs viewpoints at the forefront) as the success of the research study was not the only goal but rather the goals included the improvement of well-being. Fulfilment of this goal necessitated the avoidance of an over-riding temptation to "act" and dictate the best way to proceed.

5:5.4 Theme 4: Staff Training and Development

The aim of developing staff and their training at the CMHT was to ensure that they were equipped with skills and knowledge to manage the challenges that they faced and to develop personally and professionally.

> Taken from field notes, June 2018: Theme 4, Staff Training and Development (stakeholder initial workshop)
>
> *Co-researcher - "I think when you are supported with training it makes you feel more valuable as a nurse and you can do a better job"*

Initial ideas were underpinned by the primary drivers of staff well-being, policies and procedures (such as the appraisal system) and personal and professional development. Co-researchers suggested at the initial workshop that in-house training that was focused on areas such as stress management and resilience training would be valuable. Co-researchers felt that processes within the team were not fit to support the development of staff and that the structure of existing personal development plans and staff appraisal systems should be revisited.

Interventions that were developed by co-researchers were in keeping with the influences that needed to be brought to bear in order to achieve the aim of the study: development of empowerment to improve well-being at work, job satisfaction,

teamwork and resilience. Co-researchers considered that the major factors that would bring success in the enhancement of well-being experiences were: improved management of workload processes, management support, and professional and personal development.

Taken from field notes, November 2018: Theme 4, Staff Training and Development

Co-researcher - "Having some training on resilience will be good. We have people that will do it and when you ask, people help, and this has surprised me"

To support the focus of their initial ideas, co-researchers determined that shared activities such as peer working and peer review alongside mindfulness and tai chi were important. This decision resonated with suggestions from other theme groups, which saw value in shared activities/support opportunities.

Taken from field notes, December 2018: Theme 4, Staff Training and Development

Co-researcher - "They (community psychiatric nurses (CPNs)) like knowing that they will work with others in the team; being CPN can be lonely and you never know if you are doing it right, we can learn from each other"

A final point to make is that co-researchers in the theme found that there were ongoing issues regarding the meeting of expectations and the needs of peers. There were clearly issues of being overly ambitious at the outset and solutions were sought, but co-researchers at times tended to become despondent. When a co-researcher announced her resignation due to promotion, other co-researchers were co-opted into the theme group in an effort to re-galvanise the working group, which then set about developing a rolling programme of in-house training.

It was interesting to note that co-researchers who opted to join this group at this stage were those who had shown the most noticeable engagement. They exhibited a sense of ownership of the study and of improvement initiatives that were deemed necessary to enhance experiences at work. However, despite concerns and challenges throughout the process, co-researchers developed valuable strategies to build personal and professional development.

5:6 Lessons learnt

Constant revisiting and reflection with co-researchers were critical to represent the PAR approach to both peers and stakeholders. This incorporation of PAR in this stage of the study, and use of PDSAs as a method of change formed a process that highlighted the interaction between all elements of the PAR approach, but importantly between the themes that had been determined in Stage 1 (Chapter Four) and the changes that were made in response. All theme groups shared a common goal (well-being) and there was a complex interplay between all elements of the changes that were made.

Of significance to the application of PAR incorporated in this AR study is that MHPs themselves have determined areas that required change based on their perceptions and experiences of well-being. This approach facilitated MHPs to take ownership of the PAR approach and the AR study by developing solutions to problems (that is, areas of concern) based on experiences. This facilitation reflected the dynamic and participatory elements within PAR (McNiff, 2017), and ensured that MHPs were actively engaged in the PAR (McNiff, 2016), which was subject to constant change.

As demonstrated in the interventions that were focused on opportunities to work together, MHPs understood and wanted to guard against feelings of isolation. Co-researchers developed a range of interventions to enhance well-being. This event makes a significant contribution to the question of how MHPs can develop strategies and interventions to improve their experiences at work. Most noticeable were the skills that MHPs wielded in order to lead and instigate changes to improve the service. Their ability to use these skills related in part to being afforded the opportunity to determine what interventions would be best to overcome the challenges that they faced, and the offer of this opportunity and the PAR approach directly impacted on well-being.

The researcher found that management of this PAR approach brought challenge. This was in part due to the specific focus of QI in healthcare and the much wider development of ideas though adoption of an AR approach (Casey, O'Leary and Coghlan, 2018). The intention at the outset had been to understand, improve and evaluate MHPs' experiences and to develop a collaborative approach with multiple stakeholders, which was in keeping with an AR approach (McNiff, 2016). However, the expectation of any QI method is not to add to theoretical or practical understanding, in this case of MHPs' well-being, but more to integrate evidence into practice (Nilsen, 2015). Marrying up these approaches (AR/PAR and QI) within the study required concerted effort throughout to guard against allowing one approach to override the other. As suggested by Casey, O'Leary and Coghlan (2018), the use of a framework QI method within AR and PAR can reduce the delay between research and practice and offers the chance to practice evaluation strategy and sustainability of changes that are made.

5:7 Summary

Question 2- How can mental health practitioners enhance well-being and strengthen teamwork, job satisfaction and resilience?

In this initial evaluation of and reflection on Stage 2 of the study, there is evidence that MHPs, acting as co-researchers, can determine strategies that they believe will enhance their well-being. As MHPs worked in theme groups that had a shared central focus, they could facilitate the development of specific interventions that met the targets of each separate theme, which had been defined in Stage 1 of the study. It was beneficial to have separate theme groups, as this arrangement ensured that the interventions that were selected were specific to the improvement of different aspects of well-being. As demonstrated in Figure 13, many changes were implemented successfully at the CMHT, and this successful achievement of the goals that MHPs set for themselves highlights that, when afforded the opportunity to influence change, MHPs are ideally placed to do so. This is an important consideration and links to the NHS framework for staff well-being (2018 and 2019), as nurturing, positive environments are those where staff are able to influence the workplace and feel valued (West, Eckert and Collins, 2017).

Co-researchers were actively engaged in the PAR process throughout and they considered it valuable to be encouraged to take ownership of initiatives and to instigate and self-determine what strategies and/or interventions would be of benefit. This is important, as MHPs have previously not engaged in and determined the course of service improvement as they did in this study. This suggests that

practitioners themselves, with unique insight into the work environment, are best placed to guide, direct and influence changes to improve well-being.

The research discovered that development of an approach to this PAR and service improvement that was underpinned by a systematic method such as the PDSA was sometimes a problem. Ensuring the use of PDSA principles required resolute effort by all involved and required revisiting the purpose of the approach and the application throughout.

Co-researchers reported a keen sense that working together had been of value. All stakeholders commented on the spirit of collaboration that was developed and this cooperative atmosphere increased self-reliance to determine what actions to take throughout this stage of the study. Figure 13 shows the range of interventions that were developed, and it is apparent from the list that changes in practice are considerable. It is noteworthy that within each theme group there were interventions and changes that resulted in peer work, sharing and support. This is an important by-product of the study in that MHPs seek to address feelings of isolation (Chapter Four, 4:5) and this warrants consideration when exploring methods to enhance well-being.

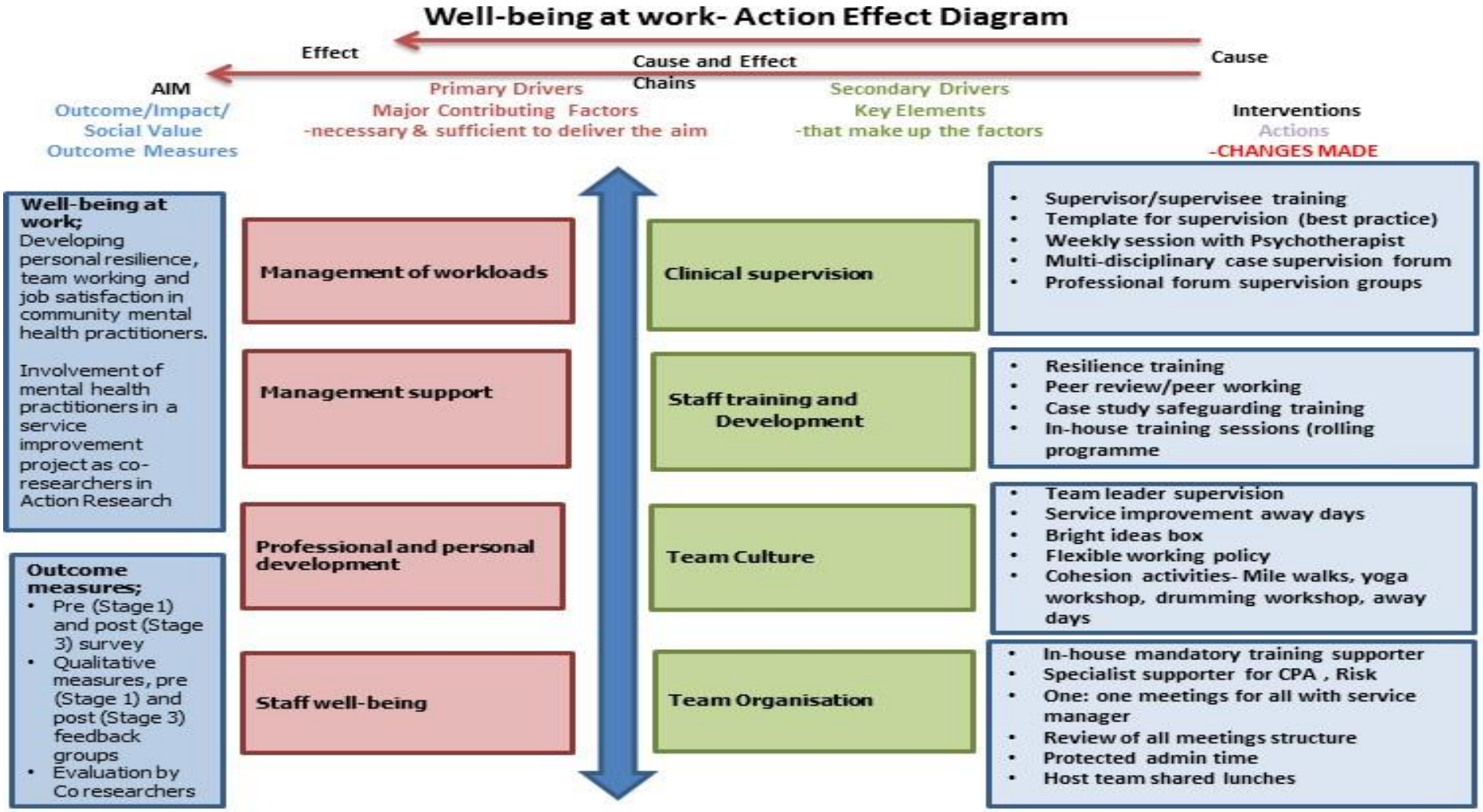


Figure 13 –Changes made at CMHT

Lastly, for the researcher there were some key learning points that were related to working with co-researchers and stakeholders throughout this stage of the study. The findings of Stage 1 (Chapter Four) suggested that MHPs felt unable to contend with conflict with peers; yet during collaborative work that involved shared goals, MHPs were more able to contend with contentious issues. Examples of this increased confidence to explore potential areas of frustration and conflict included:

- Suggesting that team leaders would benefit from team-leader supervision;
- Suggesting that the service manager should have regular one-to-one meetings with all staff;
- Giving one another feedback on progress that was being made as co-researchers in the study.

Findings from Stage 2 and the incorporation of a PAR approach, clearly suggest that MHPs, when working as co-researchers, are empowered to be able to identify, explain and lead interventions that enhance well-being and strengthen and develop teamwork, job satisfaction and resilience. The ways in which they engaged in the research process of this PAR approach and acted as co-researchers negated any need for the researcher to determine or lead this 'action' phase of the study. The application of the principles of PAR enabled co-researchers to feel empowered to act.

Factors that were deemed to have had the most impact on co-researchers in this stage of the study, following reflection and evaluation, appeared to be: an increased sense of empowerment, collaborative working and the sharing of a common goal. Sharing and learning together alongside personal and professional growth increased MHPs' feelings of pride in what they had achieved, and this negated feelings of

being isolated. Therefore, it appeared that being given an opportunity to self-determine strategies and interventions was of value to MHPs and improved their well-being.

As the PAR approach progressed, the co-researchers became more confident in their roles as co-researchers. This was evident not only in the changes that were made but in the manner in which they gathered data and involved stakeholders in feedback, review and evaluation. Initial thoughts regarding the process in its entirety were that taking time to understand fully and to appreciate MHPs' experiences in Stage 1 (January 2018-May 2018) had been critical to the study's success. There was a clear indication that affording significant time to the process of stakeholder engagement, gaining understanding of the context of the CMHT (mapping), collecting and analysing the data and subsequently ensuring that this process informed Stage 2 enabled the study to grow and evolve productively.

The work that has been described in this chapter informed the work that is explained in the next chapter, which details the evaluation of MHPs' experiences of well-being. Chapter Six addresses the question of whether involvement in leading and developing service improvement interventions to improve experiences at work enhances mental health practitioners' well-being and strengthens teamwork, job satisfaction and resilience.

Chapter Six- Evaluating Experiences and Action Interventions (Findings Stage 3)

Question 3 - Does involvement by mental health practitioners in the leadership and development of service improvement interventions to improve experiences at work enhance their well-being and strengthen their teamwork, job satisfaction and resilience?

6:1 Introduction

This chapter outlines the findings from Stage 3 of this iterative research and details the evaluation, review and reflection of the process that were conducted. As an element of this evaluative process, the survey was repeated and the findings (Stage 3) were analysed and compared against the findings from Stage 1, as detailed previously (Chapter Four). The results that are discussed in this chapter highlight MHPs' perceptions of how the influential factors that impact on their well-being at work (that is, job satisfaction, resilience and teamwork) shifted after the completion of stage 2 and the PAR approach that was incorporated in this stage of the AR study. Additional data were collected and evaluated in this final stage of data collection and analysis. This was achieved through methods that included feedback opportunity, completion of a questionnaire and group discussions amongst co–researchers and stakeholders and a repeat of the survey completed in stage 1 (Chapter Four). The purpose was ultimately to evaluate the process as a whole and to explore whether MHP involvement in the development of interventions to improve work experiences enhanced feelings of well-being among MHPs.

This chapter therefore includes the following findings.

- Quantitative comparisons of the data that were collected during Stages 1 and 3 (survey)
- Qualitative analysis of data collected during stage 3 (questionnaire)
- Stakeholder evaluation
- Evaluation of study against NHS performance data
- Validation group feedback.

The comparison of data that were collected in stages 1 and 3 of the AR study was used to explore whether there was a correlation between CMHT performances as measured by NHS Trust targets and improved well-being among MHPs. This chapter continues with examination of the limitations and challenges that were faced during the AR study 'action' phase and incorporation of a PAR approach (Chapter Five, sections 5:3 and 5:6) and plans for the AR study going forward. Finally, evaluation, review and reflections by the researcher and co-researchers are used to inform the discussion of this AR study in the concluding chapter of this thesis. The discussion contributes to the articulation of key outcomes of this AR study (stages 1-3) and considers whether the aims that were set at the outset have been achieved.

6:2 Quantitative data collection, stage 3

As stated in Chapter Four (section 4:3.2), the survey that was used in this AR study sought to understand the perceptions of MHPs toward well-being at work with specific attention on job satisfaction, teamwork and resilience. Although the survey findings were not powered to be statistically significant, as discussed previously

(section 4:3.3), the results present a clear visual account of changes in the perceptions of the factors that impact on well-being.

The findings are of importance as many of the challenges that were faced by MHPs in the initial survey remain, such as recruitment and retention concerns, and these are discussed later in this chapter. A change in the perception of MHPs toward well-being at work would suggest that the methods that were employed during this study have ameliorated the negative impact that workplace challenges may present to the well-being at work of participants.

6:2.1 Participants

Eighteen MHPs completed this final survey. This figure represents a response rate of 75%. As previously, to avoid bias, the intention was that all staff who worked at the CMHT as MHPs would complete the survey. This would have offered the 'truest' picture of staff perceptions of the key concepts in the study and would therefore have been representative of the population (McPeake, Bateson and O'Neill, 2014). The survey was sent to all 24 staff. At the time of completion, two staff members were on long-term leave, so in terms of the number of staff who were in a position to complete the survey, the actual response rate was 81% with an assumption of response from those who were not able to complete.

6:3 Data analysis of comparative survey findings, Stage 1 and Stage 3

The final survey (April 2019) showed that there had been significant changes in MHPs' responses (Tables 13-15). Unlike in Stage 1, none of the participants offered a negative (disagree/strongly disagree) response to any questions. One participant responded with a 'somewhat disagree' response to three questions that were related

to motivation, coping with stress and feeling hopeful for their future and that of the CMHT. This is an important result that brings into question the decisions that were made at the outset to omit personal data from the survey (for instance, time spent at the CMHT, role, gender and years of experience). On reflection, collection of these variables would have aided understanding of the experiences of MHPs as it would have provided more context to responses, although there would not have been sufficient data to understand differences between types of participants. Nevertheless, the survey results provided an indication that MHPs' perceptions of their well-being at work had changed in an overall positive direction during this study. For the researcher, this finding endorsed the choice of focus and the collaborative nature of the study, and the adoption of AR and incorporation of PAR (stage 2) as an approach to empower MHPs.

A full comparison of the two sets of survey results, presented as comparative graphs, is available in Appendix 7. In addition, examples are included in this discussion to highlight points that were made and to provide a visual representation of comparisons that were made.

6:3.1 Questions related to job satisfaction

Job satisfaction has been established to be inextricably linked with well-being at work and can be moderated by the level of stress (Lu, Zhao and While, 2019). Within this context and in line with the researcher's intention to empower MHPs through their actions as co-researchers, MHPs were charged with the development and initiation of changes to improve both their job satisfaction and their well-being at work. The findings suggest that this task influenced their perceptions of their work. The findings suggest that job satisfaction can be determined by the empowering

behaviours of the organisation that employs the MHPs, which can increase the MHPs' sense of control, as was observed in this study. This increased sense of control manifested itself in this study in changes in MHPs' attitudes toward the environment in which they worked. As can be seen in the findings related to job satisfaction (Table 13), there appeared to be a shift in perceptions of the factors that were likely to impact on MHPs' job satisfaction. Of particular note in these findings is the degree to which MHPs felt respected in their roles. This finding is central to understanding the importance of the morale of MHPs and the importance of staff feeling appreciated in the workplace.

Table 13 Well-being at work survey, April 2019 (job satisfaction)

	1. Strongly agree	2. Agree	3. Somewhat agree	4. Neither agree nor disagree	5. Somewhat disagree	6. Disagree	7. Strongly disagree
Autonomy **I feel able to make decisions independently and I am encouraged to do so**	**31.92%**	**53.2%**	**10.64%**	**0%**	**0%**	**0%**	**0%**
Respect **I feel that I am respected in my role**	**58.52%**	**31.92%**	**5.32%**	**0%**	**0%**	**0%**	**0%**
Relationships **I have good relationships with my colleagues and others that I have contact with**	**69.16%**	**21.28%**	**5.32%**	**0%**	**0%**	**0%**	**0%**
Environment **This is a healthy place to work**	**31.92%**	**47.88%**	**5.32%**	**10.64%**	**0%**	**0%**	**0%**
Justice **I feel that I am always treated fairly**	**37.24%**	**42.56%**	**10.64%**	**5.32%**	**0%**	**0%**	**0%**
Leadership **I am encouraged to make a contribution to developing the team as a whole**	**42.56%**	**37.24%**	**0%**	**15.96%**	**0%**	**0%**	**0%**

In accordance with a perception among staff that they could work autonomously, the phenomenon of job satisfaction accounts for important outcomes: the notion of self-governance and being respected in decision making (Dahiten, Lee and MacPhee,

2016). Findings from the survey that was undertaken in this evaluation clearly highlight a change in MHPs' judgements of their job satisfaction. This is an important factor that influences well-being. The responses that were made to the question of whether MHPs' felt respected in their roles suggested a change in perceptions compared with the previous survey findings. This comparison is shown in Figure 14. These findings reinforce the idea that positive outcomes that are related to job satisfaction result from the concept of self and a psychological sense of empowerment. In this instance, an improved sense of feeling respected reinforced the notion that working in collaboration with co-researchers had led to an increased sense of self-determination and pride, which in turn had enhanced well-being.

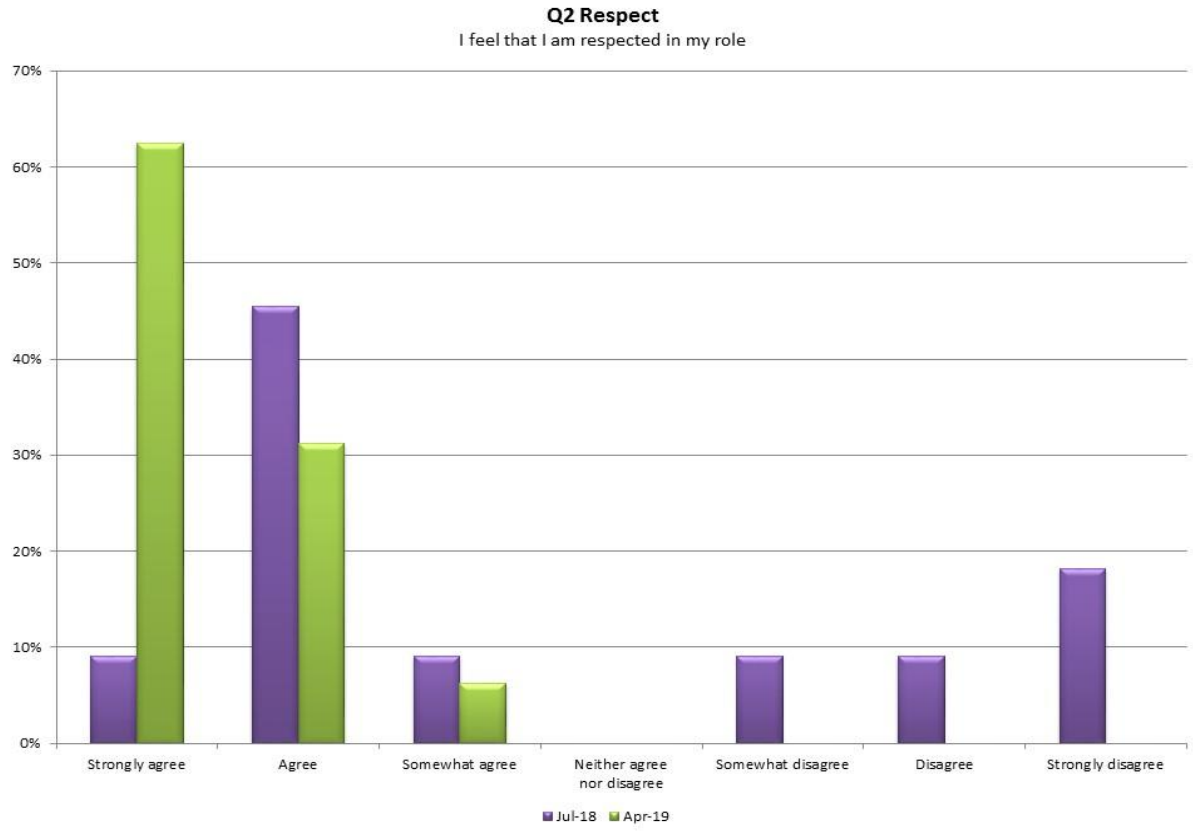


Figure 14: Feeling respected in role – comparison of survey findings stage 1 and stage 3 of the AR study

There are inconsistencies in attempts to measure job satisfaction (Lu, Zhao and While, 2019); nonetheless, it is important to understand the factors that can influence it. Fleury, Grenier and Bamvitas' 2017 study of job satisfaction among professionals in mental health teams found that the team in which MHPs worked could be an important causative factor of job satisfaction or dissatisfaction, alongside the MHPs sense of empowerment. As can be seen in Figure 15 and in line with Fleury, Genier and Bamvitas' findings, in this study there was a significant change in the perceptions of MHPs' relationships with colleagues. Similarly, Kelly et al. (2016) found that the culture of the team in which MHPs operated could moderate the impact of stress and burnout and was directly related to well-being. In this AR study, work experiences and perceptions of those experiences, such as the relationships that were shared with colleagues, were linked with an increased sense of well-being at work and directly with job satisfaction.

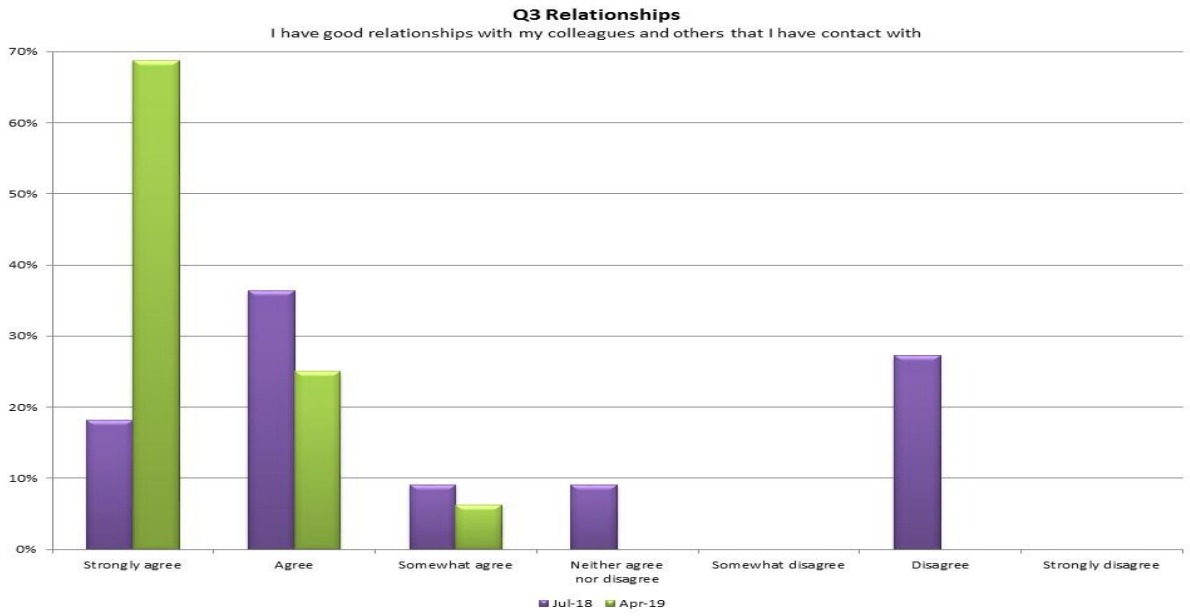


Figure 15: Changes in perceptions of relationships with colleagues- comparison of survey findings stage 1 and stage 3 of the AR study

6:3.2 Questions related to resilience

Resilience in this AR study was linked to the idea that a workforce must be equipped to meet the challenges and demands it faces if it is to improve well-being (Dow et al., 2019). Improvement of MHPs' well-being was proposed to be accomplished in this AR study by use of strategies and interventions that would be determined by MHPs themselves. As can be seen in the findings (Table 14), there is evidence that MHPs' perceptions altered during the AR study. This is notable in the responses to the question that was related directly to resilience and coping with adversity; no participants reported low resilience. This result encouraged the researcher, because findings in Stage 1 suggested that the MHPs struggled to manage well-being at work and that this had impact on the management of stress, work-life balance and motivation in their roles.

Table 14: Well-being at work survey, April 2019 (resilience)

	1. Strongly agree	2. Agree	3. Somewhat agree	4. Neither agree nor disagree	5. Somewhat disagree	6. Disagree	7. Strongly disagree
Expectations **I feel positive about my role and anticipate that I will continue to achieve my goals**	37.24%	42.56%	5.32%	10.64%	0%	0%	0%
Motivation **I feel excited by my role and I am keen to develop**	37.24%	31.92%	10.64%	10.64%	5.32%	0%	0%
Work-life balance **I am able to keep my personal and professional lives separate**	47.88%	31.92%	15.96%	0%	0%	0%	0%
Resilience **I feel that I cope well with stress and adversity at work and adapt well**	26.6%	47.88%	15.96%	5.32%	0%	0%	0%
Coping with stress **I feel that I have effective strategies to manage work stress**	26.6%	42.56%	21.28%	0%	5.32%	0%	0%

Lessening the impact of adversity at work is key to enhancing resilence in the workplace and to ameliorating outcomes that are associated with a reduced sense of well-being at work (Kim et al., 2019). When considering the negative impact of stress on MHPs, it can be suggested that the empowerment of MHPs contributes to a greater sense of being able to manage work-related experiences. It is debatable whether MHPs can ever be able to show resilience in all instances due to the unpredictable nature of their roles (Hall et al., 2016). Nonetheless, this AR study has provided evidence to suggest that resilience can be boosted by engagement in open dialogue with peers and stakeholders to determine how best to manage and develop that resilience, and that this dialogue has altered MHPs' perceptions of well-being at work and their sense that they are resilient (Figure 16).

