How traditional management approaches damage staff wellbeing

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Abstract Over the past 30 years, the way in which staff are managed in the NHS has been shaped by political and economic drivers, most notably the principles of new public management (NPM). This article explores the effects of the traditional type of staff management on frontline employees and discusses the outcomes of research on the benefits of Schwartz Rounds for staff wellbeing. Interviews with nurses and healthcare assistants reveal how staff can feel threatened, unsupported and punished by the very methods that are supposed to help them. The research adds weight to the case for more compassionate styles of leadership. An accompanying article describes the historic changes brought about by NPM and argues that the NHS needs to rid itself of this legacy.

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How is work-related stress perceived and managed in the NHS? What type of support do frontline staff receive? How effective is that support? Since the 1980s, when the principles of new public management (NPM) were introduced in the NHS, ideas and techniques drawn from the private sector have shaped how staff are managed.

This article examines what impact these historic developments have had on NHS staff today by reflecting on some of the outcomes of a recent small-scale study into Schwartz Rounds. It complements another article discussing the legacy of NPM in the NHS (nursingtimes.net/NPM-Legacy).

A study into Schwartz Rounds

Schwartz Rounds are sessions of guided group reflection, which were developed specifically for healthcare staff (Box 1). One premise of Schwartz Rounds is that they promote compassionate care by supporting staff with the emotional aspects of their work (bit.ly/PoCF-SchwartzRounds).

I recently conducted a study into Schwartz Rounds. In the first stage, I interviewed 11 nurses and healthcare assistants about their feelings of stress. I used the findings from these interviews to develop a questionnaire entitled the Organisational Response to Emotions Scale (ORES), which I gave to healthcare staff – including nurses, HCAs, physiotherapists and doctors – to complete before and after they participated in a Schwartz Round (George, 2016).

It emerged that the staff considered traditional forms of individualised support as unhelpful. In particular, they resented the provision of counselling because it implies that their stress arises from a deficiency or weakness within themselves as individuals. Newly introduced performance management policies had reinforced that message and left many feeling blamed and punished for their stress. This article
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Research

focuses on the first stage of the study, presenting and discussing the outcomes of the interviews – an article reporting the full study is available in open access (George, 2016; Bit.ly/SchwartzRounds2016).

Views from the front line
I interviewed a total of 11 staff, 10 female and one male, working on the same acute ward in a large hospital trust. Two were HCAs and nine were band 5 nurses; 10 were white British and one nurse was from India. The age range was 30-59 years and their mean length of time in post was 19 years. Six main themes emerged from the interviews and are described below.

Lack of support and consideration from management
Participants reported that their most significant source of stress arose from the fact that they did not feel considered, appreciated and supported. One senior nurse noted: “We’re a caring profession but no one cares about us”.

The role of management in supporting staff was considered critical, but many participants felt that the ward manager was too busy and under too much pressure to offer them any support.

Lack of support in the face of incivility
There was consensus among participants that their role had become more stressful in the past two years as a consequence of a rise in incivility, aggression and verbal abuse from patients and families. They linked this to high-profile cases of patient neglect and abuse that had been widely reported in the media, which they recognised had left some people feeling frightened at the prospect of being admitted to hospital.

The lack of support from line management appeared to have important indirect effects on how staff felt about this. Participants reported that the ward manager had repeatedly failed to “nip in the bud” the problem of aggressive relatives, but had invested considerable effort into avoiding complaints being lodged by patients and families. This had left staff feeling that patients and families had all the power, which therefore compounded their feelings of not being cared about. One participant said:

“It needs to come from the top – from the ward manager. There needs to be values that are modelled to families by [the manager]; this would tell people: this is how I’d like my staff to be treated.”

Box 1. Schwartz Rounds: retaining a human connection
Schwartz Center Rounds, known in the UK as Schwartz Rounds, were conceived in 1997 at the Schwartz Center for Compassionate Healthcare, founded two years earlier by a Boston healthcare lawyer, Kenneth Schwartz, in the weeks before his death from lung cancer. During his treatment, Schwartz had noticed that frontline staff varied in their ability to display compassion towards him. He concluded that the high-pressure environment of a hospital could “stifle inherent compassion and humanity.”

The aim of Schwartz Rounds is to preserve the human connection in healthcare by providing staff with space so they can reflect on their work. Sessions last one hour and are open to all staff, be they clinical or non-clinical. Each session begins with a panel presentation of stories on a particular theme – for instance ‘the patient I will never forget’. The discussion is then opened up to the audience. Two trained facilitators encourage people to focus on their thoughts and feelings, rather than engage in problem solving.

Source: Adapted from George (2016)

Many members of staff indicated that they do not feel supported by their managers

Buffering effect of colleagues’ support
The relationships within the team appeared to have an important ‘buffering effect’ on staff members’ experiences of stress. Participants reported that the support they received from their colleagues was the only thing that made work bearable.

Occupational health: a form of punishment
Changes to performance management and sickness policies in the past year had further eroded staff morale. These changes had also given rise to increased anxiety, because staff believed the new policies made it easier for their contracts to be terminated by managers on competency grounds. One HCA noted:

“If your manager refers you to occupational health [OH], it means that you have failed. It suggests you cannot cope.”

A nurse observed:

“A referral to OH is like a punishment – I dread it.”

Importantly, this had led to a change in behaviour: staff now avoided discussing stress or emotional problems with their line manager during appraisals for fear that this would trigger a referral to OH. In the interviews, participants disclosed that they would sometimes hide work-related stress by using physical illness (for example, a stomach bug) as a reason for being absent from work. This is a worrying finding because, over time, this type of behaviour could mask the true extent of stress among NHS staff.

Support services that miss the point
When staff are referred to OH, the principal source of support offered is six sessions of counselling by a private therapist, for which staff are matched with a counsellor closest to their home. For many participants, this appeared to miss the point, as they felt that the main source of their stress came from the organisation