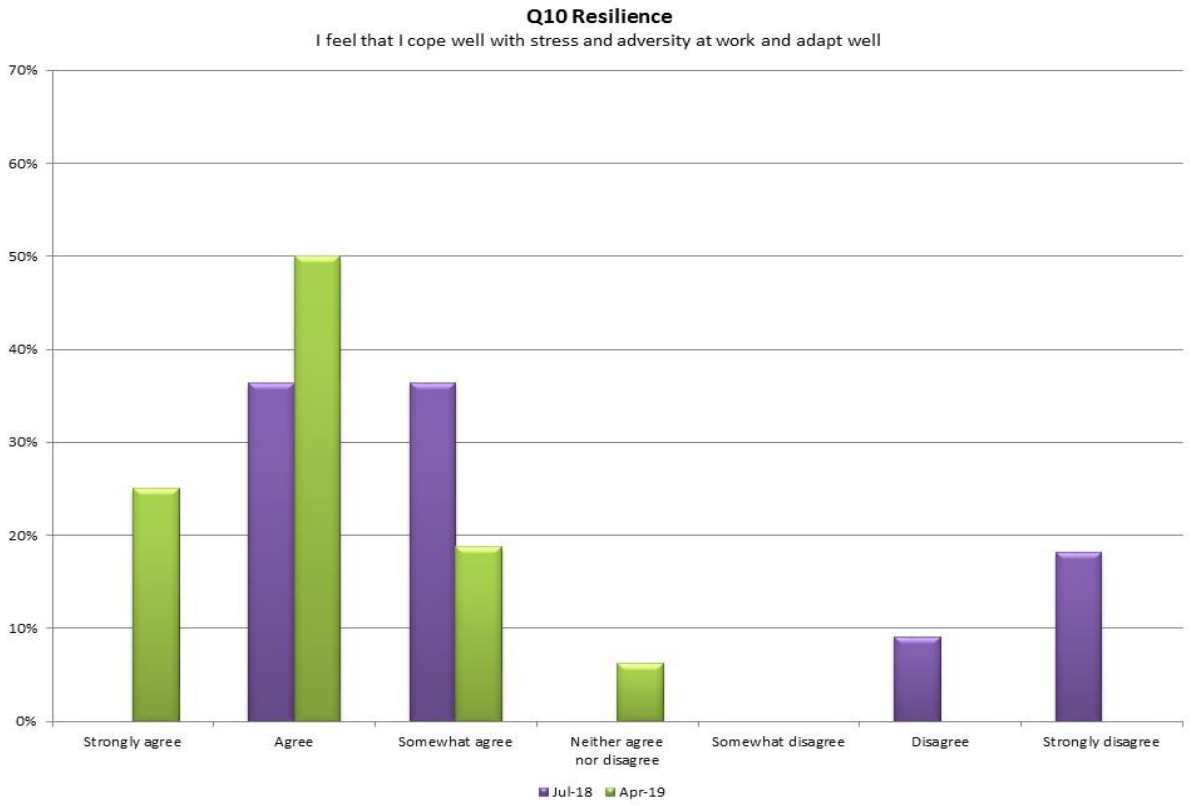


Figure 16: Changes in resilience comparison of survey findings stage 1 and stage 3 of the AR study

Retention of work-life balance can pose difficulties. MHPs in this AR study suggested through their answers to the survey that was conducted in Stage 1 (Chapter Four, section 4:3.3.2) that work experiences and worries about work encroached into their personal lives. The survey findings in Stage 3 suggested (Figure 17) that there had been a positive change in MHPs' perceptions that they could keep their work and personal lives separate, and that this finding was directly linked to their levels of resilience.

As suggested by Ott-Holland, Sheperd and Ryan. (2019), work-life balance is an important factor in the determination of well-being and, critically, in a staff member's intention to stay within a post. Therefore this finding is important to this CMHT, which has poor retention of staff. Survey findings suggested that MHPs were managing and coping better with stress and workload after the intervention, and that this, in turn, had led to improved well-being. This suggested that these MHPs were better placed after the AR study to manage adversity at work. This result was correlated with the MHPs' ability to self-determine the strategies to be employed to improve work experiences through their actions as active participants throughout the study and this sense of self-determination was linked with increased resilience. It therefore appeared that, having been empowered to improve their work-life balance, MHPs' well-being at work was improved.

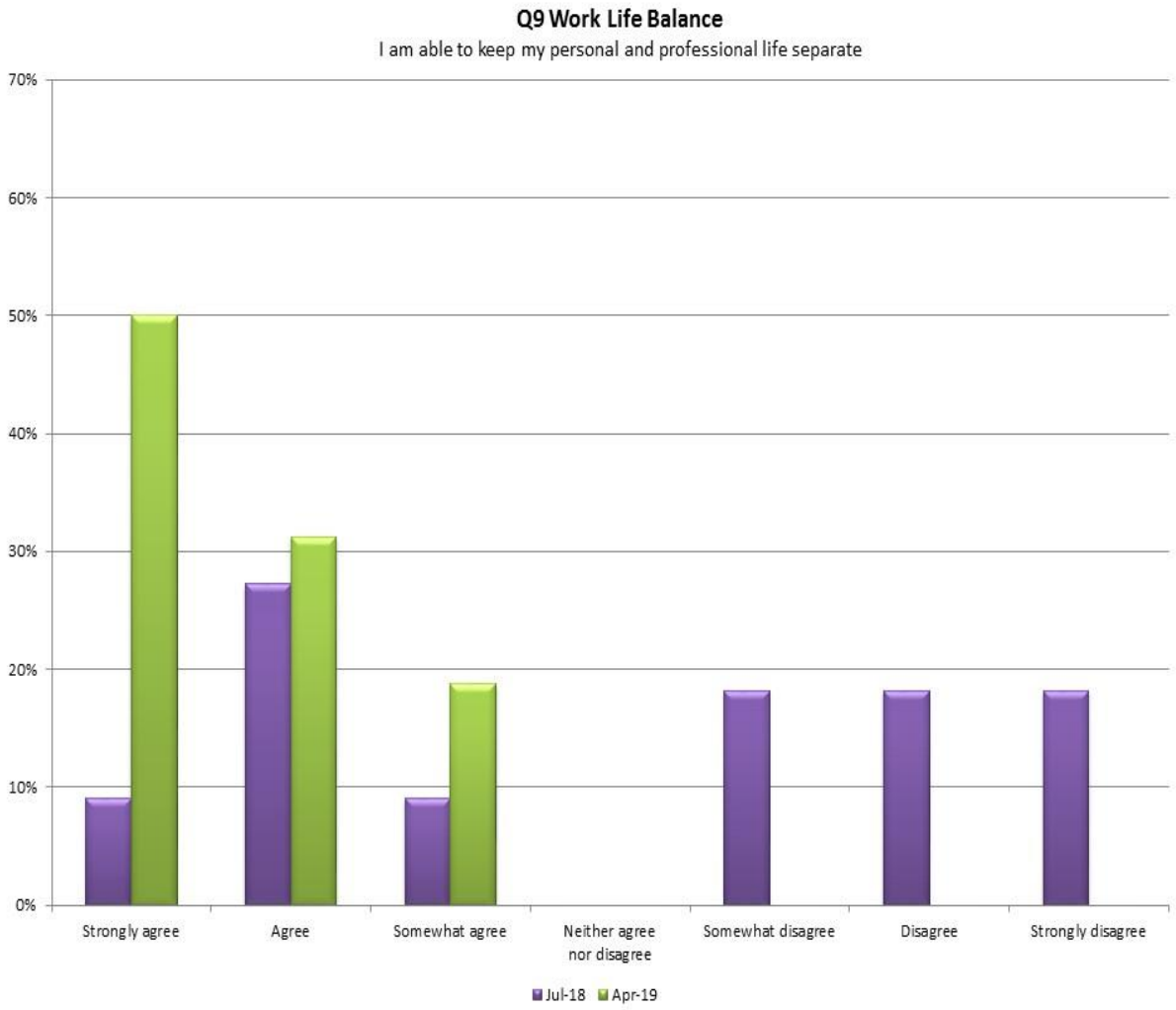


Figure 17: Work-life balance - comparison of survey findings stage 1 and stage 3 of the AR study

6:3.3 Questions related to teamwork

Teamwork is essential to ensure that MHPs can meet expectations that are placed on the team and can overcome challenges that they may face (Fleury et al., 2018). Use of a collaborative approach to inquiry can foster co-operation and have an impact on communication and relationships with peers and this change in turn can engender changes in the perceptions of MHPs toward working in the CMHT. As can be seen in the findings (Table 15), there is evidence that MHPs' viewpoints have altered as a consequence of their participation in this AR(PAR) study. Evident in the

findings is a change from the start of the study in respondents' perceptions of teamwork and in their levels of optimism; this result is reflected in answers to questions about reciprocal caring and reciprocated sharing of ideas within the CMHT.

Table 15: Well-being at work survey, April 2019 (teamwork)

	1. Strongly agree	2. Agree	3. Somewhat agree	4. Neither agree nor disagree	5. Somewhat disagree	6. Disagree	7. Strongly disagree
Working with others **I enjoy working in my team and feel very supported**	47.88%	37.24%	10.64%	0%	0%	0%	0%
Communication **As a team member I am kept up to date and always know what is happening**	**26.6%**	**42.56%**	**15.96%**	**5.32%**	**5.32%**	**0%**	**0%**
Optimism **I feel very positive about my work**	**42.56%**	**31.92%**	**10.64%**	**10.64%**	**0%**	**0%**	**0%**
Caring **I have concern and empathy for my colleagues**	**58.52%**	**31.92%**	**5.32%**	**0%**	**0%**	**0%**	**0%**
Caring **My colleagues have concern and empathy for me**	**58.52%**	**21.28%**	**10.64%**	**5.32%**	**0%**	**0%**	**0%**
Sharing **I share my ideas and concerns with colleagues**	**42.56%**	**47.88%**	**5.32%**	**0%**	**0%**	**0%**	**0%**
Sharing **My colleagues share ideas and concerns with me**	**42.56%**	**37.24%**	**15.96%**	**0%**	**0%**	**0%**	**0%**
Hopefulness **When I think about my team, I feel excited; I know we are successful and have great promise for the future**	**37.24%**	**37.24%**	**5.32%**	**15.96%**	**0%**	**0%**	**0%**
Hopefulness **When I think about my job, I feel excited; I feel that I am successful at what I do and know that I have promise for the future**	**37.24%**	**31.92%**	**15.96%**	**5.32%**	**5.32%**	**0%**	**0%**

The survey findings from Stage 1 caused great concern because they showed that MHPs sensed that the concern and empathy that they felt for their colleagues was not reciprocated. As can be seen in Figure 18, the Stage 3 survey findings suggested a shift in this perception. This result was significant for this AR study, since one aim at the outset was to improve teamwork. A sense of belonging to the team has been shown in other studies to correlate with outcomes of improved care (Fleury et al., 2018), improved decision-making and a consensus of approach (Arnold, 2017). The results of this AR study support these previous findings.

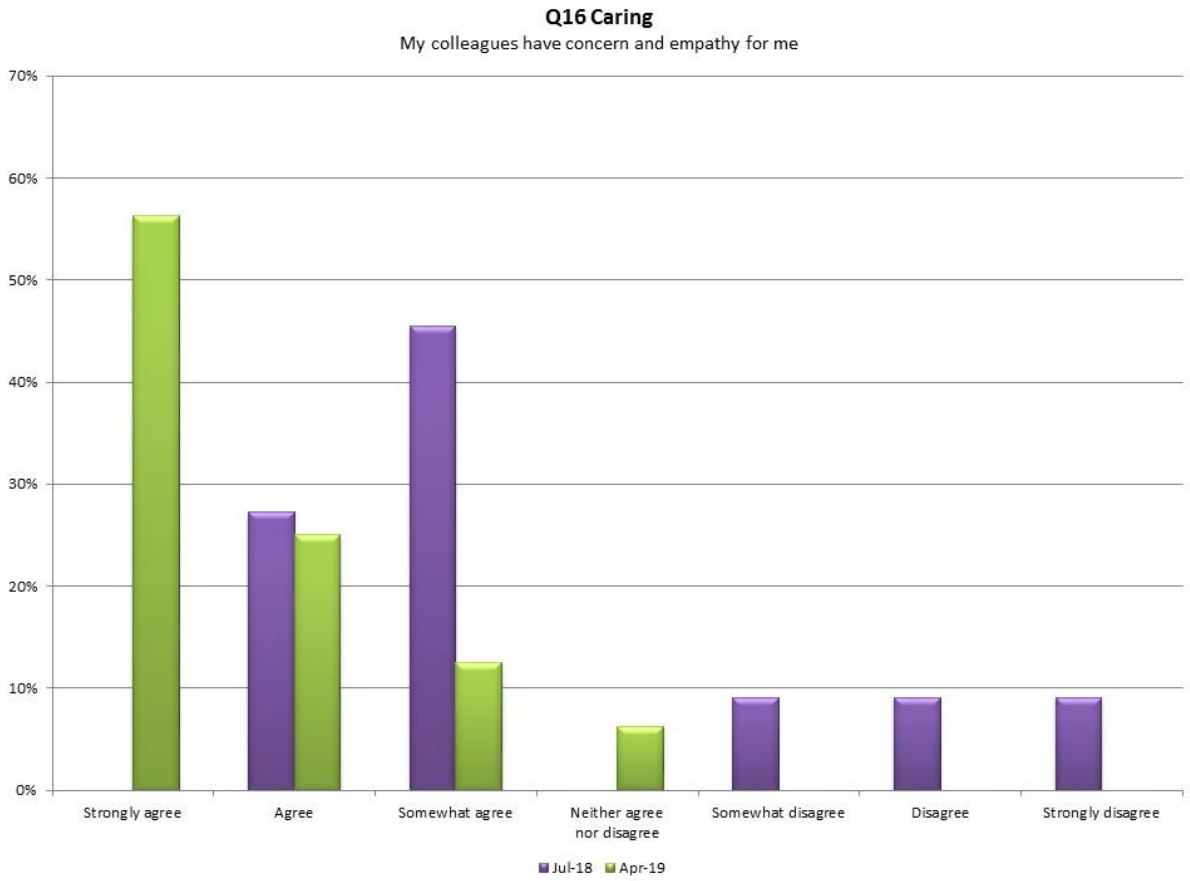


Figure 18: Colleagues' concern for each other - findings stage 1 and stage 3 of the AR study

The climate within a team can be linked explicitly to well-being. Although there is acknowledgement that there are gaps in understanding of teamwork (Rosen et al.,

2018), it is understood that personal and professional activities can influence both teamwork and the performance of teams (Welp and Manser, 2016; Welp et al., 2018). Involvement in this AR study to determine what would enhance well-being fostered a greater sense of membership of a cohesive team. This in turn influenced perceptions of teamwork and importantly the enjoyment and support that MHPs experienced in this study (Figure 19).

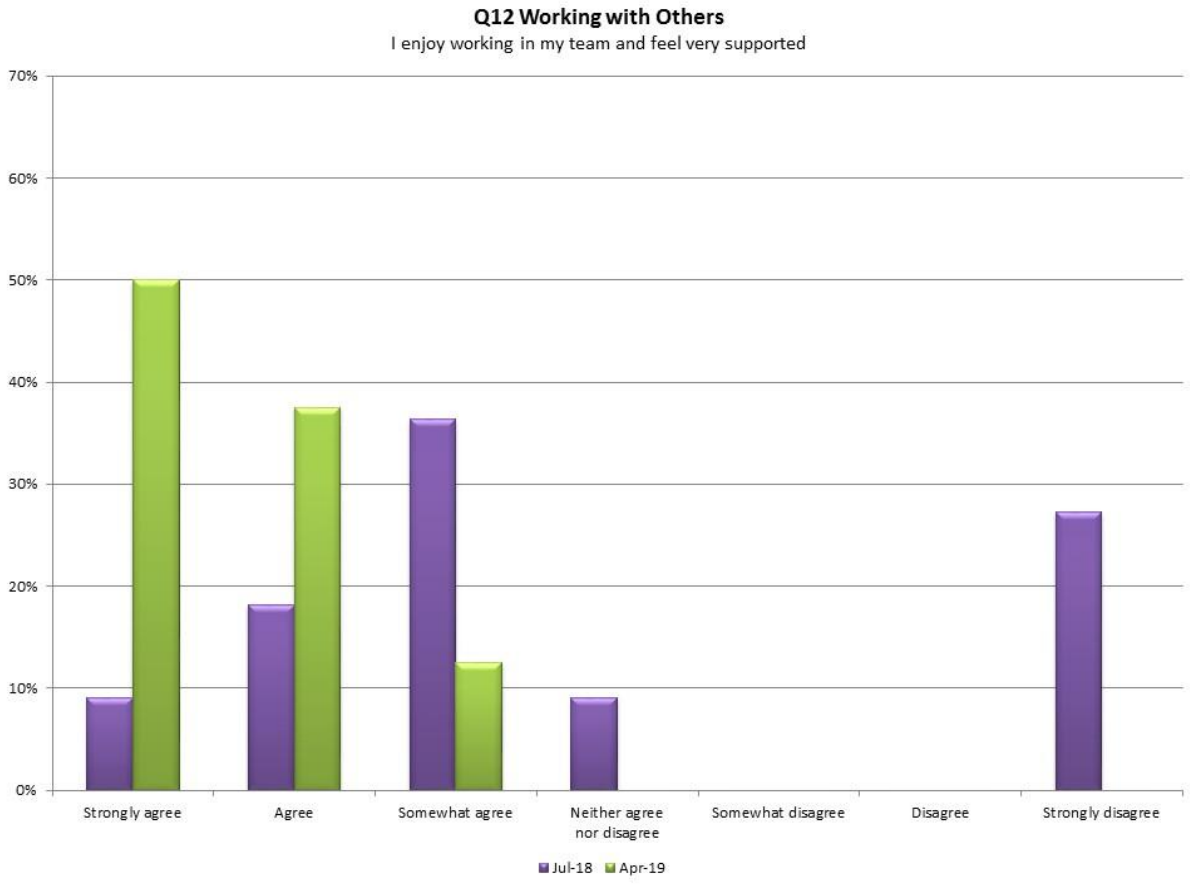


Figure 19: Changes in enjoyment of working with others- comparison of survey findings stage 1 and stage 3 of the AR study

It can be argued that the AR approach that was used influenced MHPs' perceptions of well-being at work. Incorporating a PAR approach in the AR study to make changes ensured that MHPs were empowered to determine tailored strategies to enhance their well-being at work and this altered in a positive way their perception of the factors that influenced their experiences at work. Therefore, the scope to improve MHPs' perceptions of work-related experiences was influenced by the employment of the chosen method. The survey findings aligned with the theoretical position of the researcher, as they echoed the notion that MHPs themselves were best placed to determine what would enhance their well-being at work. This was of great importance and validated the value of the AR study for participants.

6:4 Qualitative findings

Qualitative evaluation was an integral part of ensuring that the AR study was evaluated in line with how changes were constituted. This process included a critical self-review by those who were engaged in the research. This considered and pragmatic approach to evaluation and reflection aligned this study to the principles of AR. The context of this evaluation was to review the process of change and the significance that was placed on this AR study by co-researchers and stakeholders. Use of a pragmatic approach enabled consideration of outcomes and whether the findings were representative of MHPs' experiences

To complement the quantitative findings, qualitative evaluation included stakeholder feedback and exploration of chosen interventions. Crucially, this included co-researcher evaluations and reflections on their involvement and engagement in the

AR (and PAR cycle) and the AR journey itself. This is explored in greater detail in the final chapter of this thesis.

6:4.1 Stakeholder evaluation

To strengthen the evaluation by stakeholders of this study, all key stakeholders, that is co-researchers and those from the wider CMHT, were invited to attend a CMHT 'away-day' to focus on the evaluation of the AR study and to build on its success going forward. The discussion that was held at this away-day informed the evaluative, reflexive process. This was important for the researcher as it afforded an opportunity to discover whether ambitions that were set for the AR study at the outset had been realised; it was important for MHPs as it would highlight the true value of a collaborative approach to the mitigation of challenges and to the fostering of empowerment. To foster a participatory nature, and in keeping with an emphasis throughout the study on collaboration, all stakeholders participated in and contributed to the evaluation.

6:4.2 Data collection

To ensure the exact nature of participation and transparency at this point, co-researchers and the researcher reflected on the positivity that they felt towards the changes that had been made and their eagerness that, likewise, the CMHT away-day (evaluation event) would engender positive feedback from peers to support this viewpoint. To guard against any undue influence that they might have on the stakeholders' voiced opinions, that is, if stakeholders perceived an expectation of positive feedback and therefore felt unable to express negative opinions, a separate

area outside the evaluation event was used to ensure that all stakeholders could offer feedback that was based solely on their own interpretations and experiences.

To engage in this means of gathering evaluative comment, MHPs and co-researchers were challenged to consider thoughts and words that they associated with their experiences of well-being at work, job satisfaction, teamwork and resilience. This method of having a space outside the evaluation event to post comments ensured total anonymity of the commentators and acceptance that contributing was optional. This acceptance that feedback from stakeholders based on their experiences could not be shared by the researcher or her co-researchers placed importance on the uniqueness of MHPs' experiences and on an acceptance that there were many truths from different perspectives. Feedback from all stakeholders was positive and is shown below in Table 16.

Table 16: Stakeholder feedback

When I think about my well-being at work, I feel….
Words include: *Better, Good, Reassured, Valued* ***Feelings include:*** *Happy, Resilient, Content, Proud, Optimistic* ***Comments include:*** *I am so much clearer about what I do* *I am learning about the team and myself* *We should be proud we helped each other*
When I think about my job satisfaction, I feel…..
Words include: *Great, OK, Good, Learning* ***Feelings include:*** *Grateful, Proud, Love it, Liking it, Hopeful* ***Comments include:*** *Specific to my role and it is satisfying* *Learning the ropes and have no complaints* *Satisfactory when I see improvements in patients*

When I think about teamwork, I feel…..
Words include: *Very satisfying, Improved, Positive vibe, Organised* ***Feelings include:*** *Supported, Cared for, Happy, Enjoyment* ***Comments include:*** *I enjoy seeing my colleagues* *It is sharing and caring* *It is effective and professional*
When I think about being resilient at work, I feel…..
Words include: *Very, Bit, Varies, Pretty good* ***Feelings include:*** *Positive, Purposeful, Growing, Strong* ***Comments include:*** *I have proved I am resilient* *Feel resilient and I am stronger as a nurse* *I feel strong and determined to improve*

To supplement these observations, stakeholders completed a simple, anonymous questionnaire to feedback on the progress that they considered had been made during the 'action' phase of the study (Stage 2, Chapter Five, Figure 12). This questionnaire was a core component of this evaluation and reflection.

This simple questionnaire collected data from MHPs on the concepts of well-being, job satisfaction, teamwork and resilience. The significance of the answers that were provided to the questionnaire was that they enabled the exploration and evaluation of an AR position of intention to make changes and to interact with what was being researched and to evaluate the process. This participatory method of evaluation therefore put stakeholders and co-researchers at the centre of the process to highlight an ongoing commitment to collaboration and empowerment. The questionnaire yielded data that, when analysed, supported the researcher's belief that the AR study had impacted on MHPs' well-being.

6:4.3 Questionnaire data analysis

Data analysis of the questionnaires was undertaken initially with co-researchers and then by the researcher alone to ensure that all data had been scrutinised. At the outset of the data analysis, an important element was the reconsideration and conceptualisation of what well-being was for MHPs; that is, well-being was subjective, determined by many influential factors and, in this AR study, linked to job satisfaction, being in a supportive team and being able to manage adversity at work. This process supported formative understanding of knowledge of the effectiveness of the study from both a co-researcher and service perspective.

6:4.3.1 Well-being

Qualitative feedback from MHP stakeholders and co-researchers at the evaluation event suggests that MHPs regard well-being as connected with a sense of managing difficulties at work and working in a supportive team. This is shown in quotes that are taken from the questionnaires and shown below.

> *"Again this (the CMHT) is growing in strength and the team is learning how to be effective and this enhances the well-being in the team" (Male healthcare assistant; at CMHT for 5+ years)*

Although quotes highlighted that well-being had been enhanced and that stakeholders had felt a genuine engagement in this AR study, for the researcher there was awareness of the need to continue efforts to safeguard the well-being of MHPs going forward.

> "*So far so good, hoping that I don't burnout too fast" (Female Community Psychiatric Nurse; at CMHT for fewer than 12 months)*

Working in the NHS does not come without challenge and fast-paced change can directly link to burnout and stress. This underlines the importance of engaging staff in the management of and contributions to their well-being.

> *"I enjoy our away days despite my initial scepticism, it has been a difficult period but this has got better" (Female Community Psychiatric Nurse; at CMHT for 5+ years)*

These findings link to the perception that well-being means that the person is coping and being positive. This is important during management by MHPs of the competing demands that they face in the workplace (Cruz, 2017; Cruz et al., 2018). The increased sense of optimism and hope is an important factor as this can be linked with predicting staff attitudes and behaviours (Malinowski and Lim, 2015).

> *"I think it is being together and sharing, it has been really tough here last few years, but this is better" (Female Community Psychiatric Nurse; at CMHT for 3+ years)*

Although there are gaps in the understanding of how MHPs can promote well-being at work, there is a persuasive argument that involvement of MHPs in the self-determination of strategies that develop and strengthen well-being while they foster optimism and hope are directly correlated with positive experiences at work.

6:4.3.2 Job satisfaction

Job satisfaction can act as a determining factor in the development of a sense of well-being. In this AR study, the environment in which MHPs worked was found to directly correspond with job satisfaction.

"It is about being in it and enjoying it, and we need to get along" (Male Healthcare assistant; at CMHT for 5+ years)

Of relevance to this AR study was an understanding that low levels of job satisfaction could impact negatively on retention of staff, as this was of concern at the CMHT. The findings of this study indicate that an ability to pre-determine and initiate change can ameliorate low levels of job satisfaction, as evidenced in this quote below.

"Job satisfaction is pivotal to team development and achievement, I am satisfied in my current role" (Male Community Psychiatric Nurse; at CMHT 5+ years)

It could be argued that active engagement in the research process had fostered MHPs' sense of positivity both of self and within the team. Findings suggested and confirmed that the MHPs' job satisfaction was directly linked to the team in which they worked, the CMHT.

"I enjoy most days and feel we are making a difference - we need to have goals that are achievable" (Female Community Psychiatric Nurse; at CMHT 3 years)

Initial impressions when reading through participants' responses led to a feeling of satisfaction that outcomes and evaluations were positive. However, to be critically reflective as a researcher required greater scrutiny in order to explore nuances in comments that were made and to uncover further meaning. As shown in the quote below, job satisfaction needs to be considered not in isolation as part of this AR study but broadly as an ongoing concern.

"It is being appreciated and having positive feedback and we need to develop this even more" (Male Community Psychiatric Nurse; at CMHT for 4 years)

There was a clear indication that job satisfaction had been strengthened but that this was by no means guaranteed. Therefore, in line with the AR intention at the outset, it was necessary that MHPs' perceptions of job satisfaction and well-being were influenced by their opportunities to develop interventions and promote change from within the CMHT. As alluded to in the quote below, there was a suggestion that MHPs' empowerment to make changes could be at odds with past experiences of service improvements.

> *"We should be allowed to continue and decide what we think will work" (Male Healthcare assistant; at CMHT for 5+years)*

In line with the researcher's theoretical and philosophical positioning at the outset, continuation of the changes that had been made alongside opportunities for personal and professional development of MHPs was essential and this was of importance to ensure an ongoing commitment to the maintenance of well-being at the CMHT.

6:4.3.3 Teamwork

This AR study sought to improve the experiences of MHPs within a team. As suggested previously, adoption of a culture of empowerment and innovation can directly impact on both job satisfaction and perceptions of teamwork (Fleury, Grenier and Bamvita, 2017; Fleury et al., 2018). It is interesting that stakeholders made connections between the fostering of good relationships within the team and good communication.

> *"Very apparent strong cohesive team spirit which is continuing to grow - to develop we should continue to listen to each other and explore new ideas" (Male Healthcare Professional; at CMHT for 5+ years)*

There are gaps in the theoretical understanding of what constitutes teamwork and effective teamwork (Rosen et al., 2018). In this AR study, a more pragmatic approach to the understanding of what makes teamwork effective was explored. This emphasis on effective teamwork to strengthen MHPs' experiences was critical to ensuring a shared commitment towards making changes and an understanding that as the team evolved this enhanced well-being.

> *"The team is improving - we need to continue having away days" (Male Mental Healthcare Professional; at CMHT 1 year)*

> *"People get on generally quite well, supporting each other. I feel appreciated but most of all I feel proud of what we have done" (Male Community Psychiatric Nurse; at CMHT less than 1 year)*

The findings suggested that MHPs had the perception that team cohesiveness had improved. MHPs indicated that significant changes had been made in the team and that this should continue. This is interesting as, although the comments reinforced the value of the AR study, they suggested that there was some subtle fear that the recent changes in teamwork might not be sustainable going forward.

> "*We need this positivity to continue; there should be no end pint to this, we are not usually encouraged to do things together" (Female Healthcare assistant; at CMHT for 5+ years)*

This concern can be linked to previous experiences of service improvement and factors that negatively impact on well-being. For MHPs in this AR study and for the wider CMHT there needed to be assurances that they would continue to be supported to self-determine strategies that improved their experiences at work, and

this required consideration with all stakeholders. For the researcher, this was not just about completing research but also about a commitment to MHPs at the CMHT.

6:4.3.4 Resilience

Responses suggested that the empowerment of MHPs to self-determine strategies that were designed to build resilience reinforced the promotion of the contribution that could be made by MHPs to improve experiences at work. Engagement with stakeholders and peers enabled co-researchers to explore what well-being was for them and to build strategies that enhanced MHPs' perceptions of resilience.

It has been stated that resilience as a concept is poorly articulated (Wild, Wiles and Allen, 2013), but there is acceptance that building resilience can influence both the well-being and the mental health of MHPs (Robertson et al., 2015). MHPs can shape resilience but need opportunities to do so, as were offered to them in this study.

As has been demonstrated, MHPs suggested that factors such as being in a supportive team and recognising when individuals needed help was influential and these factors were dependent on seeking and giving support to colleagues.

> *"Resilience is dependent on many factors and ensuring work-life balance is key - to develop, we need to recognise when individuals need assistance" (Male Community Psychiatric Nurse; at CMHT for 2 years)*

It is evident that the MHPs' reports of feeling more able to have control over work experiences and building and sustaining relationships with colleagues formed an element of enhancement of emotional intelligence and establishment of a work-life balance. As with previous quotes, in the example below there is emphasis on the

importance of continuing with developments within the team and capitalising on achievements that have been made.

> *"Resilience is a well-supported, happy team that builds on individual resilience - we need to continue to improve" (Female Community Psychiatric Nurse; at CMHT for 3 years)*

The qualitative data that were collected and analysed suggested that there had been a significant change in MHPs' experiences of well-being at work. Active engagement in the changes that had been made at the CMHT was a significant factor in this sense of improvement of work experiences. The chosen research method of ~~study~~ AR has been vindicated, since the feedback suggests that adoption of the chosen methods ensured an active engagement of MHPs to improve their work experiences. This is an important consideration for researchers who wish to perform research within practice settings and to seek to understand the experiences of MHPs. Encouragement and engagement of those who are best placed to understand and improve their experiences may be the most appropriate way to achieve greater understanding of well-being of MHPs.

6:5 Evaluation of the study against (NHS) Trust performance targets

As discussed in the mapping exercise and stakeholder engagement in Stage 1 of the study (Chapter Four), it was evident that the MHPs at the CMHT struggled to meet the demands and expectations that they faced. It was also evident that the team itself was fractured following significant changes in structure (Chapter One, section 1:2) and because of ongoing issues with recruitment and retention (Chapter Four, section 4:2). This was coupled with the highlighting by MHPs of significant issues that impacted on their well-being; these issues were process driven (difficulty

navigating workload and organisational demands) and relational (relationships with colleagues, no access to clinical supervision). The appraisal that is offered here aims to draw attention to key components that provide an overview of the AR study and the reflections of the researcher when the findings from the data collection and analysis of perceptions and experiences of MHPs are compared with NHS performance targets.

The availability of data that were routinely gathered (that is, NHS Trust performance targets, which are collected to monitor outcomes) provided an opportunity to evaluate the AR study. To do this, stage 3 data was compared to data collected in stage 1 to highlight areas of improvement. Trust performance measures and indicators that are shown in Table 17 indicate that changes occurred in the overall performance of the team. The premise for inclusion of this data at this stage was that it could indicate effective team working and could be correlated with improved feelings of well-being at work. To highlight this point, it was evident that the level of patient health need had increased during the study period, yet when this was contrasted with evaluation by MHPs (Stage 3), there was no apparent impact on well-being. This was important because this connection to improved well-being suggested that the factors that impacted on MHPs' experiences at work had not changed, but that MHPs' perceptions of their work had. This example highlights the importance of empowerment because MHPs had a perception of being able to manage difficulties and challenges that they faced.

As previously discussed (Chapter One), MHPs work in environments that are directly linked with staff stress and burnout and hence, there are issues with a high level of staff turnover (Johnson et al., 2018). The performance indicators that were available

at this end point of the study showed that there continued to be a high staff turnover at the CMHT. This highlighted that high staff turnover did not temper the enthusiasm of MHPs to engage in the AR study as commitment was evident among the MHPs of long standing and among new staff, who were encouraged to be involved and who actively engaged in the AR study (Table 17, comments).

The performance indicator of staff appraisals showed that there had been a substantial shift from 0% of staff receiving an appraisal to more than 80% of staff having an appraisal at the end of the AR period. While this performance data is impressive, if taken in isolation it is a completed task (a target met) with no apparent attitudinal change, which is important if the culture of the team is to improve. Therefore, it is significant to note that this performance task was underpinned by a shift in the position of the service manager in supporting staff. This highlights the collaborative nature of the AR study.

The service manager took a keen interest in the AR as it developed and was shown to be linked to developments that were made to influence well-being (Chapter Five). The service manager instigated a one-to-one meeting with each staff member. The resulting change in the behaviour of the service manager to support staff in this way denotes an important element in understanding the role that leaders can play in well-being. Previous to the AR study, MHPs believed that they were not always supported in their roles (Chapter Four, sections 4:3 and 4:4). This is important as the empowerment of MHPs to self-determine how to develop their well-being had directly encouraged the service manager to embrace opportunities to meet MHPs' needs.

Another finding was linked with improved support within the CMHT. Clinical supervision is an essential component of safe and proficient practice and, as

highlighted by MHPs (Chapter Four, section 4:4.2.5), is directly linked to a sense of well-being. As indicated in the data that were collected at the start of the study and which are shown in Table 17, few MHPs received any supervision when the study began and there was no clinical supervision recorded. As the AR progressed, access to clinical supervision was improved and maintained and as the data show, six months after the end of the AR study (November 2019), 94.1% of MHPs were receiving clinical supervision. These data reinforce the findings that were discussed in the stakeholder data analysis.

Finally, although not directly linked to the intention of the AR study at the outset, performance data can be explored to make explicit links between MHPs' abilities to cope with adversity and the difficulties they face in practice. Despite evidence of some clear changes in performance, there is also evidence that in some areas (retention) cause for concern remains when compared with other areas within the NHS Trust. However, it would be incorrect to make direct correlations between performance indicators and the quality of functioning of teams. As highlighted below in the feedback that was received from the validation group, improvement of MHPs' well-being can ameliorate the impacts of stress and improve a sense of working towards shared goals but this can be at odds with what the organisation itself values.

6:6 Validation group feedback

To ensure the validity of the AR, the final evaluation with the validation group provided a critical view of the AR and service improvements that had been made. Meeting with the validation group provided an opportunity to explore and discuss the AR methods that had been used and to revisit the use of QI methods used in the organisation. The purpose of this final validation meeting was to ensure credibility

(critical friends), transferability (data collection and analysis), and dependability (peer validation) of the AR (McNiff, 2017). The validation group was able to confirm findings and decisions that had been made and compare the results with their own experiences within the context of being a group of MHPs in a CMHT.

Validation group final feedback, May 2020

> *Co-producing as a team like you have all done and having a shared idea for change for the better is key. Promoting teamwork to develop and improve the workplace is essential in all CMHTs but is lacking. The 'blame culture' is something we all fear and often staff are terrified of a lack of support. All staff would benefit from training to help with everyday practice. They are not taught how to be mental health professionals. The CMHT can relate to the evidence early on as a CMHT can be a stormy place to work with understaffing and sickness and more pressure than ever. Involving staff to work out what works for them is better than the usual approach to QI, which staff tend to avoid. This approach [an AR project] is likely to take more time, and this would need consideration before starting out on a project which takes time to complete.*

6:7 Future plans

All stakeholders as part of the evaluation of the AR study were encouraged to consider how to continue to capitalise on both the focus of the AR (well-being) and the strategies that had been determined in Stage 2 (Chapter Five, Figure 12). This would help to evolve the AR study and to sustain the positive outcomes that had been reported regarding well-being at work. To conclude the evaluation event, all stakeholders were involved in small discussion groups to explore future options for the CMHT. Co-researchers acted as facilitators in discussion groups and this guarded against espousal of their opinions on how best to proceed. This level of discernment ensured that all stakeholders' opinions were treated equally and confirmed commitment to the values of this study: collaboration and democracy.

Table 17- Trust performance targets

Data March 2018-March 2019

Mental health 7-day follow up; Trust target 95%

APR 18	MAY 18	JUN 18	JULY 18	AUG 18	SEPT 18	OCT 18	NOV 18	DEC 18	JAN 19	FEB 19	MAR 19
100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**88%**	**100%**	**100%**

Mental health: acute occupancy rate (red = high, more than 85%) – Trust-wide data comparison

APR 18	MAY 18	JUN 18	JULY 18	AUG 18	SEPT 18	OCT 18	NOV 18	DEC 18	JAN 19	FEB 19	MAR 19
94%	**132%**	**140%**	**127%**	**123%**	**173%**	**122%**	**126%**	**131%**	**126%**	**133%**	**91%**

Staff turnover rate (red = high, more than 15.2%) – Trust-wide data comparison

APR 18	MAY 18	JUN 18	JULY 18	AUG 18	SEPT 18	OCT 18	NOV 18	DEC 18	JAN 19	FEB 19	MAR 19
22.3%	**22.4%**	**22.4%**	**19.4%**	**21.1%**	**15.2%**	**15.3%**	**15.2%**	**15.2**	**13.2%**	**13.2%**	**20.7%**

Staff appraisals (red = low, less than 90%) – Trust-wide comparison

APR 18	MAY 18	JUN 18	JULY 18	AUG 18	SEPT 18	OCT 18	NOV 18	DEC 18	JAN 19	FEB 19	MAR 19
0%	**0%**	**58%**	**82%**	**93%**	**92%**	**81%**	**81%**	**79%**	**93%**	**90%**	**79%**

Comment

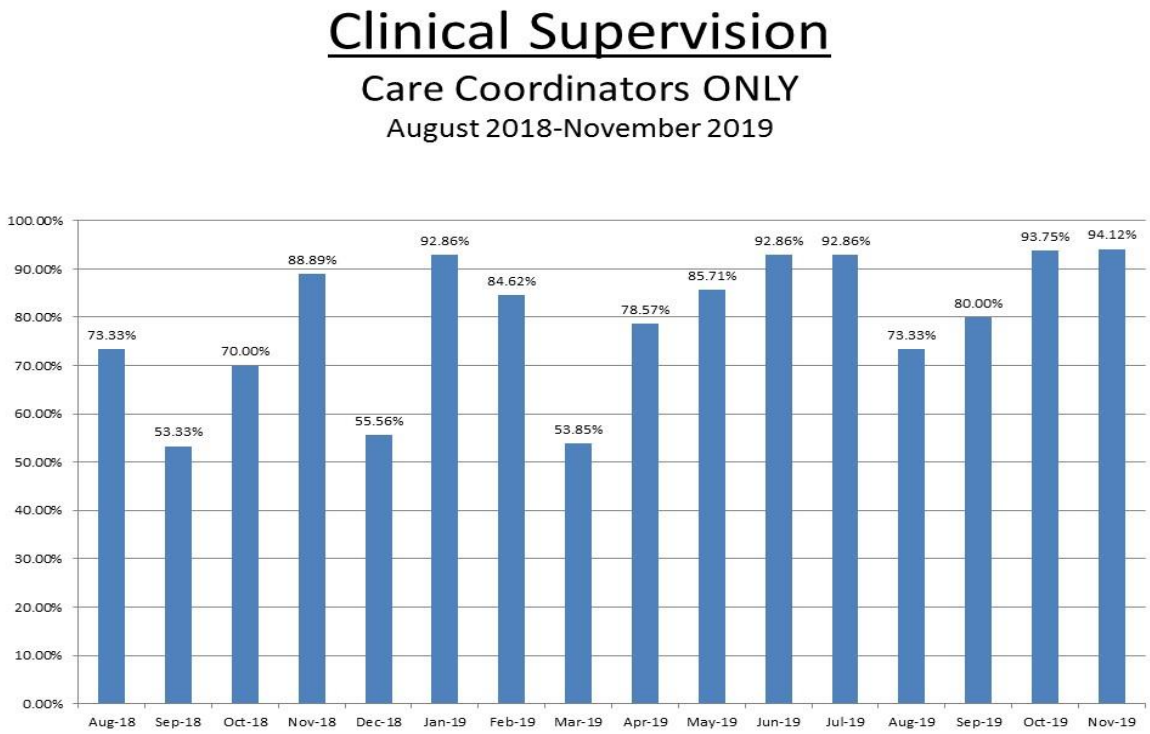
Evidence that CMHT is meeting target and exceeding NHS Trust target

This is indicative of the high level of health needs amongst the CMHT caseload and following mapping exercise (Chapter Four) there are significantly increased levels of acute need. This results in greater complexity of care packages and demands on MHPs. Despite these issues, data (Chapter Six) suggest greater well-being amongst MHPs.

Highlighted area of concern retaining staff which can be linked to organisational and service changes as discussed in Chapter Two. This highlights greater turnover which is interesting as the enthusiasm for being actively engaged in the study did not wane as new staff were encouraged by peers to become involved.

These data highlight that CMHT MHPs are largely receiving an appraisal. The data analysis (Chapter Four) suggests that MHPs value opportunities to have one-to-one meetings with a professional development focus

Complaints received from service users, families and carers
April 2018 to Sept 2018 - 8 complaints
Oct 2018 to March 2019 - 7 complaints
April 2019 to Sept 2019 - 1 complaint



During 2017 and 2018 until August, the average % for managerial supervision was 28% and 0% for clinical supervision. MHPs placed clinical supervision low on their list of priorities as they did not feel any benefit from the existing format.
As is evident from this graph, availability of and access to clinical supervision increased from August 2018 onwards, and this reinforces the data analysis findings that are discussed in Chapter Four.

This exercise with stakeholders provided an opportunity for small groups to explore short- and long-term goals for team development.

Each small group discussed their ideas with the wider team and decisions were made as to which options were felt to be most viable. Suggestions from all small groups were added as an agenda item on the CMHT business meeting agenda, thus ensuring that all stakeholders have a 'voice' in enhancing experiences at work. The contributions from each group ranged from quick wins such as smiling at each other through to developing a change initiative programme to support 'good ideas' within the CMHT. Focusing on quick wins gives immediacy to change and fosters and maintains a 'can do' attitude which can be important to continue to build momentum of change. Examples from small groups are included below and highlight the full range of ideas that MHPs have toward improving experiences at work and therefore their well-being.

Short term wins;

- Having a service improvement away day every 3 months (as in this AR study)
- Smiling at each other
- Yoga sessions for practitioners
- Meeting for coffee daily – to catch up with each other
- Going for a lunch time walk
- Saying hello and asking how people are

Longer term wins;

- Establishing a care pathway to crisis service with the crisis team
- Working with other CMHTs to share and improve care delivery
- Develop a change initiative programme within CMHT

- Establishing a complex service user pathway to support for practitioners

A whole-team consensus was then agreed on how to proceed; each small group having discussed its ideas with the wider team before decisions were made as to which options were felt to be most viable. Through this system, the stakeholders determined that the CMHT should aim to achieve the following short- and long-term goals in order to ensure that the CMHT continued to make changes that would enhance well-being at work and be certain of ongoing delivery of safe and effective care. It is interesting to note that the complexity of the longer-term goals indicates that MHPs had discerned which methods to improve the service would be instrumental to make changes. This demonstrated the MHPs' renewed levels of confidence and their belief that they could influence the ways in which care pathways developed.

Short term goals;

- Having a service improvement away day every 3 months (as in this AR study)
- Yoga sessions for practitioners

Longer term goals;

- Establishing a care pathway to crisis service with the crisis team
- Establishing a complex service user pathway to support for practitioners

6:8 Summary: evaluation and reflection

Question 3 - Does being involved in the development and leadership of service improvement interventions to improve experience at work enhance mental health practitioners' well-being and strengthen teamwork, job satisfaction and resilience?

In summary, the final evaluation and reflection of this iterative three-stage AR design has shown that due attention has been given to the research process. Findings suggest that changes have been achieved in MHPs' perceptions of their well-being

at work. This conclusion is strengthened by findings from the survey that was conducted in follow-up after this study; there are clear and distinct changes in MHPs' perceptions of their well-being. Comparisons between the results of the surveys that were conducted in July 2018 and April 2019 suggest that well-being at work has been improved as a result of strengthened teamwork, job satisfaction and resilience, thus the research hypothesis is supported. Qualitative data collection and analysis indicates similarly that the experiences of MHPs have been noticeably altered, and that these changes can be directly related to enhanced well-being at work. This variation in the experiences of MHPs (Stages 1 and 3) is attributed to their leadership and development of changes to improve their experiences and this has directly influenced MHPs' levels of job satisfaction, resilience and teamwork. Most notable is that this has indirectly led to feelings of renewed interest in being actively engaged in the pursuit of improvements to be made following this study.

In keeping with the evaluative and reflective approach that was adopted throughout the AR study, all stakeholders were encouraged to participate and give feedback. This was an important component of ensuring that the AR study was representative of all MHPs at the CMHT. Most noticeable in this evaluation is the change in feelings of participants regarding the team and a sense that there has been a significant shift in judgements about their colleagues. This is evident in the survey findings and in qualitative feedback that has been discussed. The value that has been placed on this inclusive approach in this evaluation process demonstrates what can be achieved by MHPs and, for those not directly involved as co-researchers, it acts as a motivator to be involved in further development of the team. This is apparent in quotes such as: *"We need this positivity to continue, there should be no end point to this"*, (6:4.3) which suggests that MHPs have an increased commitment to making

changes in order to improve well-being at work. This commitment is aligned with the need for the NHS to be a continuously learning, evolving and improving organisation (Ham, Berwick and Dixon, 2016).

For co-researchers it is evident that involvement in AR(PAR) and service improvement initiatives has been of value. Despite tensions in ensuring use of PDSA, obstacles and challenges that were faced have largely been met with an enthusiasm to develop strategies to improve work experiences for self and others, and this has been an important factor in improvements of relationships with peers. Explicit links have been made between the key concepts of this study and the strategies that were developed by MHPs to improve work experiences. An example of this was the development of a range of opportunities for MHPs to engage in clinical supervision. This will remain important if MHPs are to continue to feel supported and prepared to meet the challenges they face. There is evidence that co-researchers favour strategies that provide opportunities to work with peers (Chapter Five) and that, as the AR study progressed, confidence and determination strengthened to make meaningful changes.

In keeping with this AR study's three-stage iterative process, final evaluation and reflection has determined whether MHPs' involvement in the leadership and development of interventions to determine well-being at work has strengthened their perceptions of working well in a team, satisfaction with their job and feeling resilient in the workplace. This final stage has dictated the critical reflection of this AR study and therefore has provided understanding of the "what" and "how" of the central concepts in this study of well-being at work.

The increased engagement of MHPs in their work, the value that they place on relationships with colleagues (which influences hope and optimism) and the improved perceptions that MHPs have of their roles (which influence feelings of pride, ownership and improving morale) are all important outcomes of this AR study. In line with the evolving nature of the study and to highlight professional impact, major findings are drawn together in the final chapter. This affords an opportunity to explore how the AR and incorporation of a PAR approach in stage 2 of the research design has developed and how this can be influential in understanding the factors that impact on MHPs' well-being.

Chapter Seven - Summary and conclusion of this AR study

7:1 Introduction

The work that was performed for this thesis sought to answer three research questions:

1) ***How do mental health practitioners view well-being, teamwork, job satisfaction and resilience?***

2) How can mental health practitioners enhance well-being and strengthen teamwork, job satisfaction and resilience?

3) Does being involved in the leadership and development of service improvement interventions to improve experiences at work enhance mental health practitioners' well-being and strengthen teamwork, job satisfaction and resilience?

In line with the researcher's values of collaboration, lifelong-learning and fostering hope and optimism in self and others, which influenced this work, an AR approach was used. Quality improvement methods (PDSA) were used that were designed to empower the MHPs participating in the PAR approach that was incorporated within the AR to identify areas that required improvement and to develop interventions that would be acceptable to all stakeholders at the CMHT, and hence these stakeholders were more likely to implement the interventions. The impact of the interventions was tested using a mix of data collection and analysis methods that were common in AR (McNiff, 2016).

In addition to the findings that are discussed in Chapters Four to Six, major findings are drawn together here. These highlight important factors that underpin the findings that answer the research questions. Regarding Question 1, it was found that MHPs

have clear views on well-being at work and they consider that working in a supportive environment is of central importance. Regarding Question 2, key findings suggest that MHPs when engaged in a PAR approach can build strategies to improve well-being when they can work in collaboration with others and are empowered to make changes. Lastly, in relation to Question 3 it is evident that MHPs find that leading and developing service improvements enhances engagement in work.

Within this final chapter, the significance of this AR study and the implications of its findings for practice are deliberated. The strengths and limitations of the AR are considered and this includes the transferability and validity of the AR study. Evaluation, review and reflections by the researcher inform the concluding remarks. The lessons that have been learned through the process of undertaking this study are discussed. This chapter therefore specifies the key outcomes and details how the aims of the work that is described in this thesis have been met.

Major findings are now discussed in relation to previously published literature. This discussion highlights how the research questions have been addressed, the intention being to draw together not only findings but also how positive outcomes have been achieved.

7:2 Major findings: research question 1

How do mental health practitioners view well-being, teamwork, job satisfaction and resilience?

There are several findings that are significant and unequivocal regarding how MHPs view well-being at work. As highlighted in the literature review (Chapter Two,

sections 2:5 to 2:7), there is evidence that supports the notion that MHPs struggle to manage the competing demands of their roles (Bliese, Edwards and Sonnentag, 2017) and that the problems are compounded by their difficulties in management of the impact of stress on their well-being (Johnson et al., 2018).

Findings (Chapter Four, 4:4) suggest that MHPs have strong views on what their well-being involves and likewise how job satisfaction (Osborn and Stein, 2016), teamwork (Fleury, Grenier and Bamvita, 2017) and resilience (Foster et al., 2019) are important considerations to understand work experiences. It is pertinent that opinions of the key concepts of the study (job satisfaction, teamwork and resilience) correspond with established factors that can influence well-being at work. A key finding is that the environment in which MHPs work is seen as interlinked with both positive and negative experiences and underpins narratives of well-being. Environment within the context of this study relates to processes that impact on care delivery and MHPs' experiences and perceptions of the team. Key findings that relate to the role that the environment plays in MHPs' well-being is discussed next.

7:2.1 Supportive work environment

Key findings that linked well-being to the environment included feelings of isolation, a requirement for support to develop and an incongruity between the organisation's viewpoint and MHPs' viewpoints. MHPs can feel isolated in their roles and this indicates the perceived value of interventions and service improvements that involve working with peers and other stakeholders. The importance MHPs place on co-working is supported by evidence of the importance of the work environment (Kelly et al., 2016; Suliman and Aljezawi, 2018).

MHPs in this study and in similar studies accept the value of resilience to support them in their roles (Foster et al., 2019). They understand the link between burnout and care delivery (Salyers et al., 2015; Johnson et al., 2018). They consider that being in a team and working collaboratively is important (McInnes et al., 2015; Rosengarten, 2020). MHPs in this study report feelings of isolation, although the correlation between these feelings and well-being is unclear and this warrants consideration.

It is not surprising that MHPs in this study struggle to manage workloads and increasing levels of need among service users, which can lead to feelings of stress (McTierman and McDonald, 2015; Foster et al., 2020). In order to manage stress, confiding in others is widely acknowledged to be essential (Johnson, 2019), but for MHPs in a team that struggles to meet demand this can be problematic due to a lack of clinical supervision, low morale and MHPs feeling isolated, as shown in this study (Chapter Four, section 4:4). Team performance is understood to be enhanced through collaborative working (Schmutz, Meier and Manser, 2019); this was recognised during this study as the AR and PAR process helped to lessen feelings of isolation as MHPs collaborated with peers.

Amelioration of feelings of stress and a sense that they were personally and professionally supported were found to be critical factors for MHPs' well-being. However, the experience of MHPs who were involved in this study was that there were insufficient opportunities for their development and that there were gaps between their viewpoints and those of the organisation in regard to this topic. This is

an important factor if well-being is to remain a focus at the CMHT, as support for development is imperative as organisations are challenged to foster well-being in staff (Alenzi, McAndrew and Fallon, 2019; Gillet et al., 2019).

There are processes in place in the CMHT that indicate there is support for development of MHPs (for instance, personal development plans, appraisals) but participants reported few examples in practice of such processes influencing work experiences. There is a dissonance between MHPs' experiences and well-being and the CMHT's culture and work environment (Chapter Four, sections 4:4.2.)

The importance that was placed on clinical supervision by MHPs was another key finding and is supported by well-established evidence (Driscoll et al., 2019; Pollock et al., 2017). Development of clinical supervision in this AR highlighted the value that was given to supportive behaviours in the CMHT and this should lead to improved job satisfaction (Gillet et al., 2019; Markey et al., 2020).

Staff training and development was felt to be essential so that MHPs could meet the challenges that they faced clinically, and this need was coupled with the development of emotional resilience to ameliorate the impact of stress. Similar findings have been reported by others (e.g. Foster et al., 2018; Delgado et al., 2020). MHPs link the provision of support to manage adversity and professional development (Sabanciogullari and Dogan, 2015; Foster et al., 2018) and they note that this was absent at the CMHT (Chapter Four, section 4:4.2).

The team in which MHPs work is important because it is linked to feeling supported. As highlighted in data that were collected in Stage 1 (Chapter Four, sections 4:3.and 4:4.), MHPs raised concerns about team dynamics, workloads and management of competing demands, all of which are considered to be important factors (Kelly et al., 2016; Welp et al., 2018). MHPs considered that focus on the culture of the team was key to the enhancement of well-being. Development of a shared vision that fostered innovation was closely aligned with perceptions of teamwork, resilience and job satisfaction for MHPs in this study, and Cleary et al. (2020) also reported that these were important features of well-being at work. Lastly, the organisation of the team, including the processes and structures that were in place to support practice, was considered by MHPs to be linked closely with well-being, and this finding highlighted the importance of understanding collective well-being (Arnold, 2017; Dow et al., 2019).

For MHPs, it was clear that well-being at work was impacted on by factors that influenced performance: staff retention rates, sickness rates, lack of managerial support, demands on time to meet targets, no access to clinical supervision and awareness that they belonged to what was regarded as a struggling team. MHPs thought that this could be addressed through the development of a work environment and team culture that supported staff well-being, as evidenced in this AR (Chapter Five, section 5:4).

7:3 Major Findings: Research Question 2

How can mental health practitioners enhance well-being and strengthen teamwork, job satisfaction and resilience?

There are several findings that indicate that MHPs are ideally placed to manage their well-being at work if they are given the opportunity. This is shown in this AR study by the range of changes that were made by MHPs (Chapter Five, section 5:7). MHPs are clear about what changes are necessary to improve experiences at work and are well-versed in adoption of QI methods that are common in healthcare. However, it is difficult to ensure that both the process for change, in this case a PAR approach and PDSA method, and the difficulties that are faced during management of the expectations of different stakeholders, are overcome (Chapter Five, sections 5:2 and 5:3). This is widely understood to be an issue with QI initiatives (Reed and Card, 2016; McNicholas et al., 2019) and within AR studies (McNiff, 2017).

While MHPs were actively engaged in the PAR, and exploration and development of initiatives in Stage 2 (Chapter Five, sections 5:3-5:4), it was evident that there were important underlying issues regarding their well-being. These were centred on the improvement of the processes that underpinned their work (supervision and team organisation) and enhancement of the work environment (team culture and staff development). Well-being can also be influenced by factors such as: organisational culture (Bronkhorst et al., 2015), the work environment (Schon et al., 2018) and being empowered (Back et al., 2016). All of these factors support the idea that MHPs are best placed to make changes to improve work experiences, as they did in this

AR study and this was successfully achieved by the incorporation of a PAR cycle in stage 2.

The adoption of a PAR approach compounded feelings of being empowered to take ownership (of well-being), and this is a common positive outcome of AR (McNiff, 2017). For MHPs, there was a shift in the rhetoric of working towards common goals to a genuine commitment towards shared values of caring (for self and others) and sharing (with peers), as shown in Chapter Six (section 6:3.3). These values, alongside professional and personal growth (sections 6:4.3 and 6:7) were in keeping with the guiding principles of the AR study that were decided at the outset (Chapter One, section 1:4). Therefore, it is key to explore the findings with a focus on collaborative approaches, as was performed in this AR study.

7:3.1: Collaborative teamwork

The value of working with peers and stakeholders was striking for MHPs. This is a well-known feature of this type of study and participatory approach (McNiff, 2017). Collaboration with stakeholders and peers requires leadership and co-ordination (Cleary et al., 2019) and, as was demonstrated throughout the PAR process, can impact on the team function and processes. Findings that demonstrated this are detailed in Chapter Six (sections 6:2, 6:3 and 6:5) and in evidence of the impact of organisational factors such as leadership on well-being at work (Arnold, 2017). MHPs who acted as co-researchers appreciated the opportunity to explore and determine strategies to improve the service (Chapter Five, section 5:4 - field notes) and this aided their development as leaders of change. This finding is supported by Rafferty (2018), who suggests that nurses are ideal agents of change.

Therefore, to ensure that MHPs were successful as agents of change, creation of a positive work culture that equated to caring about self and others was important to the MHPs who took part in this study. This was evidenced by changes in perceptions of peers as the AR progressed, which is detailed in Chapter Six (sections 6:2 and 6:3). This finding is supported by evidence of the importance of workplace culture (Sergent and Laws-Chapman, 2012; Mannion and Davies, 2018) and this relates to teamwork.

The development of a shared vision of factors that impacted on well-being was important to MHPs, as was discovery of solutions that could overcome challenges to well-being. Success was dependent on collaboration and working in a team (Utriainen, Ala-Mursula and Kyngas, 2015). MHPs at the CMHT have keen understanding of the role of the team and the direct links that are required to form an effective team, as shown in findings that are described in Chapter Six (section 6:4.3). These findings are supported by evidence that highlights the value of teamwork and the need for healthcare settings to adopt approaches that improve teamwork (Schmutz, Meier and Manser, 2019). This is important since MHPs' perceptions of the team can dictate thoughts about well-being and effectiveness (Welp and Manser, 2016), as shown in this AR study.

Use of an AR (and PAR) approach provided opportunities for MHPs to lead service improvements and to develop collaborative teamwork. There are various approaches to innovation in healthcare settings, and these different approaches can result in different interpretations of quality initiatives that are adopted (Bytautas, Gheihman

and Dobrow, 2017). These difficulties were shown in this AR study as the problems that MHPs faced in the application of QI method (PDSAs) in practice (Chapter Five, sections 5:3 and 5:5). Despite the challenges of using a QI method such as PDSA cycles, they were overcome through the commitment to innovation that came from all stakeholders (Chapter Five, section 5:3) and the value they placed on the benefits of working together to achieve common goals using a PAR approach (Chapter Six, section 6:8).

The positive changes that were made at the CMHT were due to MHPs' personal motivations to improve their well-being and work as a team to ensure success. This is closely aligned to the importance of empowerment of staff to make changes that they initiate, which is discussed in the next section.

7:3.2 Empowerment to initiate change

It was found that considerations of how MHPs could implement interventions to manage their well-being were linked to established theories of structural empowerment (Kanter, 1988) and psychological empowerment (Zimmerman, 1995; Laschinger, Finegan and Shamian, 2001 and Friend and Sielof, 2018). Structural empowerment in this AR referred to innovation that was enhanced through facilitation and influence from within the organisation: MHPs in this AR (PAR) study were encouraged and supported to develop the study as they saw fit by a clinical director. Therefore, the organisation supported innovation and this led to MHPs' psychological empowerment, which influenced MHPs' attitudes, behaviours and performance as demonstrated by several findings (Chapters Four to Six). This discovery supported earlier evidence of the value of empowerment of practitioners

and satisfaction and productivity at work (Al-Dweik et al., 2016; Dahiten, Lee and MacPhee, 2016).

Adoption of a PAR approach incorporated within the AR study and application of the principles of PDSA (QI method) enabled MHPs to develop interventions to carry out their work and make changes in a manner that was meaningful to them (Chapter Five, section 5:3). This is an essential feature in the improvement of teamwork. It is supported by evidence of the importance of empowerment in the fostering of collaboration (Regan, Laschinger and Wong, 2016).

Empowerment and emancipation of MHPs in this study was dependent upon the application of authentic leadership (Avolio et al., 2004; Bowman and Swanwick, 2017). The support that was offered by authentic leaders within this AR influenced structural empowerment, which in turn fostered the growth of leadership skills and capability in co-researchers to manage and make changes. In turn, the empowerment and the changes led to improved service delivery (Wong and Laschinger, 2013; Fragkos, Makrykosta and Frangos, 2020).

Alongside the empowerment of MHPs was the commitment to ensure that service improvement was aligned to well-being through the exploration of solutions that ultimately improved quality of care. This was evidenced by CMHT plans to develop a crisis-care pathway for CMHT service users (Chapter Six, section 6:7). This success links to contextual factors that influence service improvements and success (Osborn and Stein, 2016; Coles et al., 2017). Evidence suggests that healthcare practitioners

have limited opportunities to make influential decisions that are related to their roles and to improve work experiences (Bronkhorst et al., 2015). Affording MHPs this opportunity has been a key feature of this AR study through incorporation of a PAR approach. This AR study, therefore, reinforces the notion that, as a concept, influencing change is dependent on an interplay of factors: leadership, relationships, support and learning, alongside careful balance of each factor (Nelson-Brantley and Ford, 2016).

For MHPs in this study, empowerment could be articulated as: development of autonomy, self-efficacy and ability to influence work experiences. This was highlighted in the findings (Chapters Four to Six). These findings are important and of relevance to support staff within the NHS, who must manage the competing demands that they face (Laker et al., 2019). For the researcher, this need for empowerment highlights the gap between organisational approaches to service improvement (and widespread adoption) and the participatory approach (PAR) that was adopted in this AR study, which involved engagement of staff to influence the decisions that are taken and make significant contributions to improve the service. In this AR study, empowerment of MHPs led to positive outcomes that were linked to well-being, job satisfaction, teamwork and resilience. This finding aligns to an understanding that empowerment of staff can safeguard experiences at work for those in healthcare settings, which is known to be important (Dahiten, Lee and MacPhee, 2016; Lyman and Moore, 2019).

7:4 Major findings: research question 3

Does being involved in the leadership and development of service improvement interventions to improve experience at work enhance mental health practitioners' well-being and strengthen teamwork, job satisfaction and resilience?

Findings from this study suggest that being involved in and leading service improvements improves experiences at work and enhances well-being. These are detailed in Chapter Six (section 6:8). MHPs know what would be useful to improve their experiences and this is linked to: an overall sense of satisfaction, being in a supportive team and coping with the demands of their roles. There have been changes in performance that are of importance to the organisation (performance indicators - clinical supervision) (Chapter Six, section 6:5), but largely the team that was involved in this AR continues to struggle to meet demands in some key performance targets. However, what are significant are the changes in perception amongst MHPs of the team in which they work and this is demonstrated by positive changes in feelings toward colleagues (Chapter Six, sections 6:3.3 and 6:4.3). This cohesiveness can influence perceptions of teamwork and impacts on well-being, as highlighted by McInnes and colleagues (2015).

A strength of using a PAR approach to improve the service has been the shared sense of value that MHPs have placed on each other, as the findings demonstrate (Chapter Five, section 5:4 - field notes). There were changes in the perceptions of the roles of MHPs (as leaders of change) and this led to improved morale and a sense of pride (Chapter Five, section 5:6) and a value that the MHPs placed on ownership of interventions to improve work experiences and well-being (Chapter Six,

section 6:8). As MHPs worked with peers throughout the process they built hope and optimism as they influenced their experiences of well-being at work. This fostered feelings of pride in being a MHP.

Professional pride may be linked to active involvement in leading and making changes to improve service delivery (Vikstrom and Johansson, 2019). In this AR study, the process of actively engaging in the AR (PAR) as it evolved gave MHPs as a collective (and as individuals) this sense of pride (Chapter Six, section 6:3). It is evident that increased pride in what you do directly impacts on morale. Adoption of an AR approach to service improvement, as in this study, highlights the complexities of improving morale. Morale, although not measured within this study, is linked to job satisfaction and teamwork and is reliant on improved communication between practitioners. The adoption of a method that increases collaboration can increase morale and improve performance at work (Stapleton et al., 2007).

Enhancement or improvement of well-being and consequently morale was the central aim of this study. This enhancement is linked to: enhancement of skills, management of emotions and working in a supportive environment (Gilbody et al., 2006). However, as indicated from early findings (Chapter Four, section 4:4), MHPs experience high levels of stress that impact on satisfaction, teamwork and ability to cope with challenges. As has been discussed previously, this is not an anomaly to this CMHT but a common factor in MHPs' well-being (Johnson et al., 2018; Oates, Drey and Jones, 2018).

Adoption of an AR approach facilitated collaboration and improved communication that led to service improvements. This process cultivated an increased sense of capability amongst MHPs who took part in this study and this is closely linked to improved resilience and morale (Foster et al., 2018). Collaboration with peers and involvement in active learning is a predictive factor of improved well-being (Festin et al., 2019) and this effect can be seen in this study's findings (Chapter Six, sections 6:3 and 6:4). Involvement in and leading decision making and service improvement undoubtedly resulted in positive outcomes for MHPs and this included increased morale (Adrianssens, De Gucht and Maes, 2015) and improved engagement of MHPs with work. Increased engagement increased capability and will be explored next.

7:4.1 Work engagement

Psychological engagement with work is widely established as a critical element in employee investment of their full capabilities in their work (Bakker, Albrecht and Leiter, 2011). Organisations need to understand psychological engagement in order to employ workers who "give their all" to their jobs. Improvements in work engagement, was dependent in this AR study on MHPs changing the culture of the CMHT through instigation of changes. Their participation in PAR and the 'bottom-up' approach has led to a higher level of work engagement and this also nurtured well-being (Knight, Patterson and Dawson, 2017). The link between psychological empowerment and work engagement of MHPs was correlated with job satisfaction and motivation, as demonstrated in Chapter Six (sections 6:4 and 6:5). This link is an established factor in well-being and links to resilience, burnout and job satisfaction (Kim et al., 2019).

The empowerment of MHPs to improve their work experiences, and therefore well-being, led to increased levels of work engagement (Joo, Lim and Kim, 2016). A combination of factors were important for the researcher: being supported, being empowered and having leadership that enabled self-determination of improvements. Work engagement was an important factor in this AR (PAR) and this in turn led to positive outcomes for the organisation (Chapter Six, section 6:5) and for MHPs (Chapter Six, sections 6:3 and 6:4). This links to the importance of engagement in professional practice (Keyko et al., 2016).

There was an inextricable link between MHPs' levels of optimism and hope and their work engagement, which was evident in this study (Chapter Six, section 6:8). The importance of this is supported by Stander, De Beer and Stander. (2015). Personal resources such as optimism are important for work engagement and this can relate to leadership styles (Othman et al., 2017). This AR has engendered increased optimism and this is an important observation for other healthcare organisations that wish to improve work engagement of staff (Fiabane et al., 2013).

Work engagement showed clear links to the satisfaction that was experienced by MHPs, so was important in this AR study (Bargagliotti, 2012). MHPs were evidently engaged (personally) and this influenced emotional connections to the study (Chapter Six, section 6:4). Their active involvement and personal engagement in the work to influence the workplace acted as safeguards against factors that could have negatively influenced work engagement such as stress (Keyko et al., 2016; Kinman

and Leggetter, 2016) and this observation reinforced the value of the adoption of an AR (PAR) approach.

Finally, there is clear evidence that the research questions have been addressed. There are conclusive signs that, within the context of the CMHT, well-being at work is aligned with: being in a supportive environment; being empowered; and working in collaboration. There are also indications that active engagement in AR (PAR) and service improvement has engendered work engagement and improved morale among MHPs. Consequently, as a direct result of the methods that were adopted and the evolving nature of the study, MHPs' experiences of well-being at work have improved, and this informs subsequent discussion of implications for practice.

7:5 Implications for practice

This AR study has shown that improvement of MHPs' well-being leads to positive effects on satisfaction at work, ability to cope with challenges that the MHPs face and improved relationships with peers. The study has also shown that there is disconnect between staff and organisation perceptions and experiences of QI initiatives. This disconnect has been found in other studies (Brand et al., 2017). This is important as, for well-being initiatives to work, they must be valued by the staff at whom they are targeted, and this has been an important feature within this AR study and use of a PAR incorporated within it. Therefore, well-being initiatives should start with an understanding of what staff value alongside understanding their perceptions of well-being at work.

This study has employed an effective method to gain this understanding. This study has shown that use of an AR approach and application of a process whereby MHPs are able to prioritise and determine what interventions they favour to improve well-being at work are more likely to lead to implementation by staff of those interventions. As this study shows, development of such interventions is important in light of the need to improve well-being of staff working in the NHS, and particularly so after the Covid-19 pandemic (Bailey, West and Kings Fund, 2020).

Some challenges that MHPs face are commonplace and these challenges can impact on well-being at work. Within this AR, implications for practice have been highlighted that are pertinent to both the CMHT and other practice settings. Given the evidence of burnout (Johnson et al., 2018) and a national recruitment and retention crisis in mental health practice (Renwick et al., 2019) and generally within the NHS, it is clear that there is a compelling need to develop a robust workforce (NHS, 2018). Within a climate of economic constraint, the NHS is charged with ensuring that its workforce is able to cope with the challenges that staff face (Johnson and Sollecito, 2018) and that the well-being of healthcare workers is protected (Roelen et al., 2018).

It is evident in this study that understanding, implementing and evaluating strategies that improve the well-being of MHPs has increased work engagement and empowered MHPs to make changes that they value. There is a disconnection between what practitioners favour to improve their experiences at work and the broad adoption of service improvement initiatives within an organisation (Pascoe, 2016). As shown in this study, MHPs can make connections between workplace

factors that influence their well-being, and this approach is lacking in widespread organisation-led initiatives that are adopted to improve well-being.

In this study and others, well-being from a MHP perspective was found to be related to: job satisfaction (enjoying what they do) (Osborn and Stein, 2016), teamwork (working in a cohesive team) (Fleury et al., 2018) and resilience (being able to cope with challenges that they face) (Foster et al., 2019). Implications for practice in the CMHT, and other similar teams, are that elements that influence well-being at work are linked to having: robust support (clinical supervision), structures and processes in place to manage workloads (team organisation), opportunities to develop personally and professionally (staff training and development) and finally a supportive environment in which to work (culture of the team). Exploration of well-being from this perspective enables practitioners to interpret unique work experiences and take account of the factors that impact on well-being.

Adoption of approaches to service improvement in the NHS that account for and value the unique experiences of practitioners should be considered (Brand et al., 2017). The influence that active learning and AR (PAR) have on MHPs' viewpoints of service improvement is important. Adoption of organisational approaches to service improvement that adopt the principles of authentic leadership (Hoert, Herd and Hambrick, 2018) would ensure that practitioners could engage in collaborative and empowering service improvement opportunities. This is important for practitioner well-being.

It is a given that AR approaches can foster supportive environments as individuals work together toward a common goal (Casey, O'Leary and Coghlan, 2018). Use of approaches that build capacity in practitioners to self-determine interventions that improve service delivery and consequently care delivery is important (Williams et al., 2018). Engagement of practitioners in action learning can reduce feelings of isolation that MHPs may experience as it provides greater opportunity for them to engage with peers. Working in collaboration with peers can empower practitioners and lead to positive outcomes for both the organisation and for the practitioner (Bronkhorst et al., 2015). As organisations are charged with fostering wellbeing in staff (NHS workforce health and well-being framework, 2018 and 2019), engaging with staff to understand and improve their experiences is an opportunity to ensure that any interventions are tailored to the unique experiences of staff. As previously stated there are links between staff health well-being at work and health and safety, and engagement in opportunities to improve well-being at work which impacts on the care that is delivered.

Given the impact of increasing demands on the NHS to manage well-being of employees, the cultivation of work engagement is critical to enable practitioners to fulfil their potential (Hoert, Herd and Hambrick, 2018). There is a suggestion in this AR study that organisations should reconsider application of service improvement initiatives to understand first the culture of the workplace (Williams and Caley, 2020). An exhaustive approach, such as was taken in this AR, to determine the factors that influence work experiences can prevent widespread adoption of approaches to change that are not underpinned by robust evidence, and which therefore may not support sustainability of changes in practice (Davidoff et al., 2015). A triumph in this

AR study has been the incorporation of a PAR approach and the use of a QI method (PDSA) as a framework for the action element (Stage 2). This is of importance if practitioners are to engage in research as it enables them to apply methods (PDSA) that they are familiar with (Casey, O'Leary and Coghlan, 2018). Therefore, as both a MHP and a researcher, the process of engagement in this type of research activity involved overcoming fears at the outset, making informed choices as the study progressed and reflecting on how, throughout the process, the researcher has developed.

7:6 Researcher reflections

To facilitate the process of reflection, this account is structured to revisit fears that were experienced at the outset of the study and to explore the process of managing the expectations of stakeholders and the researcher and the choices that were made as the study progressed. This includes how choices that were made have changed over time and this process has informed what has been learnt during the process by the researcher. Lastly, the reflections conclude that, as a result, there is a sense of becoming a better researcher.

At the starting point of the study the researcher's fears were centred on: not meeting expectations; and that her relationship with MHPs at the CMHT would place pressure on individuals to engage actively in the study. Therefore, throughout the action phase of this AR, the researcher was keen to ensure that undue influence was not placed on co-researchers either to produce positive results or to drive through change to meet AR deadlines. There was careful consideration and adherence to values at the outset and a genuine commitment to the belief that MHPs were best placed to determine what worked for them. As a result, there has been a keen wish

to ensure that initiatives are embedded in practice; therefore the involvement and collaboration of co-researchers has been essential, and this has been achieved.

Critical evaluation of the AR process is influenced by reflection on what is understood by research-based approaches to making changes and improving the service while managing the expectations of MHPs who are involved in the study. MHPs have intuitive knowledge of what works in practice and, in this study, the researcher needed to pay attention to this aspect to avoid the researcher becoming influential or determining which interventions should be prioritised among those that were proposed by co-researchers.

At each stage of the study, reflection informed problem-solving and decisions that were made by co-researchers and the researcher (McNiff, 2017). The researcher had to strike a balance between facilitating opportunities for critical reflection with co-researchers and developing a community amongst co-researchers for them to reflect critically together (McNiff, 2013). It is this type of consideration that has ensured learning for the researcher and has formed part of her critical reflection.

Throughout the process there were challenges for co-researchers as they adapted to the expectations of being involved in the study and their 'new' role as researchers. As suggested by Schon et al. (2018), this problem can occur as participants are adapting to a different approach whilst operating in an organisation that shapes their behaviour. Schon et al. (2018) proposed that learning could disrupt the constancy of managed organisational life. Therefore, it was essential that co-researchers took

time to reflect and this aligned with the value of lifelong learning that was articulated at the outset of the study. For the researcher, it was important that co-researchers continued to develop and grow and could see their influence when considering thoughts and actions.

The process was overwhelming at times as the researcher tried to manage anxiety that was related to working alongside co-researchers whose agendas differed. Affording integrity to the intention that was set at the outset of the AR study necessitated that the researcher modify and manage her expectations to meet those of co-researchers and stakeholders. Field notes highlight that this was difficult but essential to ensure that informed choices were made as the study progressed.

Excerpt from field notes, October 2018

> *I am annoyed that I am struggling to manage my frustration that some stakeholders and co-researchers do not seem as committed (as me). This is at odds with my espousal of virtues of empowering others and I need to manage this. I will now keep reminding myself of what I know - this team have had a difficult time; they are low in staff numbers and despite this they want to be involved. It is me that needs to consider ways of managing anxiety.*

The researcher's position changed over time. During evaluation of key findings throughout Stages 1 - 3 (Chapters Four to Six), there was exploration of the potential pitfalls of both insider and outsider research. It was of specific value to the researcher to have started the process as an insider and then at Stage 2 to become an outsider. This was a privileged position as she could understand the context of the research at the outset but subsequently as an outsider she was not concerned by issues of role duality and potential issues around power (Holian and Coghlan, 2013). This ensured engagement with peers at the outset and a useful outsider

perspective as the study progressed. This warrants consideration by action researchers who undertake research within their organisation. The researcher (as an outsider) fully embraced outcomes and interventions that were valued by co-researchers, rather than by the organisation, and this acted as a primary motivator in support of change.

As a novice researcher undertaking AR, there were challenges of working alongside co-researchers. These were centred on the management of personal expectations of how the study should progress alongside an eagerness for the study to succeed. Although co-researchers were clearly committed to the process, there were challenges as stated and this necessitated a focus for the researcher on use of interpersonal skills that would foster autonomy amongst co-researchers. Throughout the process, it was imperative that the researcher ensured an emphasis on collaboration and empowerment, and this has informed feelings of increased confidence as a researcher. This confidence as a researcher has enabled the review of the AR study to explore what lessons have been learned and those that will inform ongoing development as a researcher.

7:7 Lessons learnt

The key learning points centre on the importance of making sure (as an AR researcher) that there was a conscientious effort to ensure that the study developed along the lines of the values that were specified at the outset. Taking time to ensure that the study was built on robust foundations guarded against problems with adherence to the method. This included adoption of a PAR approach, and a QI method (PDSA) that was familiar to MHPs. This level of appreciation of the

foundations of AR ensured positive outcomes and resulted in a transition for MHPs toward empowerment to make changes that would improve well-being and this was achieved through incorporating a PAR approach within the AR study.

It was a challenge to establish interventions to enhance well-being through use of PDSA cycles. Co-researchers showed a tendency to rush through cycles to move to 'doing' and this in part was linked to the nature of work in the NHS, where change is constant and often immediate or unplanned. Use of a service improvement method (PDSA) to underpin innovation and implementation in this AR (PAR) contributed to its success. However, it is clear that there is tension between AR and service improvement (Casey et al., 2017), although in this study, the use of PAR and a framework upon which to develop practice (PDSA) ensured that an evaluative approach was taken that improved the sustainability of changes that were made.

MHPs and co-researchers enjoyed opportunities to grow, develop and learn together. This sense of being together was linked to comments that were made throughout Stages 1-3 that highlighted feelings of isolation. Throughout the study, an emphasis on empowerment and collaboration has been key; for the researcher, this was of ongoing importance as it was aligned to her personal values.

There was an inadvertent benefit to co-researchers, who were encouraged to develop and this development fostered a feeling of confidence in their active engagement in research. Without question, the most significant finding for the researcher was the renewed sense of pride for her co-researchers in all they had achieved. Although not highlighted in early parts of the study, increased pride in work

has been an important finding that is aligned with MHPs' well-being. This level of critical reflection and evaluation underpins an ability to present a comprehensive appraisal of the study that accounts for both the strengths and limitations of the method that was employed.

7:8 Strengths and limitations

To understand both the strengths and the limitations of the approach that was adopted, each stage of the study design is explored in this section. This approach enables the researcher to revisit each stage of the study and methods that were adopted to provide an accurate account of factors that influenced and informed the decisions that were made. Although the study was situational as it was undertaken within the unique context of the CMHT, issues that were deliberated enables consideration of factors that affect transferability to other settings.

The data that were collected and analysed in Stage 1 (Chapter Four) to inform and guide the study provided rich narratives of MHPs' experiences. The time that was afforded to both the mapping exercise and the engagement of stakeholders ensured that data that were gathered provided a full account of the culture of the team. Without question, taking enough time to account for the relevant influences on MHPs' well-being, both directly and indirectly, was imperative to success. Consideration and involvement of co-researchers and a validation group throughout the iterative design have ensured commitment to the values that underpinned this approach and this is evident in the findings (Chapter Six, sections 6:3, 6:4 and 6:5).

Despite a robust attention to AR principles that were outlined at the outset, there are nevertheless issues that warrant attention. Findings are always open to interpretation and can be dependent on a viewpoint, or professional bias. Due to the support given by the organisation to the study it would be difficult for MHPs not to engage in the study and some may have felt a compulsion to be involved. However, this was addressed within the study by ensuring that all stakeholders' contributions were given value and the option to contribute as co-researchers was voluntary. Finally, as the researcher was initially an insider, co-researchers could have felt that they should be actively engaged in the study to show support for the researcher. This was managed at the outset through clear explanation of the study intentions and the intended role of the researcher and the co-researchers.

Active engagement in the study by stakeholders and co-researchers, as demonstrated in Stage 2 (Chapter Five), highlighted the aptitude of MHPs to lead and develop strategies to enhance well-being. A strength of the study was the approaches (AR, PAR) and methods (PDSA) that were used which led to genuine collaboration of all participants to engender change and actively to promote and build communication. The empowerment of MHPs led to positive outcomes for individuals and the organisation and this added value to the study methods that were employed.

To create an environment of change and to challenge the status quo in the team posed difficulties. One issue during Stage 2 was the ongoing need to manage and guard against the dominance of some personalities to determine interventions. Ensuring equitable contribution from all stakeholders has in some studies

necessitated the revisiting of the intention of the study (McNiff, 2016). Adoption of a method that focuses attention on challenges that participants face and finding potential solutions can overwhelm participants and lead to some feeling disheartened (McNiff, 2017).

In the final stage of the iterative design (Stage 3 - Chapter Six) there were findings that supported the democratic process that underpins AR. Confidence of co-researchers grew as the study progressed, as indicated by future plans that are outlined in Chapter Six (section 6:7). MHPs were able to explore different perspectives and this led to open dialogue (Chapter Five, sections 5:4 and 5:6). The evolving nature of the study ensured that co-researchers could develop skills to lead improvement and act as catalysts for change, which improved their enjoyment of work.

Despite the renewed vigour of MHPs, at the final stage of the study there were some limitations that warranted attention. Use of the chosen methods relied on the motivation and enthusiasm of co-researchers and in future studies this cannot be guaranteed. Embracing AR (PAR) necessitated the spending of extra time and demands were placed on MHPs. In the short term this could have been problematic and could have led to despondency. Lastly, for the researcher the time that was required to set up and facilitate the study was underestimated and as a novice researcher was overwhelming at times. Despite this, the strengths of the methods appear to have contributed to positive outcomes and this outweighs the challenges that were faced.

With a focus on ‘knowledge in action’, the study was developed based on the generation of knowledge that was situational and specific (O’Leary, 2004). The researcher and co-researchers’ immersion in the AR (PAR) ensured the validity of findings, which reflected the real, everyday world of clinical practice (McNiff, 2016). There was an acceptance that from an epistemological position the study necessitated ‘changing the world’ (Reason and Torbert, 2001; Bradbury, 2015; McNiff, 2016). Undertaking a final critical reflection was imperative to understand both the strengths and limitations of the approach but also to inform the lessons learnt through this process.

7:9 Validity and transferability of the AR study

As suggested by McNiff (2017), establishing validity refers to testing the value of the research and explaining how evidence has been triangulated. Transferability of research suggests it is generalizable and in this AR study, as the study was only undertaken in one CMHT, there are limitations as to how far the work is generalisable. Transferability can be established by the evidence that the findings are relevant to other contexts and situations and populations. The limitations of generalisability of this AR is that not all CMHTs are the same, each has factors that impact directly on overall functioning and well-being of the staff within a given context. This AR study has employed different methods, but different choices may be made at different points by different teams which is the intention of AR studies. It is not expected that this AR study is repeatable per se for the reasons highlighted, but the general principles of encouraging ownership of change is. There are considerations that are important to explore and these relate to understanding

factors that impact on well-being and the universal questions that remain as to what equates to job satisfaction, resilience and teamwork. Links made to well-being and instigating changes in this AR study have been valued by MHPs and this suggests a link to being empowered to implement and lead change and this is important.

Building on the notion that engaging MHPs in an AR study as co-researchers is important, findings have suggested that taking the time to understand, improve and evaluate practitioners' experiences at work can translate to protection of well-being. Whilst it is acknowledged that findings may not be fully generalisable, there are commonalities in mental health settings that highlight that MHPs struggle to mitigate against the impact of stress and burnout and that performance at work can be linked to perception of well-being. Revisiting the literature describing implementation of QI initiatives in healthcare suggested that MHPs can determine the best course of action and are ideally placed to establish a range of interventions to manage their well-being, job satisfaction, teamwork and resilience and this is an important point. Every effort has been afforded within this AR to ensure the acceptance of findings to the wider population of MHPs and this in part is demonstrated through consideration of validity.

Within the AR there has been emphasis throughout on being able to account for and test out external validity through use of a validation group. The use of an external source, such as a validation group, has meant that the AR as it evolved was accountable for method and vigour and subject to critique from an external source not invested in outcome of the AR but the adherence to the principles and

acceptability of methods and approaches employed. This level of critique throughout is one method of testing and demonstrating validity of knowledge. Within this AR study validity can also be demonstrated as the AR study can show that the intention of the study (to improve well-being) has been met. Construct validity (McNiff, 2017) is demonstrated in this instance through multiple approaches that have been employed to underpin the conclusions that have been drawn within this AR.

Throughout the development of this AR study there has been adherence to the aims of AR and this linked to validity criteria suggested by Heikkinen et al. (2012). In the first instance the criteria relate to historical continuity, and this requires evidence that action has evolved historically. In the case of this AR, there is evidence of conception of initial ideas (Chapter One) through to the end point of the study as it evolved (Chapter Six).

The position of the researcher and reflexivity are likewise a criteria to establish validity, and this has been shown throughout the AR study as the researcher accounts for and recognises her beliefs and judgements and impact on the research and within this thesis are included as researcher reflections. Building on this, the principles of dialectics (Winter, 2002) has enabled the researcher to ensure that, as the AR evolved, insights were developed through dialogue with others and this is evident through Chapters Four- Six as the researcher's thoughts about the AR are influenced by feedback and discussion with stakeholders and participants.

The principle of workability and ethics is another means of establishing validity (Heikkinen et al., 2012) and this is demonstrated throughout this AR study by engagement with co-researchers and stakeholders to determine the approaches and methods employed in the study and includes feedback and contribution from all likely to be impacted by the study. Lastly, the principle of 'evocativeness' relates to the emotional connectedness to the study (Heikkinen et al., 2012). This was apparent within this AR study by the feelings that stakeholders and participants expressed throughout, but is most significant in findings in Chapter Six which describes how MHPs' view of self and others had changed and impacted on their well-being.

7:10 Summary

This AR study has considered and explored the complex determinants of well-being for MHPs. The rationale for the study was the large evidence base, which indicated that MHPs struggled to maintain and manage their well-being. This struggle leads to difficulties in the management of the experiences of working in mental health settings. Examples of these experiences include increased aggression (Renwick et al., 2018), stress (Johnson et al., 2018), and burnout (Hall et al., 2016). The introduction and background to the study (Chapter One) highlighted the difficulties that were faced by MHPs in the management of competing demands. With consideration of the realities of working within the NHS, the researcher explored her own values and principles to determine how these could add significance to the research methods that were adopted. A critical and systematic review of the literature (Chapter Two) supported the notion that maintenance of well-being is a dynamic process that is dependent on multiple factors. The literature review concluded that there were three central themes that were of importance to MHPs:

well-being at work, well-being as it related to care delivery and organisational factors that influenced well-being.

The evidence from previous studies supported the adoption of an AR approach to explore factors that ameliorated stress and impacted on well-being. The narrative review of the literature highlighted gaps in the evidence and supported researcher ideas that MHPs were best placed to determine interventions to improve their own well-being. This further supported the use of an AR approach, and the empowerment of MHPs by adopting PAR within the study, also represented the researcher's personal and philosophical stance (Chapter Three).

The epistemological position of this research was to make changes and to interact with what was being researched. This was achieved through engagement of co-researchers and stakeholders and the changes that were made. Ontologically, reality is knowable through interaction within the context of the CMHT. The study found that, within the CMHT, MHPs had a clear sense of what influenced well-being and they could identify ways to enhance it. The rich narratives that MHPs offered and the in-depth review of practices at the CMHT (Chapter Four - Research question 1) highlighted concerns regarding a team that was struggling to meet demands (which was demonstrated by failure to meet performance indicators) and to fulfil their roles. It is apparent, from the data that were collected here, that MHPs have a wealth of experience and ideas about how to improve well-being and the factors that are important (namely, as decided in this study, Clinical Supervision, Team Culture, Team Organisation and Staff Training and Development). MHPs have strong ideas

on interventions that would be of value, but this was at odds with an organisational approach to quality improvement that did not embrace the concept of practitioner self-determination and empowerment. The data that were collected clearly showed that the well-being initiatives that were developed by MHPs were unlike those that have been developed through other similar studies that measure well-being initiatives (Williams et al., 2018) or those that have been imposed by the organisation, which may not be valued by the staff (Dow et al., 2019).

The researcher found that taking time at the outset to appreciate fully MHPs' thoughts about well-being was instrumental in ensuring changes in perceptions. Throughout the process and principally in the final evaluation, the researcher guarded against exploiting her position of trust by being clear and transparent from the outset about her intentions and role as a researcher. This ensured that all stakeholders were able to evaluate findings without any undue influence as the researcher ensured that various methods of data collection were used and all participants were assured of the value of their contributions. Throughout, the researcher was anxious as to whether the study would enhance well-being and strengthen the key factors that contribute to it: teamwork, job satisfaction and resilience. It is noteworthy for the researcher that findings in Stage 3 suggested positive outcomes for MHPs, co-researchers and the organisation as evidenced by improved performance indicators (such as the numbers of complaints received, appraisals and supervision) and this was despite higher levels of patient need and increased levels of staff turnover.

The researcher's final evaluation and reflection was fraught with anxiety that was related specifically to the outcomes and the value that MHPs placed on the study. The researcher's commitment to the study aims at the outset and to the philosophical tenets of AR prevented the paying of any undue or unwarranted attention to assurance of positive outcomes. The ongoing focus on the principles that underpinned the study and the methods that were employed ensured success by informing decisions that were made throughout the study as it progressed. This conscious approach ensured that all stakeholders were able to provide honest accounts of study outcomes, which were driven entirely from their position as MHPs at the CMHT.

Researcher reflections from field notes, April 2020: they believed they could and they did!!!

> *I am totally humbled by the experience of doing this AR. I know first-hand what the team have been through; they have been let down more than once by managers coming in and then leaving. Coupled with the monumental changes in the team structure, the need for the study was clear but whether staff would engage – less so. I feel emotional when I think back to the early thoughts about the study and how clear the voice of MHPs was that they knew what well-being was and what it meant to them. Never did we imagine that despite such difficulties such significant outcomes would occur.*

As evidenced in this AR (PAR), MHPs, when working as co-researchers, are empowered and able to identify and articulate interventions that enhance well-being at work and strengthen and develop teamwork, job satisfaction and resilience (Chapter Five). The process of engagement in the research process and action as co-researchers resulted in several changes that addressed the needs that had been shown by MHPs' experiences at work and this result improved well-being. By leading the adoption of self-determined solutions or interventions, co-researchers became more able to demonstrate leadership skills and manage conflicts as evidenced by

suggestions that team leaders would benefit from supervision (Chapter Five, section 5:5.2). There was a sense of responsibility toward improving the CMHT which was seen in findings throughout Chapters Four to Six.

The iterative process of this AR study determined that practitioner involvement in development of interventions to improve well-being at work had strengthened the MHPs' perceptions of working in a team, being satisfied with their job and feeling resilient in the workplace (Chapter Six). Critical reflection and evaluation provided understanding of how and why interventions that were chosen had impacted on well-being. For instance, of note was the renewed value that was placed on colleagues and the team by MHPs and the positive changes in perception of their roles. Lastly, there was a sense of ownership of the AR through incorporation of PAR and concern regarding how this could be continued, which was shown in a keenness to make plans to continue to make changes going forward (Chapter Six, section 6:7). This enthusiasm corroborates the findings that relate to the value of the approach that was adopted.

Finally, the adoption of AR (and incorporation of PAR) to develop the study was supported by the findings. Few opportunities are afforded to MHPs to determine and manage their experiences at work. Empowerment of MHPs to lead and instigate change has involved challenge and constant adherence to the intentions of the study at the outset was imperative. Use of AR and a participatory approach (PAR) in combination with the QI method of PDSA to drive change necessitated fidelity to both the AR approach and the value of systematic approaches to service improvement. Working with co-researchers reinforced the philosophical position of

the researcher and ensured integrity to these principles throughout. Most rewarding for all involved was that the study addressed and answered the research questions and met the study objectives, the impact of which are explored further in the portfolio that accompanies this thesis. For the researcher the most significant reward was affording MHPs the opportunity to be actively engaged in improving their well-being and to watch a struggling team transform and flourish throughout this AR study.

This chapter concludes this thesis and the AR study. This thesis is supported by a separate portfolio that details the impact of the study and the links between this AR and practice.

As an end note, as a novice researcher there is comfort in knowing that the improvements that have been made to well-being of MHPs at work in the CMHT have placed them in a better position to contend with the many challenges that are likely to occur during and post the Covid-19 pandemic. As suggested by Blake and colleagues (2020), organisations should consider how to protect and maintain well-being of health workers during and after the pandemic. This study has shown that MHPs are ideally placed to know what works best for them in order to maintain their well-being at work.

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Appendix 1- Data extraction and synthesised findings

Theme – Importance of well-being at work (sub theme- care delivery)					
Study	Title/relevance	Method	Findings/outcomes	Researcher Comment	Synthesised category
Kinman and Leggetter (2016)	Emotional labour and Wellbeing; what protects nurses?	Questionnaires n=351(student nurses) Emotional labour and Emotional exhaustion	Relationship emotional labour of nursing and exhaustion Some evidence of value of support and coping (emotion)	Broader relevance- Student nurses- enjoyment and gratification important factor Link to job satisfaction	Importance of Well-being at work
Chana, Kennedy and Chessell (2015)	Nursing staffs' emotional well-being and caring behaviours	Questionnaires n=102	Link between burnout and psychological distress Correlation to stressors, coping and self-efficacy	Relevance- Statistically greater risk of stress among nurses- can impact on overall well-being and care delivered- value of AR to enhance sense of well-being. Links to care delivery important	Importance of Well-being at work
Bliese, Edwards and Sonnentag, (2017)	Stress and well-being at work; A century of empirical trends and societal influences	Literature review n=606 abstracts of published articles journal applied psychology	Stress and well-being research reflects wider trends and societal influences (workforce, austerity) Greater emphasis and acknowledgement of impact stress and well-being at work	Wider relevance-Need to explore strategies to help practitioners manage stress to improve well-being	Importance of Well-being at work

Baum and Kagan (2015)	Job Satisfaction and Intent to Leave Among Psychiatric Nurses: Closed Versus Open Wards	Convenience sample n=52 n=52 self-administered structured questionnaire	Negative link job satisfaction and intent to leave Closed-ward nurses reported a higher intent to leave MHN Age/working full time is important factor positive link intention to stay	Workplace determinants impact satisfaction at work. ? Relevance to UK setting but worthy of consideration due to issues in UK with retention and recruitment of MHN What factors influence retaining staff? And why?	Importance of Well-being at work
Kelly et al (2016)	Well-Being and Safety among Inpatient Psychiatric Staff: The Impact of Conflict, Assault, and Stress Reactivity	**Online survey** n=323 69% had experienced assault at work in last 12mths	Staff well-being(physical/mental health) and safety concerns affected by relationships with staff/individual response Improvement well-being –staff relationships/personal health/coping skills/managing adversity	Relevant to MHP-Links between working in teams and well-being of staff. Developing skills to manage stress and personal well-being important to ameliorate negative work experiences. What are the important factors of team work that promote greater well-being among MHN? And why?	Importance of well-being at work
Holland et al., (2019)	The impact of perceived workload on nurse satisfaction with work-life balance and intention to leave the occupation	**On-line survey-**n=2934	Perceived workload impacts on well-being and intention to leave Satisfaction and work-life balance act as mediating factors against intention to leave	Relevant -Being involved reduces impact of high workload and well-being of nurses. Intention to leave in current climate-inclusive AR can ameliorate negative impact of workload on wellness of staff	Importance of well-being at work

Renwick et al., (2019)	The physical and mental health of acute psychiatric ward staff and its relationship to experiences of physical violence	**Cross-sectional survey** *n*=31 psychiatric wards at *n*=15 hospitals UK (London and greater London)	Better Mental health age and ethnic background Physical health not mental health influenced by exposure Quality of care- links to health	Relevant; adverse work experience in MH Type of work experiences and overall health and well-being Links to time in role and age and this is important for retention/well-being	Importance of well-being at work
Oates (2018)	What keeps nurses happy? Implications for workforce well-being strategies	**Article** -subjective well-being and subjective experience of mental health problems in UK mental health nurses. Strategies can support well-being in/outside work Importance of outside work activities physical exercise, mindfulness, music Well-being clear work life boundaries, translating learning at work to home Value placed on clinical supervision		Good evidence; The importance of subjective well-being and building positive psychological capitol among MHP Capitalise on SWB to actively engage in AR and well-being strategies and share with others.	Importance of well-being at work
Kings Fund, (2015)	The Spending Review: what does it mean for health and social care?	**Publication** Significant cuts to some NHS budgets Fall in social care funding Rising demand for services Unsustainable financial pressures and increased demand		Broad evidence of pressure faced by those in NHS and social care. Increased demand and less resource-impact on staff well-being and therefore delivery care	Importance of well-being at work
Johnson et al., (2018)	Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications	**A critical review of the literature**	Poor well-being and burnout increasing in healthcare Mental health staff report higher levels and this impacts on care delivery Increased cost to services as stress and burnout impacts retention and sickness	Good evidence; Well-being dynamic impacts on care and the experiences of MHPs to manage and cope with the many stressors that they face Interventions aimed at improving well-being have value in stress and burnout prevention	Importance of well-being at work

Boorman, (2009)	NHS Health and Well-being	**NHS Health and well-being review** Need to invest in staff health and well-being Benefit of well-being to staff and patients National and local action needed to implement strategies to improve staff well-being Essential to ensure delivery of sustainable high quality services Commitment to NHS constitution –staff engagement, productive jobs, improved productivity and reduced sickness		Support for AR approach; Suggest not sole responsibility of managers and leaders but all in NHS to improve well-being. Importance of well-being to ensure staff health and patient care delivery in line with quality	Importance of well-being at work
Van Bogaert et al (2013)	The relationship between nurse practice environment, nurse work characteristics, burnout and job outcome and quality of nursing care: A cross-sectional survey	**Cross sectional survey** n=1201 Grounded on previous empirical findings	Practice area indicative of job outcomes and perception of quality of care Influence of perception of work load, involved in decisions, and relationships with peers Burnout mediating role between practice areas and outcomes- care quality	Relevance in UK-Psychological empowerment of staff important factor alongside perceptions of roles	Importance of well-being at work Care delivery
NHS, (2018)	NHS Health and well-being Framework	**Health and Wellbeing Framework (interactive)** Outlines steps to improve staff health and well-being Organisation planning and delivery strategy to improve health and well-being of staff Tools to assist organisations- health enablers/organisational enablers		Relevance- National acceptance of importance of well-being. Improving culture of teams and organisations to improve well-being.	Importance of well-being at work
Salyers et al (2015)	Burnout and Self-Reported Quality of Care in Community Mental Health	**Surveys** (N=113). The Self-Reported Quality of Care scale	Reported quality of care delivered linked to burnout and to depersonalisation	Good evidence-Links between the care that is delivered and the well-being of community MHN.	Importance of well-being at work -Care delivery

			Conscientiousness is important variable	What influences a sense of accomplishment in practitioners and what factors/type of care does this influence?	
Romppanen and Haggman-Laitila (2017)	Interventions for nurses' well-being at work: a qualitative systematic review	**A quantitative systematic review** *n=8*	Variations in measures of well-being Interventions carried out in various ways Moderate support of interventions Need longer term follow up	Important-no consistent measure of well-being but interventions can influence well-being ?benefit of MHP self-determining interventions	Importance of well-being at work
Happell and Koehn (2011)	Seclusion as a necessary intervention: the relationship between burnout, job satisfaction and therapeutic optimism and justification for the use of seclusion	**Questionnaires** n=123 nurses employed in inpatient units across eight mental health services	Links between seclusion use and burnout and therapeutic optimism Those with higher optimism and less emotional exhaustion less likely to use seclusion	Good evidence Perception of practitioners directly impacts on performance of role. Value in positive viewpoints translate to less restrictive care delivery. What role does work environment /team work play in personal sense of optimism?	Importance of well-being at work Care delivery
Maben (2012)	'Poppets and parcels': the links between staff experience of work and acutely older people's experience of hospital care	**Mixed methods case study** survey, interviews, non-participant observation.	Staff experiences influenced by staff experiences Low control, high demand, poor co-worker relationships add difficulties to experiences Importance of perception of staff and of patients influences care	Relevant – perception of experiences on staff and patients. Work stress and well-being important- staff experiences and how to manage – personal and professional development	Importance of well-being at work Care delivery

Laschinger and Fida (2015)	Linking Nurses' Perceptions of patient care quality to job satisfaction: the role of authentic leadership and empowering professional practice environments	**A cross-sectional survey** n=723	Leadership positive effect on empowerment In turn link to perception of support, and negative impact on perception that poor staffing impact on care delivery Good predictors of job satisfaction	Relevant- Low job satisfaction linked to care delivery. Leadership influential in managing/ creating positive environment	Importance of well-being at work Care delivery
Masum et al (2016)	Job satisfaction and intention to quit: an empirical analysis of nurses in Turkey	**Surveys** n=417	Link job satisfaction and intention to leave Relationship with support and supervisor important consideration Need to increase satisfaction and ensure quality care delivery	Important- Retention of staff relates to satisfaction and therefore team and environment need consideration	Importance of well-being at work Care delivery
Hall et al (2016)	Healthcare staff Wellbeing, burnout and patient safety: A systematic review	**Systematic Review** n=27	Burnout and poor wellbeing associated with poorer safety levels for patients Need for organisations to promote staff well-being and protect staff from burnout	Relevant-Links to care delivery wellbeing linked to patient safety. Organisations to consider staff wellbeing to improve delivery. Strategies to enhance well-being therefore important for staff, patient and the service	Importance of well-being at work Care delivery

Jackson et al (2007)	Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A review of the literature	**Literature review**	Nurses can strengthen their resilience Resilience help manage workplace adversity Need to incorporate resilience training into education and professional development	Relevant- Practitioners can develop resilience which impacts well-being Using AR can ensure self-determination by MHP	Importance of well-being at work Care delivery
Clearly et al., (2016)	Hope and mental health nursing	**Comment, critique and inspiration column** Hope in self and wellbeing and direct impact on service user care Overview of current perspectives of MHN and how mental health and well-being can be maintained in practice. Importance of optimism Value of self-awareness Impact of teams		Important- practitioners expected to have hope despite challenges faced. Importance of environments that foster positive approach despite difficulties faced ?impact on wellbeing for both patients and staff Value of hopefulness	Importance of well-being at work Care delivery
Woltman et al., (2008)	The role of staff turnover in the implementation of evidence based practices in mental health care	Implementation intervention project (across 52 sites-42 teams) Qual/Quant data collected	Changes in staff and turnover impact on projects Practitioner perception is important	Important- perception of practitioners to continue with AR projects despite facing challenges – suggestion that positive approach and workforce factors are of value Ensure that experienced staff engage in AR study to support and manage difficulties	Importance of well-being at work Care delivery

Theme –Factors influencing practitioner well-being Sub themes; Stress &burnout, Job satisfaction, Resilience and managing adversity, Subjective well-being, Therapeutic optimism, Team work					
Study	Title/relevance	Method	Findings/outcomes	Researcher Comment	Synthesised category
Oates, Jones and Drey (2017)	Subjective well-being of mental health nurses in the United Kingdom: Results of an online survey	Exploratory study Survey n=*225 UK registered mental health nurses (MHN)*	Low subjective well-being of MHN Need qualitative study needed to explore reasons for low subjective well-being of MHN	Relevance Importance to understand how MHN can manage and develop their well-being. What and how do MHN improve their well-being? Small scale -value of wider investigation MHN needed	Factors Influencing practitioner well-being Subjective Well-being
Buchan et al., (2019)	A critical moment: NHS staffing trends, attrition and retention	Health Foundation report Retention in NHS has not improved and in some areas is worse Increased pressures and demand on services has influenced staff stability Measures of staff in role at beginning and then at end of a year This may give insights into why staff stay		Relevance- understanding of complexities faced by MHP and adds value to intention to use AR to empower staff to make a difference despite the many and complex challenges that they face.	Factors Influencing practitioner well-being Stress and Burnout
Edwards et al (2000)	Stress and burnout in community mental health nursing: a review of the literature	Literature review N=19 (8 stress and burnout/11 CMHN	Stress-workload, administration, safety and time management inappropriate referrals Role stress-role conflict, role changes Relationship with others- lack of supervision	Important- still the case? Understanding the factors that impact on MHN and how stress can be relational to role and team. Important factors related to burnout include; Lack of supervision Relationships with staff Role Responsibility	Factors Influencing practitioner well-being Stress and Burnout

Sabanciogullari and Dogan (2015)	Effects of the professional identity programme on the professional identity, job satisfaction and burnout levels of nurses: a pilot study	Quasi-experimental study n= 63/personal data, survey ad questionnaire	Nurses professional identity significantly improved Burnout reduced in study group/increased in control group No influence on job satisfaction of nurses	Importance of Nurses identity - Professional identity improves level of burnout experienced and could impact on personal well-being	Factors Influencing practitioner well-being Stress and Burnout
McTierman and McDonald (2015)	Occupational stressors, burnout and coping strategies between hospital and community psychiatric nurses in a Dublin region	A between-groups study, *N=69 participants*	Stressors focus organisational issues Stressors lack of resources, workload and organisational process Community nurses higher sense of accomplishment Both groups reported average levels of emotional exhaustion	Good evidence Stress at work is linked to care delivery and community workers as those in the AR study are likely to have greater sense of professional accomplishment What accounts for MHN in community settings having greater accomplishment and why and how is this important?	Factors Influencing practitioner well-being Stress and Burnout
Pryjamachuk and Richards (2007)	Mental health nursing students differ from other nursing students: Some observations from a study on stress and coping	A cross-sectional survey *(n=1362),*	MHN differed from peers in type of stress Differences in MHN coping skills Coping skills influenced well-being Importance of sense of control	Some evidence-Value now? Show shifts in interpretation Although student nurses may be indicative of a perception of resilience in the face of type of stressors in the workplace. *How do MHN differ from other nursing groups?*	Factors Influencing practitioner well-being Stress and Burnout
Clearly et al., (2020)	Mental Health and Well-being in the Health Workplace	Comment, critique and inspiration column Health staff need to address self-care in workplace Work life balance to maintain well-being Addressing negative emotions Leaders can develop culture to improve team well-being		Relevant although not empirical evidence highlight importance of factors that influence the well-being of practitioners and the importance of colleagues. Suggest that there is	Factors Influencing practitioner well-being

				understanding of ways staff can maintain well-being.	Stress and Burnout
Hayes, Douglas and Bonner (2015)	Work environment , job satisfaction, stress and burnout among haemodialysis nurses	Survey n=417	Job satisfaction linked to perception of work environment Those who were older and had worked in clinical area had higher satisfaction Age factor in less stress and lower level burnout	Broader relevance-Job satisfaction relates to positive work environment ?team work	Factors Influencing practitioner well-being Job satisfaction
Walsh and Walsh (2002)	Caseload factors and the psychological well-being of community mental health staff	Questionnaires n=79	Staff mental health linked to caseload size Client gender also a factor Link staff mental health and their work	Evidence Understanding of impact of workload and complexity and maintaining well-being of mental health practitioners. Suggestions from more recent evidence remains the case for CMHT staff Other mental health practice areas?	Factors Influencing practitioner well-being Job satisfaction
Ward (2011)	Mental health nursing and stress: Maintaining balance	Qualitative, critical, feminist exploration *n=13*	Support evidence that MHN is stressful Managing work stress directly linked to job satisfaction	Good evidence (with caution) Clear links between stress and job satisfaction as important factor. Consideration though of gender perspective of the research. Enjoying what you do can positively impact on stress	Factors Influencing practitioner well-being Job satisfaction
Osborn and Stein (2016)	Mental Health Care Providers' Views of Their Work with	Questionnaires *N = 105*	Recovery orientated approaches linked to staff personal growth Working relationships with patients link to job satisfaction	Evidence Professional and personal well-being clearly linked to job satisfaction. Clear	Factors Influencing practitioner well-being

	Consumers and Their Reports of Recovery-Orientation, Job Satisfaction, and Personal Growth		Importance of view of work on personal and professional well-being	links between care delivery and well-being What accounts for the value of working with service users and how and what develops personal growth and satisfaction?	Job satisfaction
Rossler (2012)	Stress, burnout, and job dissatisfaction in mental health workers	Discussion of evidence *Several studies identify factors specific to those working in mental health such as stigma of profession and relationships with patients* *Relationship and difficulties with other mental health staff is important* *Lack of positive feedback and work environment*		Important consideration-Provides an overview of pertinent papers and evidence that highlight; Relationships and complexity of service users Difficulties of team dynamics Poor work environment Male MHN perspectives may differ?	Factors Influencing practitioner well-being Job satisfaction
Lu, Zhao and While (2019)	Job satisfaction among hospital nurses: A literature review	Literature review n=59	Job satisfaction linked to environment Value of organisational commitment Stress, satisfaction, ,professional commitment have mediating effect	Relevance-Work environment critical to job satisfaction and this is important and validates use of AR in this study	Factors Influencing practitioner well-being Job satisfaction
Rodwell and Munro (2013)	Well-being, satisfaction and commitment: the substitutable nature of resources for maternity hospital nurses	Cross-sectional survey *n=226*	Variance in well-being, job satisfaction and organisational commitment Support important and organisation justice Job satisfaction linked to job demands and supervisor support	Relevant-Sense of control over job and role important mediating factor in overall performance and to well-being. Importance of being supported and sense of organisational fairness/justice Importance of job satisfaction/well-being	Factors Influencing practitioner well-being Job satisfaction

Dahiten, Lee and MacPhee (2016)	Disentangling the relationship between staff nurses' workplace empowerment and job satisfaction	Cross-sectional survey n=1007	Predictor of job satisfaction structural empowerment Leader empowering behaviours important Psychological empowerment	Important- link to AR and empowerment. Being empowered can be influential on sense of being satisfied or not	Factors Influencing practitioner well-being Job satisfaction
Castenda and Scalan (2014)	Job satisfaction in nursing: A concept analysis	Concept analysis Job satisfaction attributes are; autonomy, interpersonal relationships and patient care Affective reaction to desired and expected outcomes Various measures of job satisfaction		As with this AR study autonomy can be predicative factor of job satisfaction. Team work and care delivery important considerations.	Factors Influencing practitioner well-being Job satisfaction
Wilson and Crowe (2008)	Maintaining equilibrium: a theory of job satisfaction for community mental health nurses	Grounded theory, *1-year period n= 12 CMHNs.*	Mediating factors; role, organisation, team work and personal life Role impacted on performance, therapeutic relationship and satisfaction	Evidence Links between managing satisfaction and working in a supportive environment. Important factors can influence subjective sense of wellness at work. Difficulties of bias and subjectivity.	Factors Influencing practitioner well-being Job satisfaction
Brennan (2017)	Towards resilience and wellbeing in nurses	Article- overview of literature Benefit of developing resilience Studies suggest that organisations can promote well-being; leadership, staff training, stress recognition Implement solutions to meet local need Need for case studies how to develop well-being and resilience		Important understand how being resilient can impact on well-being and the need for organisations to develop leaders to support and develop practitioners.	Factors Influencing practitioner well-being Resilience
Delgado et al (2017)	Nurses' resilience and the emotional labour of nursing work: An integrative review of empirical literature	Integrative review n=27	Residence build resources and address emotional discord Relationship between resilience and emotional labour needs to be explored Resilience interventions needed	Important- stress need to develop interventions to build resilience and this is can manage stress and enhance well-being	Factors Influencing practitioner well-being Resilience

Kravits et al., (2010)	Self-care strategies for nurses: A psycho-educational intervention for stress reduction and the prevention of burnout	Psycho-educational intervention positive self-care behaviours =resilience Wellness plan for staff Importance of nurse specific risk factors, relaxation techniques coping patterns Further research is needed		Relevance- nurses can determine and understand their wellness. Improving self-care and wellness requires engagement which is important- this AR staff will pre-determine what will work for them.	Factors Influencing practitioner well-being Resilience
Foster, Cuzzillo and Furness (2018)	Strengthening mental health nurses' resilience through a workplace resilience programme: A qualitative inquiry	An exploratory qualitative inquiry *n=29*	Nurses self-efficacy improve following resilience programmes Resilience helps to manage difficult emotions and responses to others	Evidence-Value of developing skills to manage workplace adversity. Link between well-being and resilience- important acknowledgement of resilience and relationships with peers- team work Transferability? Economic constraints in healthcare, what aspects of a programme have most impact on sense of coping?	Factors Influencing practitioner well-being Resilience
Hart, Brannan and De Chesney (2014)	Resilience in nurses :an integrative review	Integrative review n=7	Importance of interventions to build resilience Resilience linked to retention of nurses Organisations need to foster positive work culture	Broad evidence- need to appreciate how organisations can improve culture at work. Resilience links to performance, staff well-being	Factors Influencing practitioner well-being Resilience
Oates, Drey and Jones (2018)	What keeps nurses happy? Implications for workforce well-being strategies	Survey n=237 mental health nurses about their mental health and well-being n=27 interviews with individuals with personal experience	"Well-being was associated with clear boundaries between home and work life, regular clinical supervision and translating learning from work with patients to nurses' own lives." Well-being linked to work /life boundaries	Good evidence Strategies that can ameliorate against mental health issues for MHN and developing awareness of managing stress and well-being	Factors Influencing practitioner well-being Subjective well-being

			Regular clinical supervision Translating work to home learning	More exploration to understand managing well-being	
Brunetto et al., (2013)	The importance of supervisor–nurse relationships, teamwork, wellbeing, affective commitment and retention of North American nurses	Cross sectional Survey n=730	Intentions to leave explained by well-being, teamwork, supervisor relationship Older nurses higher levels of well-being and commitment Importance of workplace relationships	Relevant- value of teamwork and workplace relationships as linked to well-being. Need to understand how being in team can influence well-being of MHP- how to improve teamwork at CMHT	Factors Influencing practitioner well-being Subjective well-being
Morrissy, Boman and Mergler (2013)	Nursing a case of the Blues: an examination of the role of depression in predicting job related affective well-being in nurses	Questionnaires *n=70*	Job related affective well-being linked to depression, optimism and anxiety Depression predictive factor of job related well-being	Relevant-Links between well-being/optimism and subjective well-being AR aim to encourage MHP to engage in study and improve well-being at work. Optimism value.	Factors Influencing practitioner well-being Therapeutic optimism
Sergent and Laws-Chapman 2012	Creating a positive workplace	Feature article Link between resilience and mental and physical well-being Influence of leadership and on patient care Trusts address well-being through resilience training Value of managing link between well-being and care delivery		Relevant-links between well-being and care delivery. Managing well-being and sustaining well-being of staff requires consideration of work experiences, training and developing positive culture / optimism add value to this AR	Factors Influencing practitioner well-being Therapeutic optimism
Cruz (2017)	Quality of life and its influence on clinical competence among nurses: a self-report study	*Surveys n=163*	Clinical competence linked to experience, role, education and emotional well-being and social and physical functioning	Importance of practitioner perceptions in marinating positivity in workplace-link to care delivery Position of clinical competence and link to emotional well-being	Factors Influencing practitioner well-being Therapeutic optimism
Foster et al (2019)	Resilience and mental health nursing: An	Literature review n=12: Theoretical concepts of resilience and	MHN can strengthen resilience range of strategies	Good evidence Understanding coping with adversity of MHN. Internationally.	Factors Influencing

	integrative review of international literature	Knowledge on mental health nurses' resilience".	Role of organisations to provide strategies and safe environment Need opportunities for professional development	Important factors to consider; Role of organisations Importance of strategies to manage and build coping	practitioner well-being Resilience
Malinowski and Lim (2015)	Mindfulness at Work: Positive Affect, Hope and Optimism Mediate the Relationship between Dispositional Mindfulness, Work Engagement and Well-being	*Questionnaires n=299*	Mindfulness if engaged in predicts general well-being and work engagement Well-being and work engagement mediated by positive job affect, hope optimism and resilience and self-efficacy	Broader relevance-Building resilience and psychological capital impacts on care, attitude ad behaviours	Factors Influencing practitioner well-being Therapeutic optimism
Grumbach and Bodenheimer (2004)	Can health teams improve primary care practice?	*Discussion paper* Importance of team work Need clear goals –measurable Clinical and management processes Training and effective communication		Broader relevance- need for shared goals- gaining consensus important in the AR study. Team work and cohesion leads to better outcomes and /well-being of staff	Factors Influencing practitioner well-being Team work
Lemieux-Charles and McGuire (2006)	What do we know about healthcare team effectiveness? A review of the literature	Literature review n=33	Larger teams can be less satisfied with team function Perceived effectiveness linked to positive team processes	Relevance-AR will be dependent on effective team work wider team and co-workers. Team perception and team outcomes. /what constitutes effective team.	Factors Influencing practitioner well-being Team work
McInnes et al (2015)	An integrative review of facilitators and barriers influencing collaboration and teamwork between general	Integrative literature review n=11	Role definition, communication and organisational constraints impacts on collaboration in teams Need to consider role of leaders and also staff retention Importance of developing teamwork	Broader relevance- Importance of role, organisation, value of collaborative working. AR collaborative	Factors Influencing practitioner well-being Team work

	practitioners and nurses working on general practice				
McCann et al (2013)	Resilience in the healthcare professions: A review of recent literature	Literature review n=61	Inconsistencies in measuring and defining resilience Difficult in contrasting different professional groups Individual ad contextual factors impact	Important-Team work and job satisfaction linked. Need to develop nurturing environments to reduce stress	Factors Influencing practitioner well-being Team work
MCulloch et al (2011)	Interventions to improve teamwork and communications among healthcare staff	A systematic literature n=14	Borderline evidence of value of interventions Quality of studies Hawthorne No evidence of clinical benefit	Does teamwork influence less issues/problems in performance	Factors Influencing practitioner well-being Team work
Schmutz, Meier and Manser (2019)	How effective is teamwork really? The relationship between teamwork and performance in healthcare teams: a systematic and meta-analysis	Systematic review and meta-analysis n=31	Teamwork moderate impact on performance Value of teamwork and need to adopt approaches to improve teamwork	Relevance-links between team work and performance. Teamwork impacts on performance regardless of task AR will enhance opportunity for collaborative work	Factors Influencing practitioner well-being Team work
Cheng et al (2016)	Transformational leadership and social identity as predictors of team climate, perceived quality of care,	cross-sectional study n=201	Emotional labour and care delivery Team climate can help manage emotions Link between team and impact of burnout/retention	Relevant-Teams can moderate impact of stress and burnout. Reduced well-being linked to team climate	Factors Influencing practitioner well-being Team work

	burnout and turnover intention among nurses				
Fleury et al (2018)	Variables associated with perceived work role performance among mental health professionals; the importance of team dynamics	Questionnaire *n=315*	Perception of work role performance Value of relationships with peers Team processes Training in teamwork needed	Good evidence-There are clear links between the team in which practitioners work and the delivery of care. Effective team work leads to increased sense of being supported How do professional groups view teamwork? What are the important factors? And why?	Factors Influencing practitioner well-being Team work
Welp (2018)	The importance of reflecting on practice: How personal development activities affect perceived teamwork and performance	Cross sectional survey study N= 244	Positive perception of teamwork and performance associated with activities for personal and professional development If nurses perceive development activities as useful greater reflective thinking	Important-Personal and professional development activities equates to enhanced care delivery and team work. Being involved in AR will facilitate personal and professional growth	Factors Influencing practitioner well-being Team work
Rosen et al (2018)	Teamwork in Healthcare: Key discoveries enabling safer high quality care	Review of literature (psychological research)	Link teamwork and outcomes Role of teams in shaping collaboration in practice Context of team important More research needed	Important- teamwork is important and links to care delivery. ?positive perception of team upon well-being of staff. Well-being dependant on team work and more understanding is needed	Factors Influencing practitioner well-being Team work

Theme- Organisational factors that influence Well-being Sub theme; Workforce Development					
Study	Title/relevance	Method	Findings/outcomes	Researcher Comment	Synthesised category
Yu et al.,(2019)	Personal and work related factors associated with nurse resilience: A systematic review	Literature Review n=38	Resilience lead to personal and professional growth Can reduce emotional exhaustion and increase engagement with work No consistent measure of resilience in nurses	Broader relevance- personal and professional growth important to well-being. Improving well-being linked to interventions that can help MHP to manage adversity and stress	Organisational factors that influence well-being
Gillet et al (2019)	Managerial style and well-being among psychiatric nurses: A prospective study	Prospective questionnaire n=294 French nurses measures of perceived supervisors' autonomy-supportive behaviours and of psychological need satisfaction, work engagement and job satisfaction 1 year later.	Perceptions of supervisors' autonomy-supportive managerial style related to their vigour, dedication, absorption and job satisfaction 1 year later positive effects on meeting psychological need	Relevance in UK? /practice and supervision models etc But- The workplace can influence the satisfaction of MHN. The value of supportive behaviours by mangers highlight value in relation to job satisfaction What behaviours by managers influence MHN well-being? And why?	Organisational factors that influence well-being
Arnold (2017)	Transformational Leadership and Employee Psychological Well-Being: A Review and Directions for Future Research	Literature review n=40	Transformational leadership and link to improved well-being=indirect impact Well-being dependant on acceptance of shared goals Mindful of impact of follower stress	Broader relevance- , transformational leadership positive measures of well-being/negatively predicts negative measures of well-being	Organisational factors that influence well-being

Wong and Laschinger 2013	Authentic leadership, performance and job satisfaction: the mediating role of empowerment	non-experimental, predictive survey n=280	Authentic leadership significant in empowerment Empowerment influenced job satisfaction Influence performance	Relevant –role of leaders and organisations to empower staff. Using an AR approach will empower MHP to act as co-researchers determining what works for them to improve well-being. Indirect support of organisation to support AR and therefore create positive culture	Organisational factors that influence well-being
Dow et al (2019)	Practitioner wellbeing as an inter-professional imperative	*Editorial* Practitioner well-being precursor for health outcomes consider inter-professional interventions and then easier to detect improvements in well-being In light of stress and burnout and retention issues need to de construct inter-professional practice to begin to understand collective well-being Importance to care delivery as inter-professionals		Importance of well-being at work Organisational factors that influence well-being Workforce development Relevance Well-being and resilience and understanding the concept continues to evolve. Value of inter professional viewpoint. CMHT staff multi- professional MHPs	Organisational factors that influence well-being
Avey et al., (2011)	Meta-analysis of the impact of psychological capitol on employee attitudes, behaviours and performance	Meta-analysis 51 independent samples (representing a total of N = 12,567 employees)	Positive relationship of psychological capitol and job satisfaction, organisational commitment and well-being Negative relationship between anxiety, stress cynicism and undesirable work behaviours	Very Broad relevance-Importance of subjective well-being to manage work experiences. Managing and well-being linked to being resilience and to optimism and hope. Relevance to MHP who are struggling to manage many challenges that they face	Organisational factors that influence well-being

Utriainen, Ala-Mursula and Kyngas, (2015)	Hospital nurses' wellbeing at work: a theoretical mode	Survey n=233	Developed theoretical model Well-being-importance of management and leadership	Important- Developing shared vision and allowing innovation by nurses is important	Organisational factors that influence well-being
Alenzi, McAndrew and Fallon, (2019)	Burning out Physical and emotional fatigue: Evaluating the effects of a programme aimed at reducing burnout among mental health nurses	Quai- experimental design Pre and post test control/study intervention group	In short term significant improvement in intervention group Burnout prevention programmes can be effective Could add to coping skills to manage work stress	Relevant- although not UK study there is global issues with staff in healthcare and mental healthcare experiencing burnout. Importance of role of organisation to foster ways that MHP can maintain well-being and mange adversity	Organisational factors that influence well-being
Williams et al., (2018)	Interventions to improve employee health and well-being within health care organizations: A systematic review	Systematic review *n*=44 studies	Methodological issues Some interventions are of benefit No benchmark or measure	Relevant- can using an AR approach and empowerment of MHPs to determine strategies have influence on well-being	Organisational factors that influence well-being
Schon et al., (2018)	Resources for work-related well-	Exploratory design interview n=23	Importance of relationships to patient	Importance- value of team work and relationship with peers, understanding	Organisational factors that

	being: A qualitative study about healthcare employees' experiences of relationships at work		Relationships with colleagues	experiences will enable more positive work experience so to develop-enhance well-being AR= collaboration.	influence well-being
Kim et al., (2019)	Factors influencing well-being in clinical nurses: A path analysis using a multi-mediation model	**cross-sectional design** n=310	Well-being links to resilience, gratitude disposition, burnout, compassion satisfaction Job satisfaction, and intervention programmes? Improve well-being	Important- Links between job satisfaction, resilience and well-being. Value of increasing resilience and job satisfaction.	Organisational factors that influence well-being
Salyers et al., (2017)	The relationship between professional burnout and quality and safety in Healthcare	**A Meta-Analysis**	Systematic and quantitative analysis burnout and delivery healthcare Burnout linked to perceived negative relationship care and safety Need for burnout interventions	Relevant- Importance of ameliorating the effect of burnout. Links made to patient safety and care delivery. Impact on staff well-being of stress and burnout.	Organisational factors that influence well-being
Bronkhorst et al., (2015)	Organisational climate and employee mental health outcome:-A systematic review of studies in health organisations	Systematic Review of literature n=21	Climate associated with positive employee mental health outcomes such as lower levels of burnout, depression, and anxiety. Relationships between co-workers important- the mental health of health care workers.	Relevance- Well-being of practitioners linked to culture of the organisation. Leadership and co-worker collaboration Importance of teams	Organisational factors that influence well-being

			Leadership and supervision affect mental health outcomes.		
Back et al (2016)	Building Resilience for Palliative Care Clinicians: An Approach to Burnout Prevention Based on Individual Skills and Workplace Factors	**Article** Approach to managing burnout and therefore improving well-being Model suggests that well-being influenced by work demand and personal resources of clinicians Building resilience is important Normalising of stress and value of this		Broad relevance- value of empowerment to enhance well-being at work to manage stress. Sense of coping is important and using AR empowers to develop and grow.	Organisational factors that influence well-being

Appendix 2 Semi structured interview schedule

Initial questions	Main questions	Additional questions	Clarifying questions
Please tell me a bit about yourself?		**Ask age?** **What is your professional experience/role?** **Years of experience? Time in current role?**	
How long have you worked at the CMHT?		**Has your job changed?**	**What attracted you to the role?**
Tell me about your role here at the CMHT?		**What are the positive aspects of your role/job? Why is this?** **What are the challenges that you face in your role/job?** **Why is this? What is it like?**	**Can you tell me more about..?** **Can you tell me more about..?**
I am going to ask some questions about your experiences at work and in particular well-being	**When you think about your well-being at work what do you think about?**	**What is good or bad about it?** **What are the challenges that you face in managing well-being?** **Is there anything that might be important that helps you?**	**Can you tell me more about..?** **Can you give me an example of this?** **Can you give me an example of this?**
	How do you view team - work? **How do you view job satisfaction?** **How do you view personal resilience?**	**What is good or bad about it?** **What is good or bad about it?** **What is good or bad about it?**	**How does this affect your role/job?** **How does this affect your role/job?** **How does this affect your role/job?**
	How do you develop team-work? **How do you develop job satisfaction?** **How do you develop personal resilience?**	**What is the most important aspects of this?** **What is the most important aspects of this?** **What is the most important aspects of this?**	**Can you give me an example of this?** **Can you give me an example of this?** **Can you give me an example of this?**
How can we develop team-work? **How can we develop job satisfaction?** **How can we develop personal resilience?**	**Why would this help?** **Are there any opportunities to do this?** **Why would this help?** **Are there any opportunities to do this?** **Why would this help?** **Are there any opportunities to do this?**	**Can you give me an example of this?** **Can you give me an example of this?** **Can you give me an example of this?**	

What specific interventions can we use that develop and strengthen team- work? **What specific interventions can we use that develop and strengthen job satisfaction?** **What specific interventions can we use that develop and strengthen personal resilience?**	**Why would this help?** **What is the most important aspect of this?** **Why would this help?** **What is the most important aspect of this?** **Why would this help What is the most important aspect of this**	**Can you give me an example of this?** **Can you give me an example of this?** **Can you give me an example of this?**	

Appendix 3 Focus group schedule

Overview;
The purpose of research is to widen understanding of initiatives in practice that develop and strengthen team-working, job satisfaction and personal resilience. Resilience is defined in this instance as being an ability to cope with stress and to learn from experiences.

Ground rules;

- No right or wrong answers, only differing points of view
- We're tape recording, one person speaking at a time/consent
- We're on a first name basis
- You don't need to agree with others, but you must listen respectfully as others
- share their views
- We ask that your turn off your phones. If you cannot and if you must respond to a call, please do so as quietly as possible and re-join us as quickly as you can.
- My role as moderator will be to guide the discussion
- Talk to each other

First questions;
Let's do a quick round of introductions.

Can each of you tell the group your name,

Your role at the CMHT and how long you have been here

My next questions are related specifically to the project and will hopefully help us understand a bit more about how we can begin to improve TW, JS and PR

On the post it notes can you put 3 things that are good about working at the CMHT and 3 things that are not so good about working here and put on the flipchart sheets

Now we have done that we will begin to think about well-being and what that means to you as a MHP.

Well-being
What are your thoughts about well-being?
How do you feel about it?
What is good about it?
What is not so good about it?

What strategies might improve well –being?

Team-work

What are your thoughts about team-working?

How do you feel about team-work?

What is not good about team-work?

What is good about team-work?

What type of strategies/ interventions might improve team-work?

Job satisfaction

What are your thoughts about job satisfaction?

How do you feel about job satisfaction?

What is not good about job satisfaction?

What is good about job satisfaction?

What type of strategies/ interventions might improve job satisfaction?

Personal resilience

What are your thoughts about personal resilience?

How do you feel about personal resilience?

What is not good about personal resilience?

What is good about personal resilience?

What type of strategies/ interventions might improve personal resilience?

If you could all put what you feel is the best solution on (a post it note) to improving TW, JS and PR on each of the designated areas

Finally, *all things considered if we had to say what the most important thing about TW, JS and PR what would it be?*

Of all the things we discussed, what to you is the most important?

Summary
Is this an adequate summary?

Final question
So bearing in mind the purpose of the study, have we missed anything?

Appendix 4 Ethical approval

Ms Nicki Moone
Student No: 10468967

College of Nursing,
Midwifery & Healthcare
Research Ethics Panel
Paragon House
Boston Manor Road
Brentford TW8 9GA
Tel: +44 (0)20 8209
4110/4145
email:
cnmh.ethics@uwl.ac.uk

12 April 2017

Dear Nicki

Re: Application for Ethical Approval No. UWL/REC/CNMH-00066

Thank you for sending in your application for approval. The Chair of the Committee has considered this and approved the research.

If the research does not progress, or if you make any changes to your research proposal or methodology can you please inform the Committee in writing as this may entail the need for additional review.

It is your responsibility, as the principal investigator, to submit a report on the progress/completion of the research twelve months from the date of this letter. The Committee wish you well with your research and look forward to your report.

Yours sincerely

Heather Loveday

Professor Heather Loveday
Director of Research
Richard Wells Research Centre
Joanna Briggs Institute Collaborating Centre
College of Nursing, Midwifery and Healthcare
UNIVERSITY OF WEST LONDON
Paragon House
Boston Manor Road
Brentford,
Middlesex TW8 9GB
Tel: +44 (0)20 8209 4110
e-mail: heather.loveday@uwl.ac.uk
URL: http://www.uwl.ac.uk

Appendix 5 Ethical considerations

Ethical Implication	Details of Implication	Reduction Plan
Issue of power	The researcher is a senior clinician and this needs to be taken into account in all stages of the process	• Transparency of role as a researcher and as a clinician • Senior staff involved will be involved in groups outside of their line management roles • Supervision and feedback to ensure that collaboration remains at heart of the process • Explore ownership and co researcher roles at outset with participants
Appraisal of Consent	Ensuring the participants fully understand the aim of study and what it entails before they agree to participate.	• Ensure that participants understand the nature of action based research and their role within by doing a presentation (not given by the researcher) and receiving written information
Confidentiality	It is important for all data collected particularly at stage 1 to be kept confidential and to ensure the participants are not identifiable as individuals. NB this will relate to feeding back findings from the project as a whole	• It is important that all co researchers are able to contribute to all stages of the process • Data collected at stage 1 will be anonymised to ensure anonymity • All co researchers will be made aware that confidentiality will only be broken if there is potential to harm or a breach of professional codes of conduct • Ground rules to be established during phase 1 data collection
Undue Influences	In some studies the participants may feel obliged to take part which will affect the validity of the study.	
Pressure to be involved	Not all team members will wish to be involved and this must be clearly stated to all potential co researchers that it is optional	• A presentation to the team will outline the project and how action research works in practice • Staff will not be approached to join the project but will be invited by peers or by volunteering • Senior staff involved will be involved in groups outside of their line management roles • Ground rules developed for phase 1 data collection
Perceived consequences	Some participants may perceive that they will be viewed in a negative manner during the initial stage of the process if they share personal experiences	

Appendix 6 Consent forms (Participants and Co-Researchers)

UNIVERSITY OF WEST LONDON

Participant Consent Form

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Research Consent Form

Title of Project: ***Working with community mental health practitioners to develop team working, job satisfaction and personal resilience: An Action Research project (AR)***

Lead Researcher: Nicki Moone

Please sign your initials in the boxes to show you consent to each point:

1. I confirm that I have read and understand the information sheet dated ..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my interview will be recorded. ☐
3. I understand my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
4. I understand that the results of the study may be shared with the researchers' colleagues, as a way of reviewing the findings. I understand that the data from the interviews may be kept confidentially for up to 5 years before being destroyed. ☐
5. I agree to take part in the above study. ☐

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Final Version May 2017

Participant Information Sheet

The Research Study

I am conducting a study looking at developing well-being, team-working, job satisfaction and personal resilience at the CMHT. You have been asked to be a part of this study because you are currently working at the CMHT. The aim of this research is to involve CMHT practitioners in developing strategies that will improve the identified 3 areas.

What does the study involve?

The study will include an interview/ focus group which will last approximately 1 hour. The questions are;

1. How do mental health practitioners view well-being, team-working, job satisfaction and personal resilience?

2. How do mental health practitioners develop well-being, team-working, job satisfaction and personal resilience?

3. How can mental health practitioners develop well-being, team-working, job satisfaction and resilience?

4. What specific interventions do mental health practitioners use that develop and strengthen team-working, job satisfaction and personal resilience?

Risks and Benefits

During the interview it may be possible that sensitive topics are discussed, therefore you are encouraged to take this into consideration before agreeing to take part. It is understandable that talking about your experiences at work can be difficult. The researcher undertaking the interviews is an experienced practitioner and so is confident in supporting you if you do become distressed at any time. You have the right to stop the interview at any point and you can withdraw from the study at any time. You will also be provided with information on other services which can help if needed. There is no direct benefit to taking part in the study however many people say that having the opportunity to talk about their situation and experiences' has a benefit for them.

What will happen to my personal information?

All identities and personal information will be kept confidential throughout the study. First names will be used during the recorded interviews and real names will not be used in the writing up of the study. All copies of the interviews and the recordings will be kept in a locked drawer or held within a password protected computer file. You will also have the opportunity to look through the transcripts to ensure no information is identifiable. If this study gets published into a journal article, all volunteers will be notified beforehand. During the writing up of the study, the researcher may need to discuss the findings with their colleagues. This is to check the results are valid and again that no identifiable information is visible. The colleagues are also bound by confidentiality rules within their place of work. The Berkshire Healthcare NHS Foundation Trust Research and Development Team may need to access the data to comply with ethical approvals.

Do I have to take part?

You do not need to volunteer to participate unless you want to. You are also free to withdraw at any time and do not need to give an explanation if you do not wish to continue. If you choose to withdraw from the study at any point it will not affect your role at the CMHT.

Who is organising and funding the research?

The researcher is conducting this research through the University of West London and has a named supervisor who is overseeing the study. The study has also been approved by the University of West London ethics committee and by the audit department within Berkshire healthcare NHS trust. Contact for further information: If you would like more information about the study you can contact either myself or the research supervisor on the contacts below.

Researcher	**Supervisor**
Nicki Moone	Elizabeth Barley (Professor)
Reading CMHT	CNWH
Prospect Park Hospital	University West London
Reading, Berkshire	Brentford, London
RG30 4EJ	TW8 9GA
Telephone 011895612	Telephone 02082094210

Thank you very much for your time

Participant Information Sheet

Co-Researchers

The Research Study

I am conducting a study looking at developing well-being, team-working, job satisfaction and personal resilience at the CMHT. You have been asked to be a part of this study because you are currently working at the CMHT. The aim of this research is to involve CMHT practitioners in developing strategies that will improve the identified 3 areas. This study is an Action Research study and this means that Co-Researchers actively engage in the research and in this case develop interventions to improve well-being at the CMHT using PDSA as a method of quality improvement. As you work at the CMHT you can engage I the study as it develops as a co-researcher.

What does the study involve?

The study will include an interview/ focus group which will last approximately 1 hour. The questions are;

1. How do mental health practitioners view well-being, team-working, job satisfaction and personal resilience?

2. How do mental health practitioners develop well-being, team-working, job satisfaction and personal resilience?

3. How can mental health practitioners develop well-being, team-working, job satisfaction and resilience?

4. What specific interventions do mental health practitioners use that develop and strengthen team-working, job satisfaction and personal resilience?

The study also includes

Co-researchers working together and with other stakeholders to look at findings from the interviews and any other relevant data and to consider how best to develop changes to be made that will improve the well-being of staff at the CMHT.

Risks and Benefits

As a co-researcher it may be possible that sensitive topics are discussed, therefore you are encouraged to take this into consideration before agreeing to take part. It is understandable that talking about your experiences at work can be difficult. The researcher undertaking the action research is an experienced practitioner and so is confident in supporting you if you do become unable to continue as a co-researcher at any time and for any reason. You have the right to stop being a co-researcher at any point and you can withdraw from the study at any time. There is no direct benefit to taking part in the study however many people say that

having the opportunity to be a co-researcher in a study about their situation and experiences' has a benefit for them and can also mean acquisition of new research skills.

What will happen to my personal information? And information of peers?

All identities and personal information will be kept confidential throughout the study. First names will be used during the recorded interviews and real names will not be used in the writing up of the study. All copies of the interviews and the recordings will be kept in a locked drawer or held within a password protected computer file. You will also have the opportunity to look through the transcripts to ensure no information is identifiable. If this study gets published into a journal article, all volunteers will be notified beforehand. During the writing up of the study, the researcher may need to discuss the findings with their colleagues and you as co-researchers. This is to check the results are valid and again that no identifiable information is visible. The colleagues are also bound by confidentiality rules within their place of work and this also applies to the role of a co-researcher. The Berkshire Healthcare NHS Foundation Trust Research and Development Team may need to access the data to comply with ethical approvals.

Do I have to take part?

You do not need to volunteer to participate unless you want to. You are also free to withdraw at any time and do not need to give an explanation if you do not wish to continue. If you choose to withdraw from the study at any point it will not affect your role at the CMHT.

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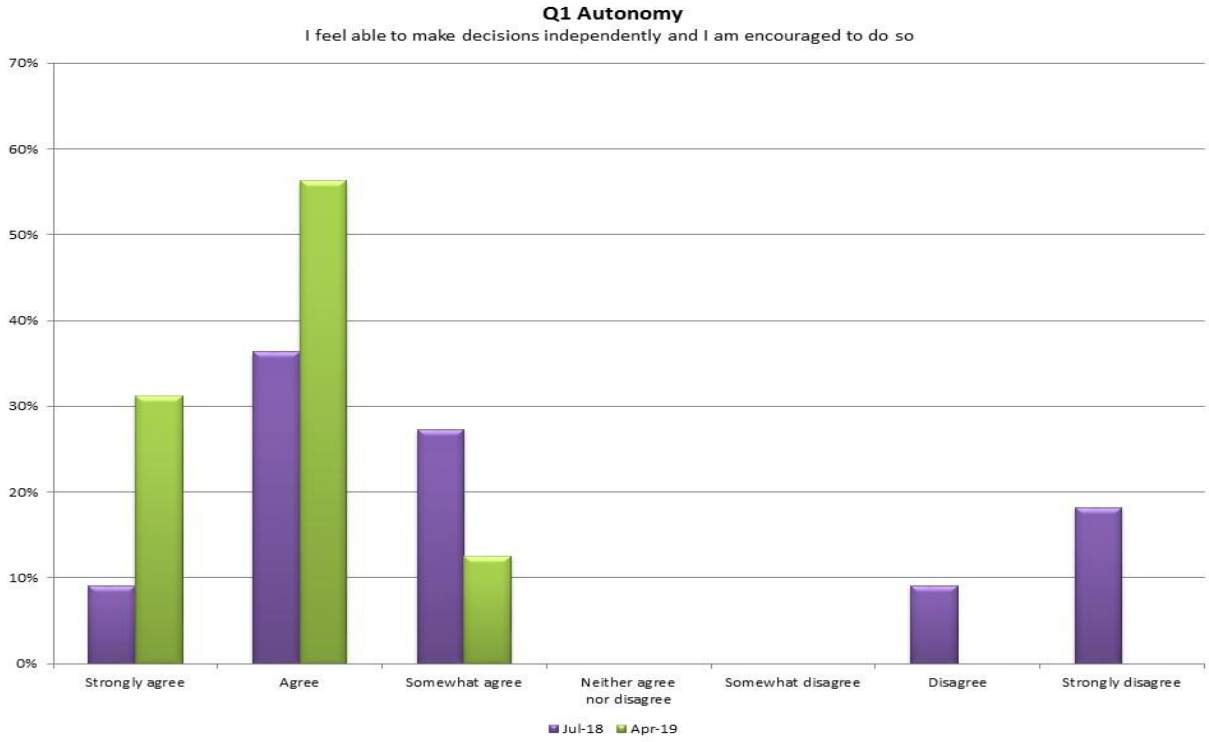
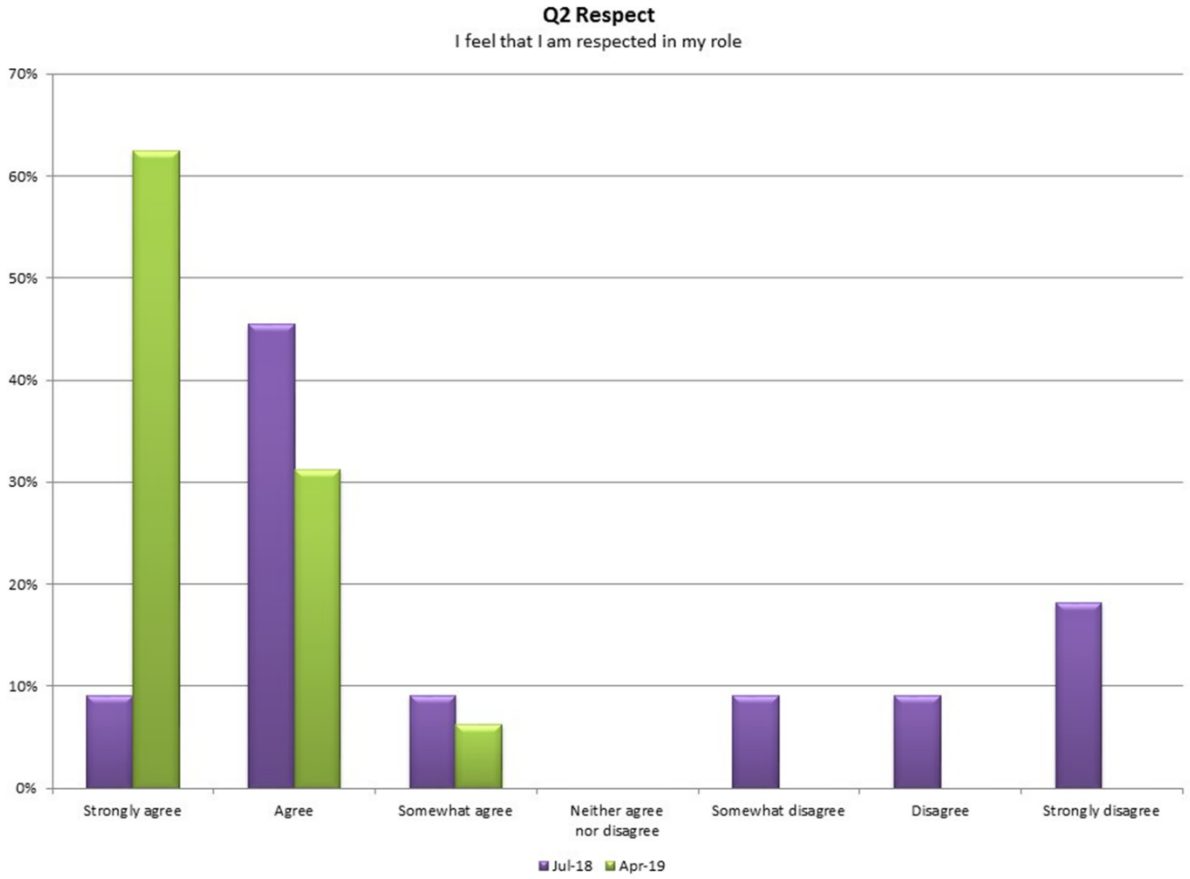
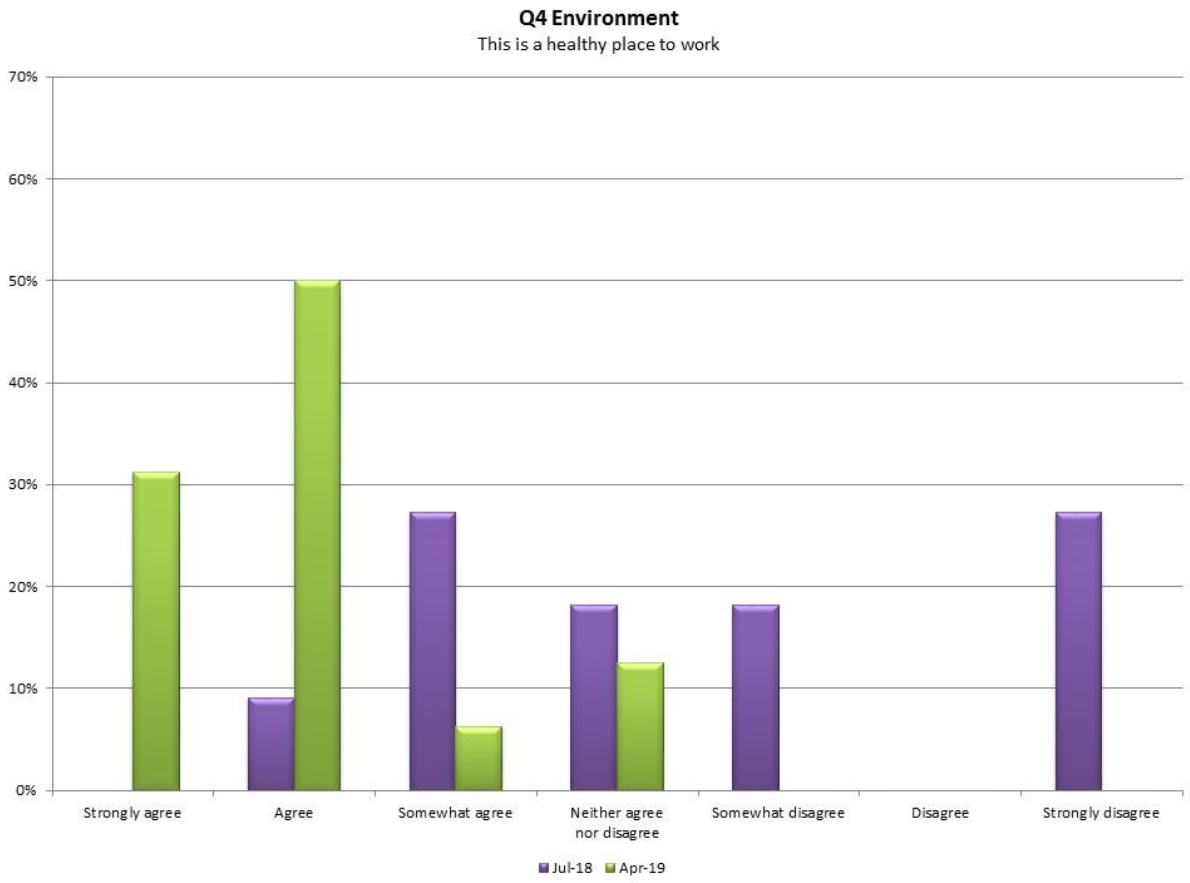
Nicki Moone	Elizabeth Barley (Professor)
Reading CMHT	CNWH
Prospect Park Hospital	University West London
Reading, Berkshire	Brentford, London
RG30 4EJ	TW8 9GA
Telephone 011895612	Telephone 02082094210

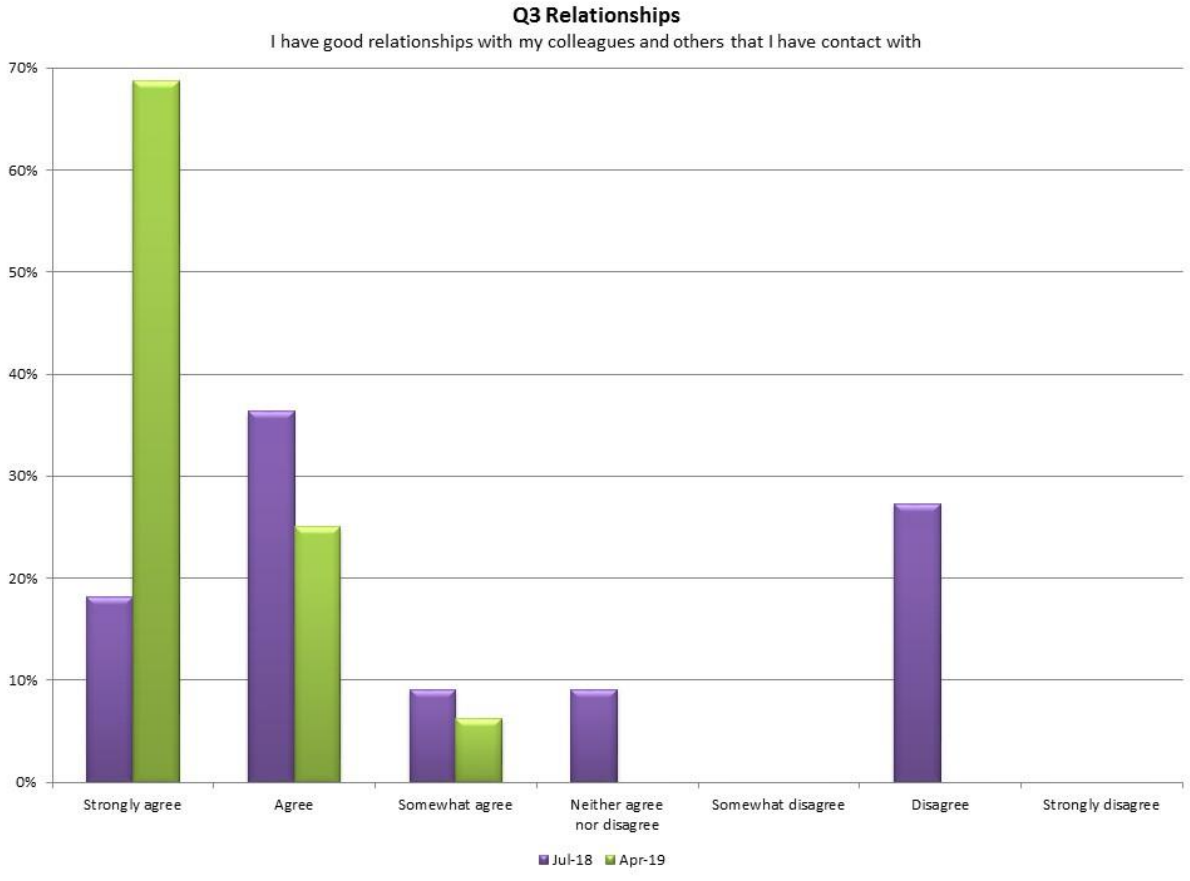
Thank you very much for your time

Appendix 7- Survey results July 2018-April 2019



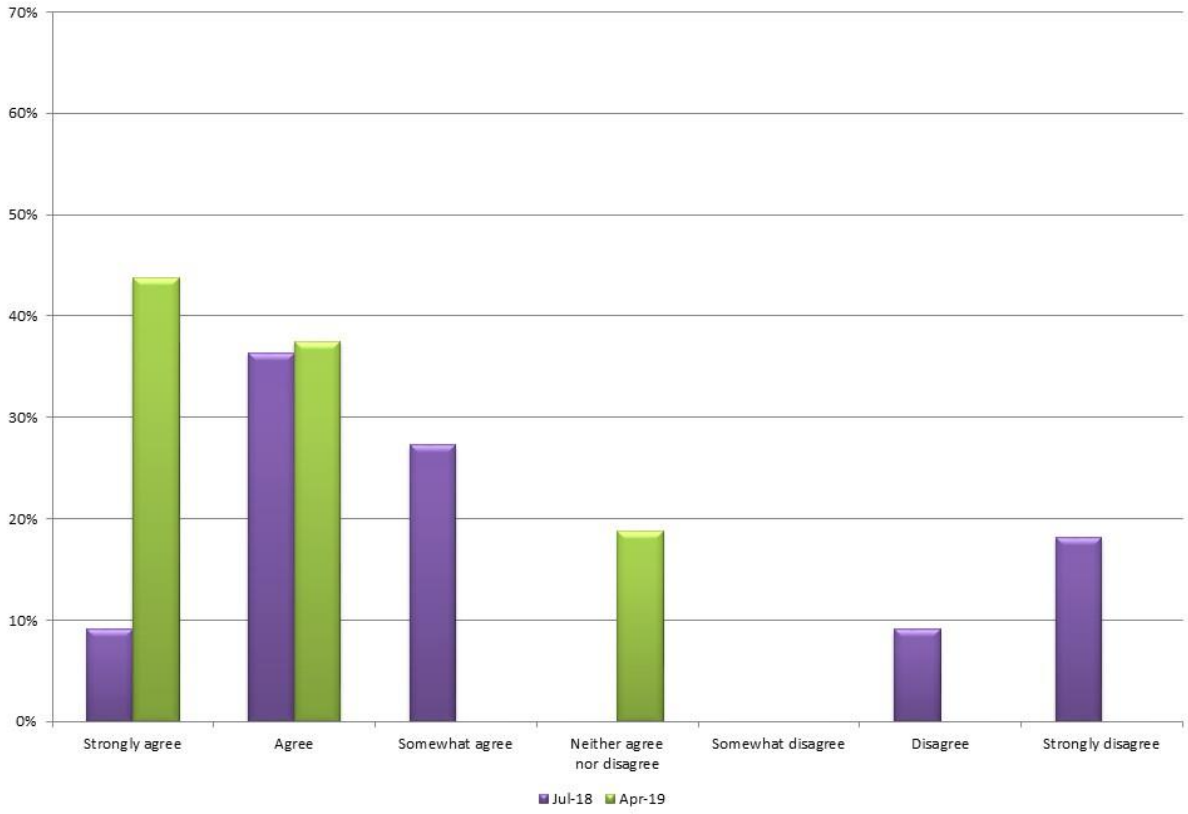



Q4 Environment
This is a healthy place to work
70%
60%
50%
40%
30%
20%
10%
0%
Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree
Jul-18
Apr-19


Q3 Relationships
I have good relationships with my colleagues and others that I have contact with
70%
60%
50%
40%
30%
20%
10%
0%
Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree
Jul-18
Apr-19

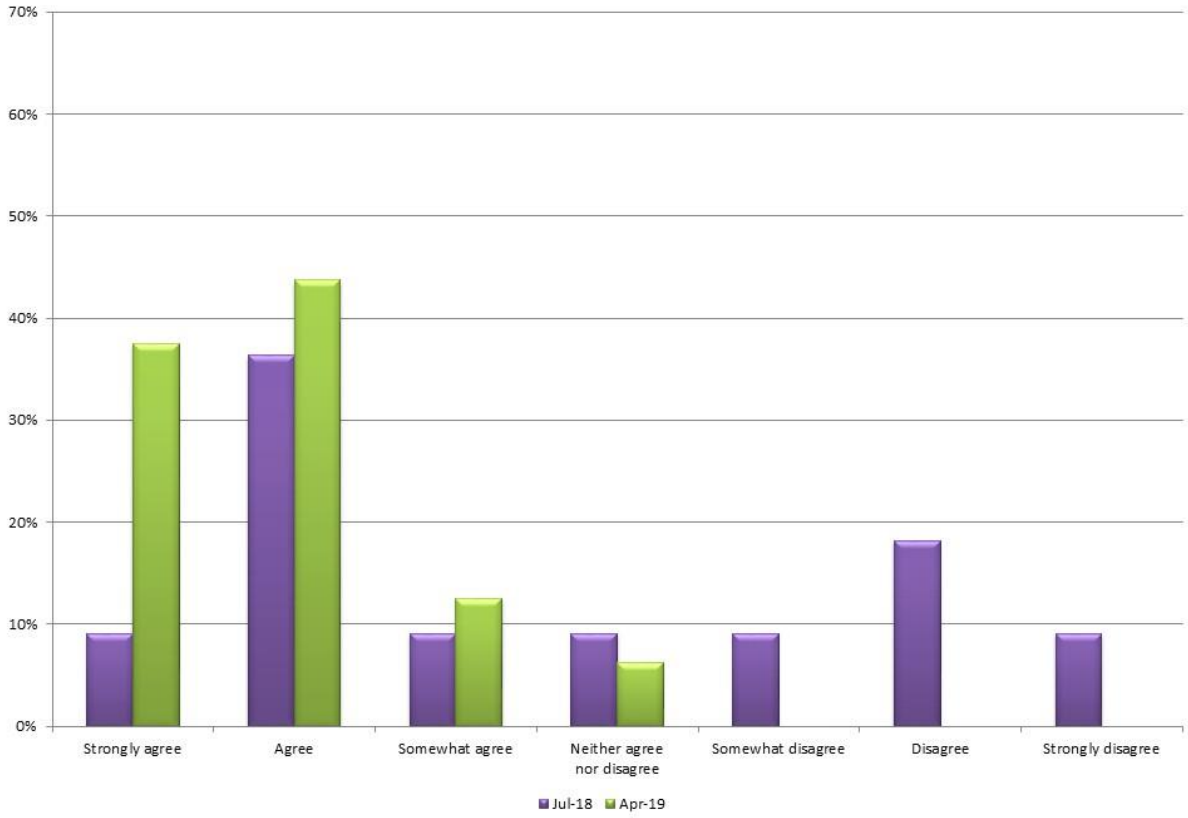
Q6 Leadership

I am encouraged to make a contribution to developing the team as a whole



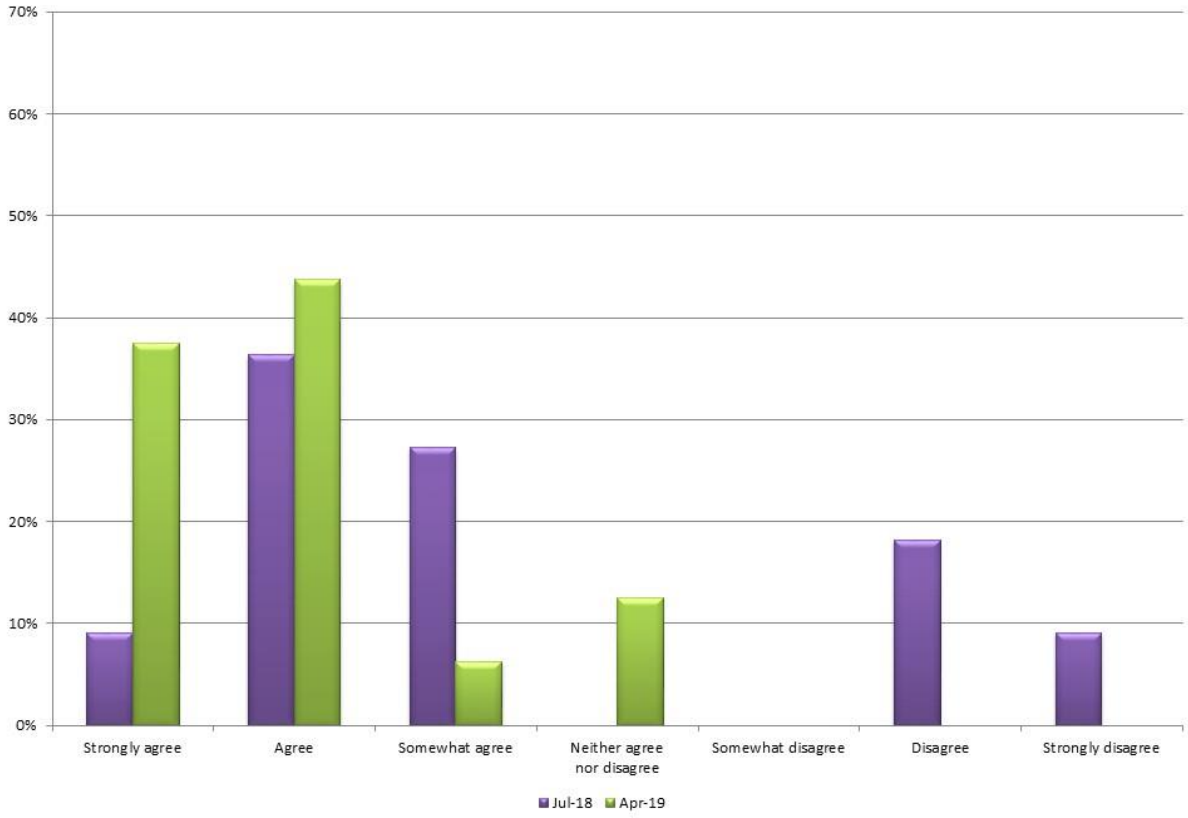
Q5 Justice

I feel that I am always treated fairly



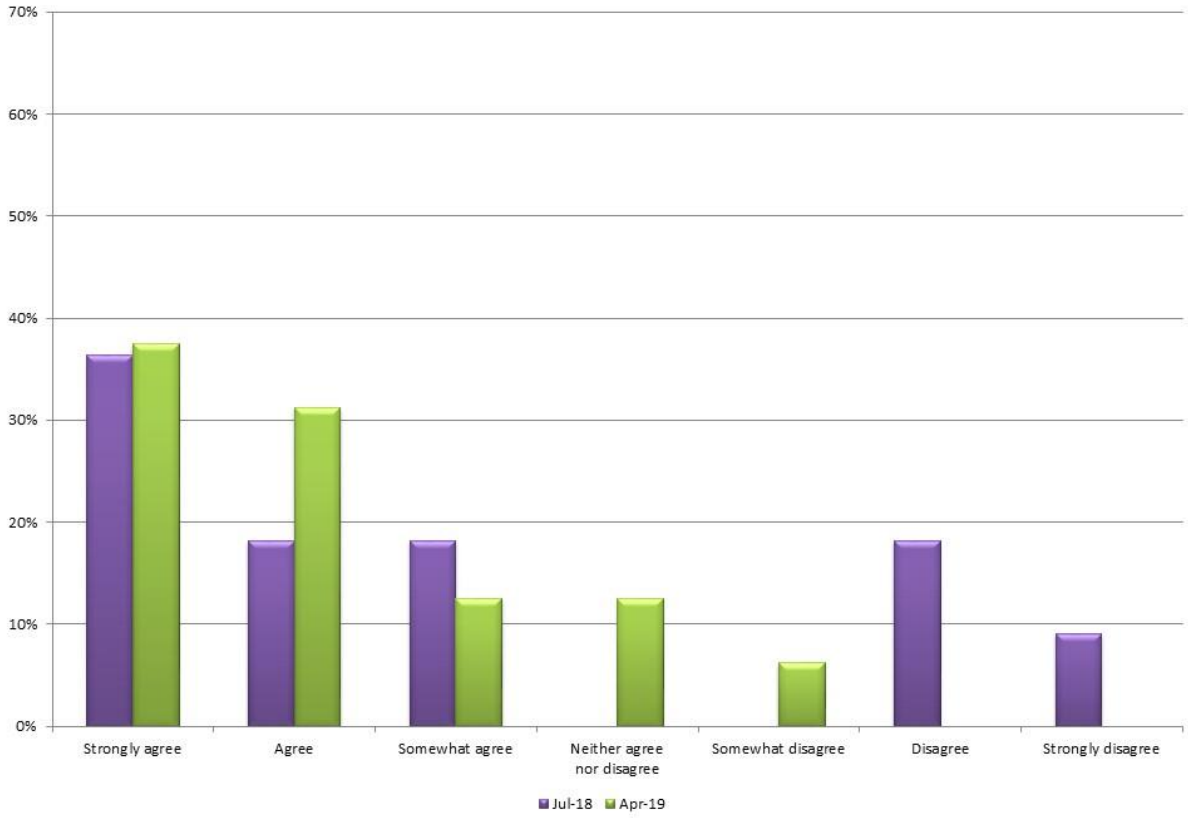
Q7 Expectations

I feel positive about my role and anticipate that I will continue to achieve my goals



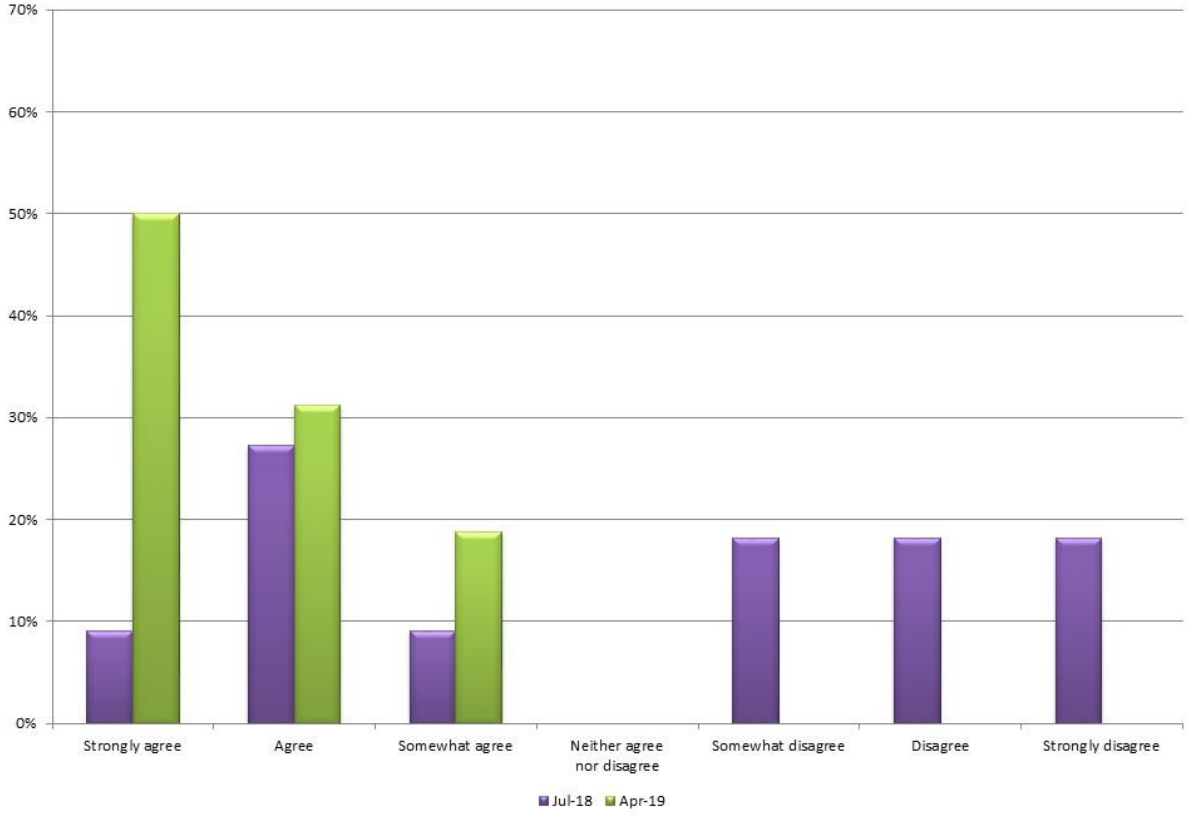
Q8 Motivation

I feel excited by my role and I am keen to develop



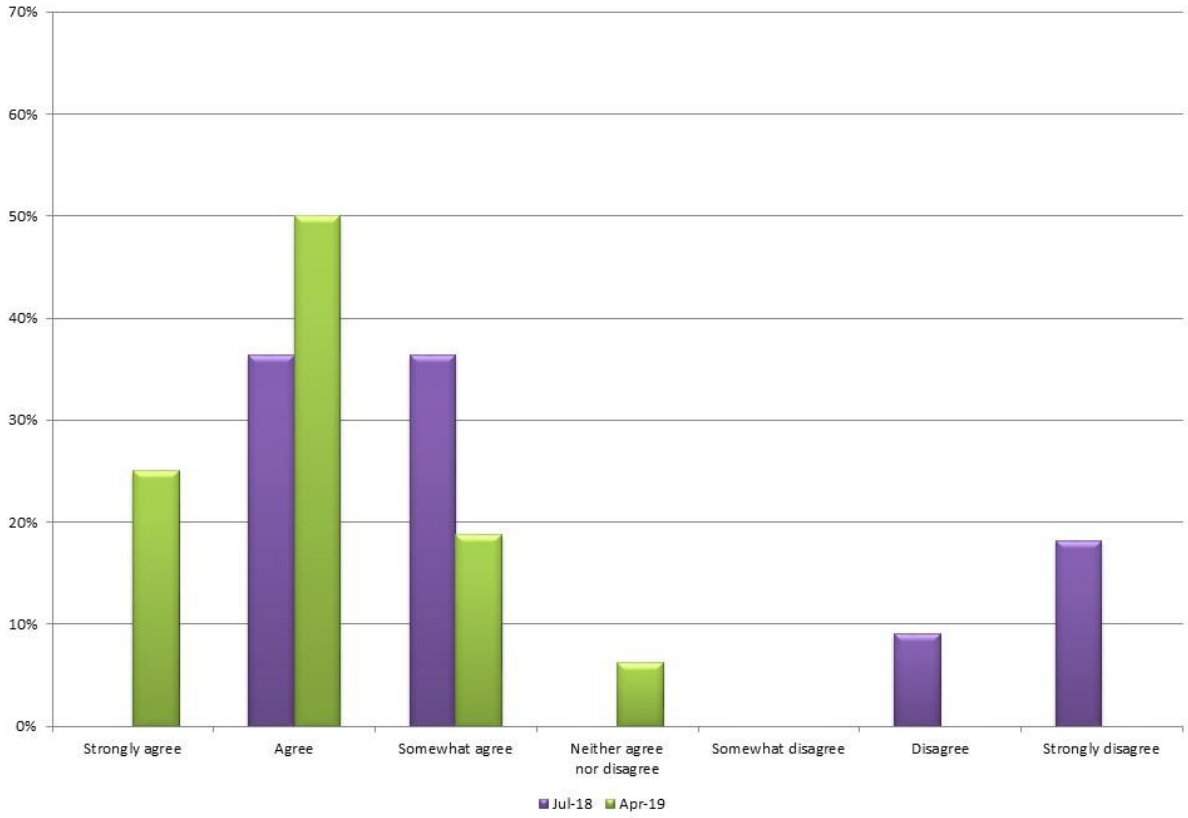
Q9 Work Life Balance

I am able to keep my personal and professional life separate



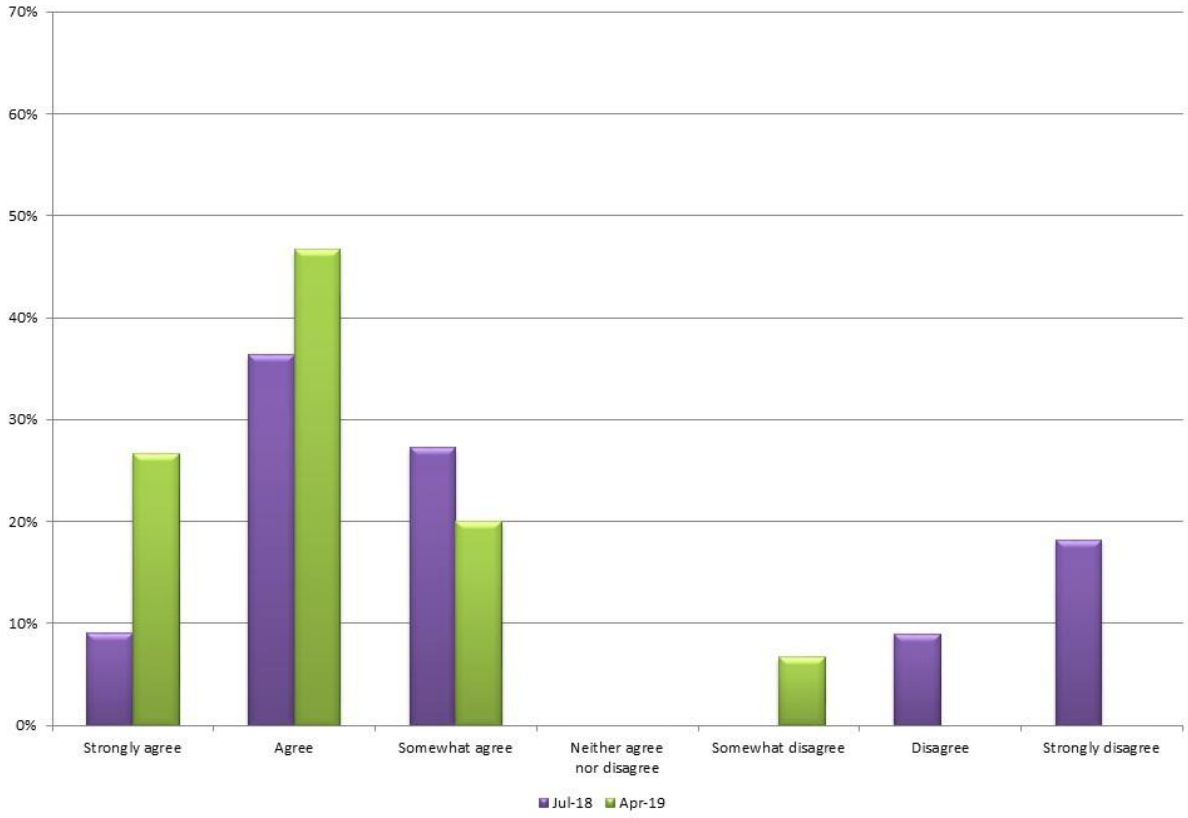
Q10 Resilience

I feel that I cope well with stress and adversity at work and adapt well



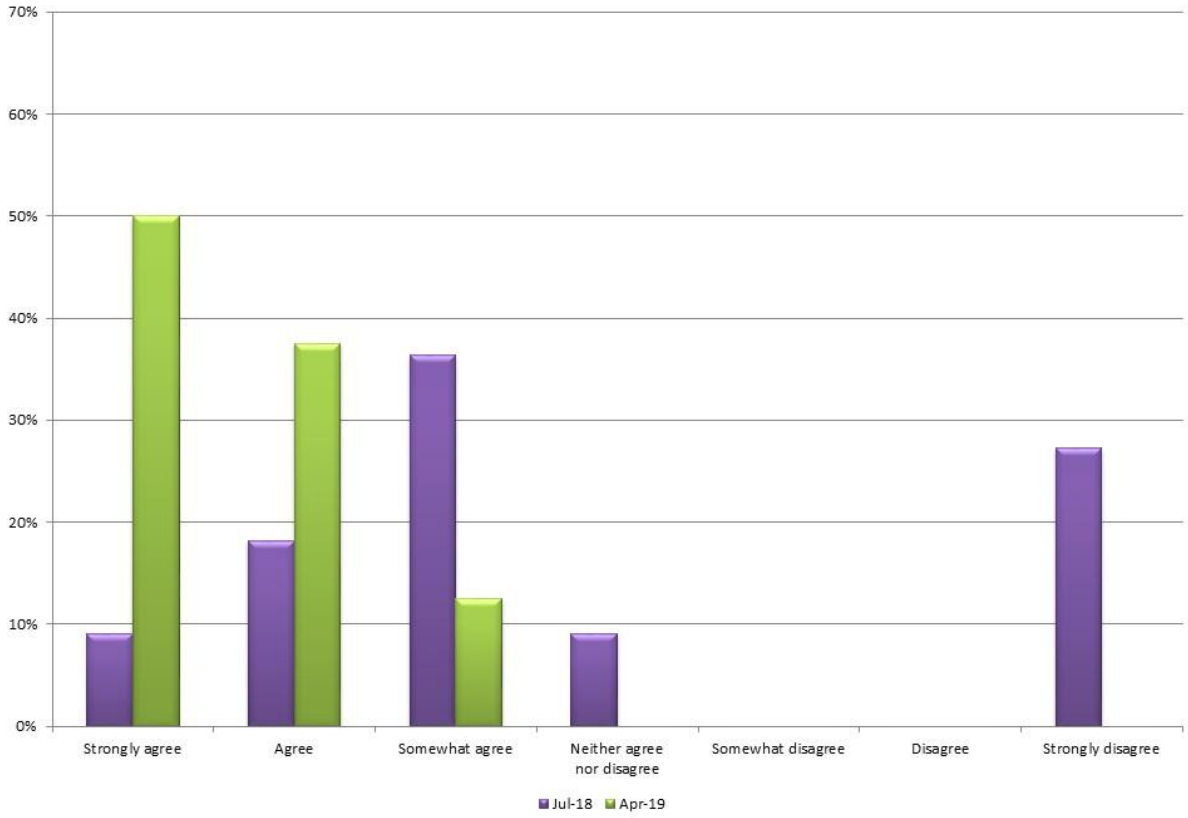
Q11 Coping with stress

I feel that I have effective strategies to manage work stress



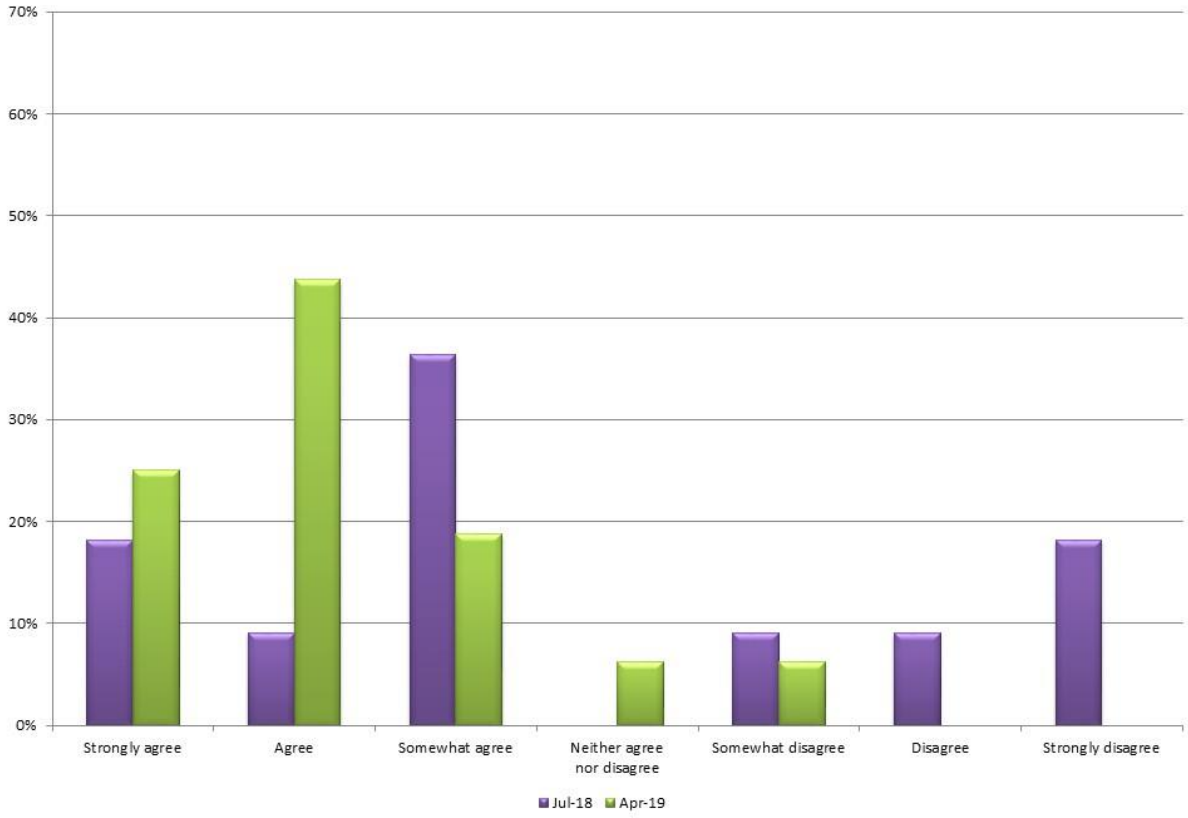
Q12 Working with Others

I enjoy working in my team and feel very supported



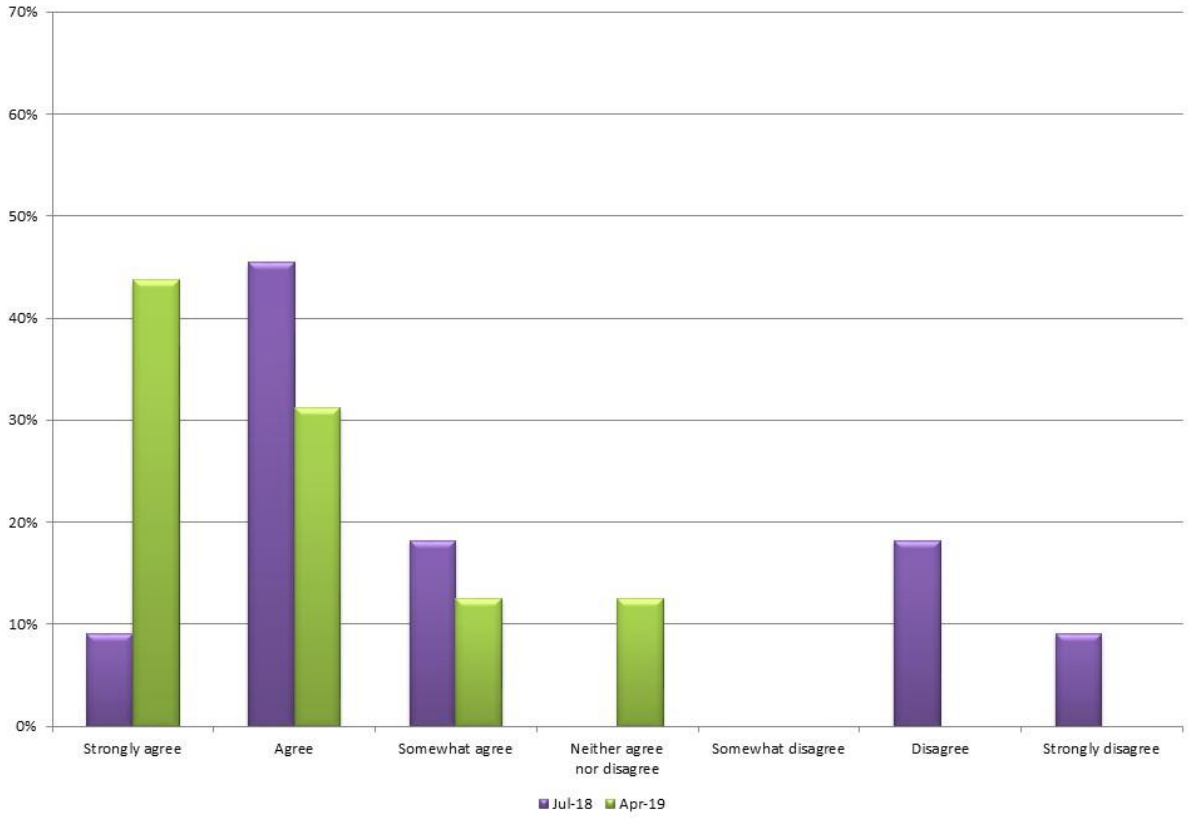
Q13 Communication

As a team member I am kept up to date and always know what is happening



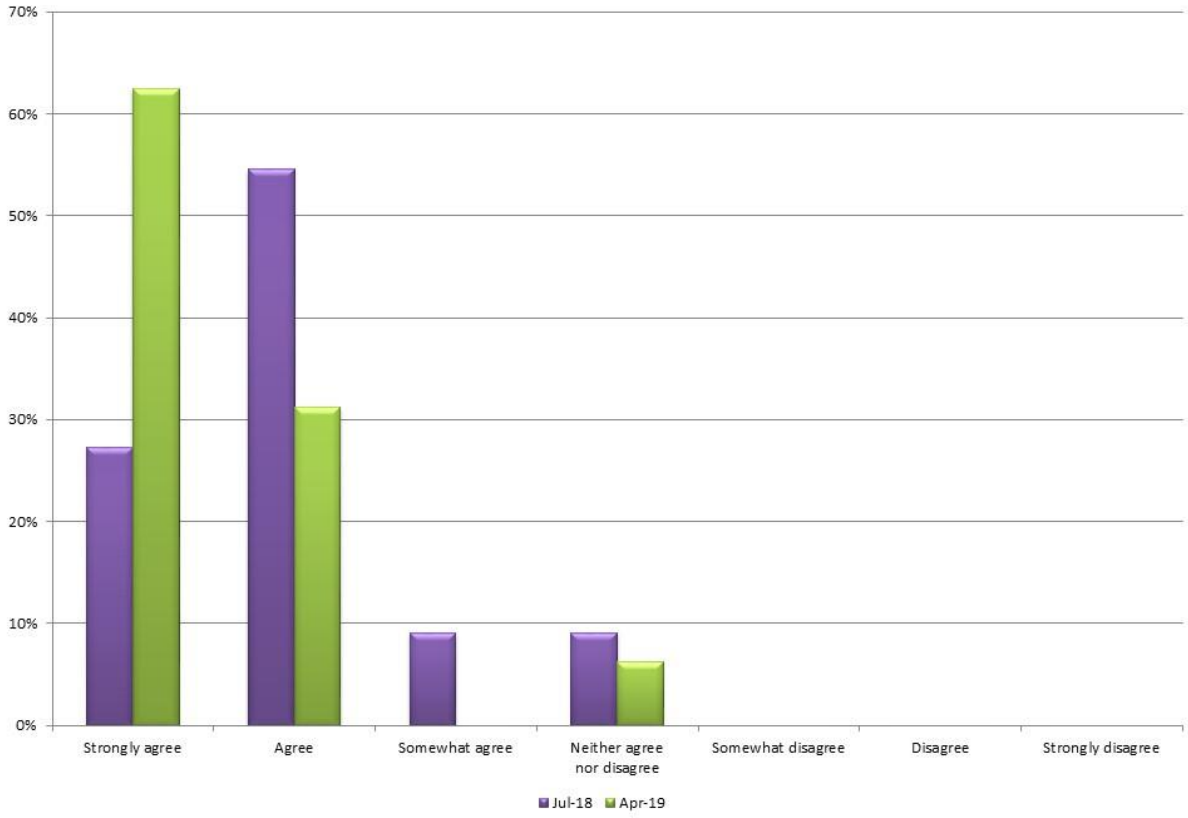
Q14 Optimism

I feel very positive about my work



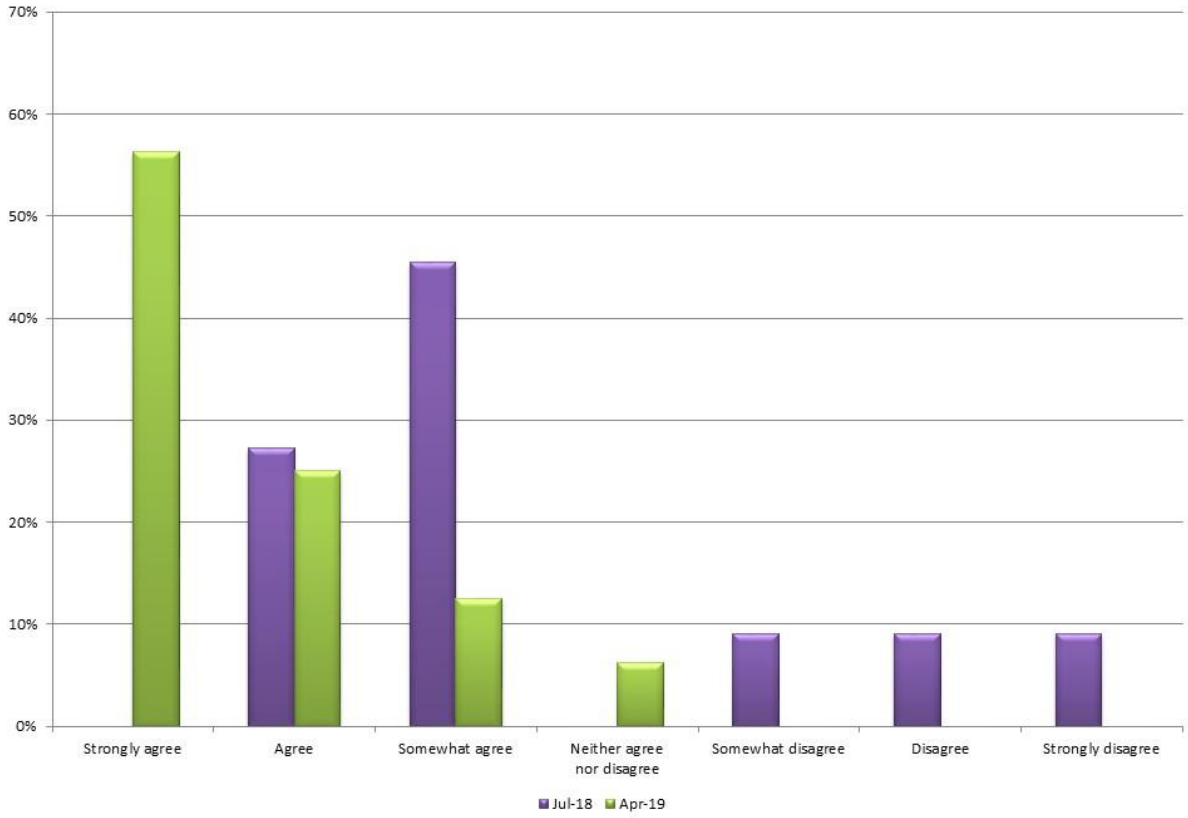
Q15 Caring

I have concern and empathy for my colleagues



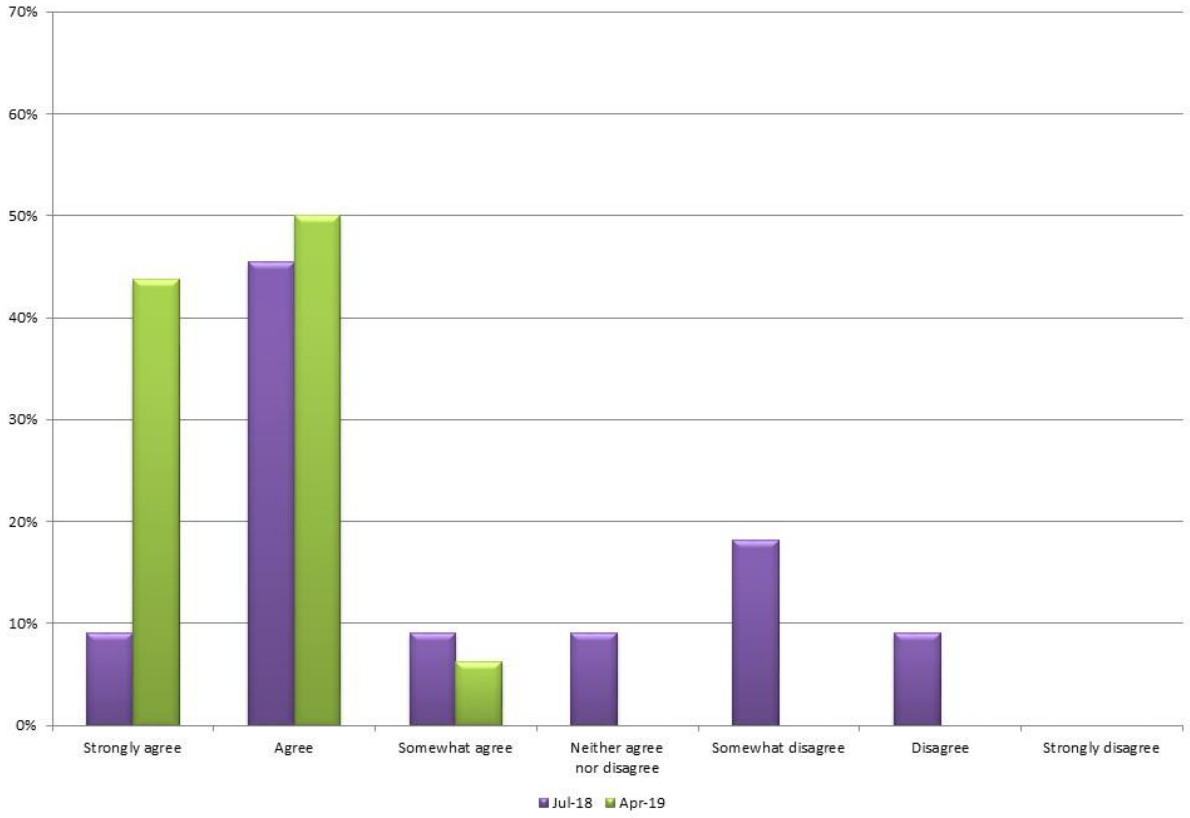
Q16 Caring

My colleagues have concern and empathy for me



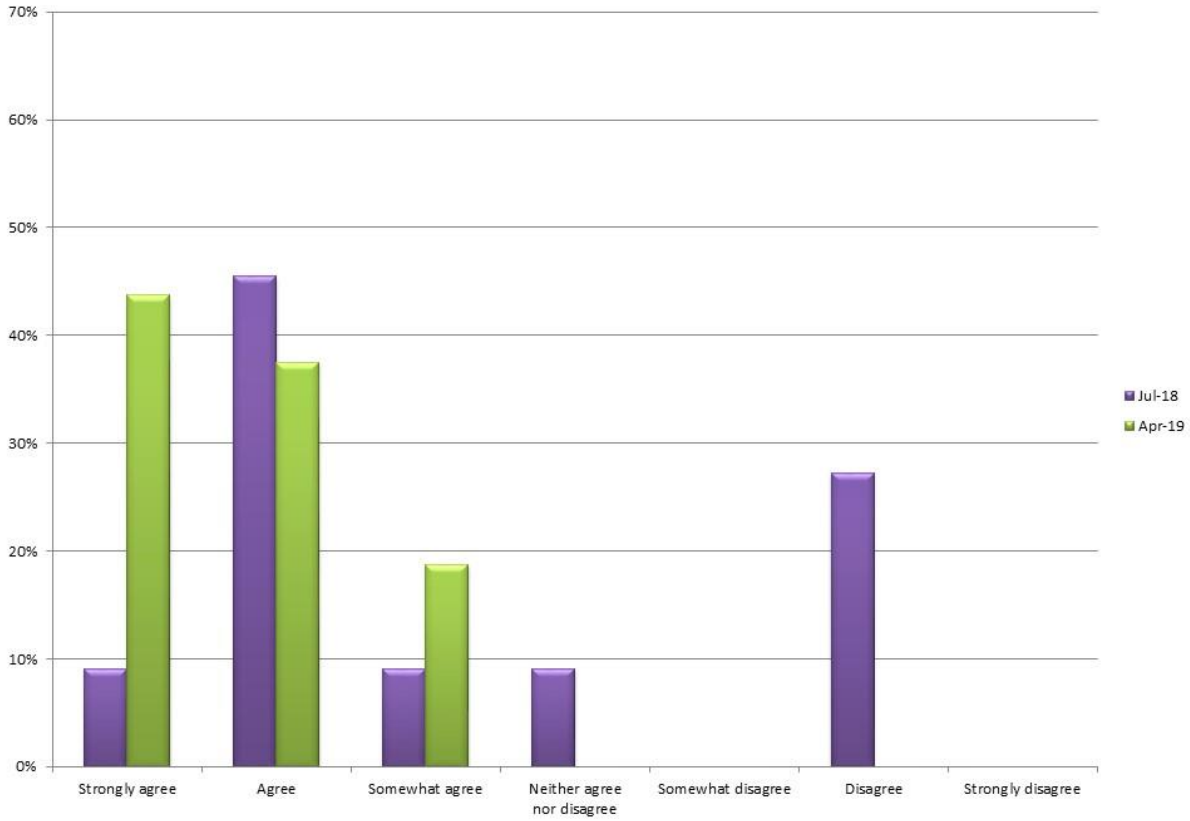
Q17 Sharing

I share my ideas and concerns with my colleagues



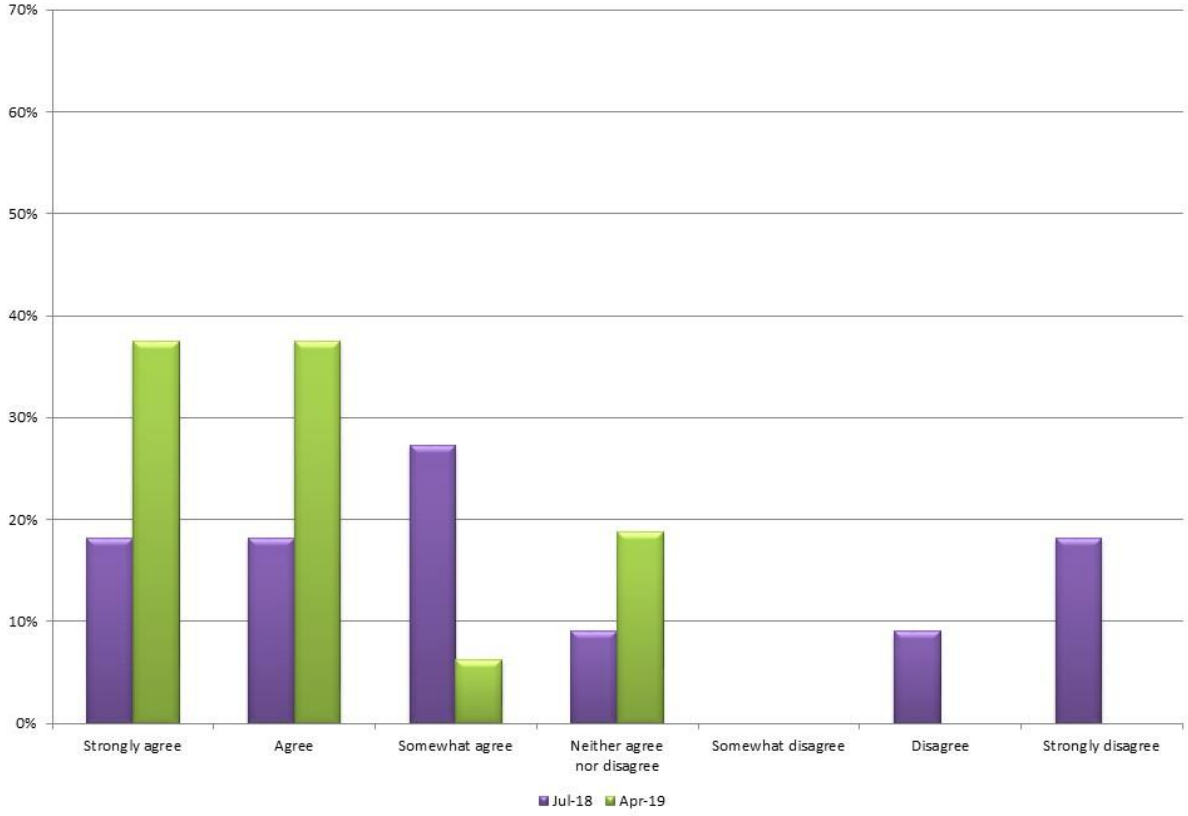
Q18 Sharing

My colleagues share ideas and concerns with me



Q19 Hopefulness

When I think about my team I feel excited, I know we are successful and have great promise for the future



Q20 Hopefulness

When I think about my job I feel excited, I feel that I am successful at what I do and I know that I have promise for the future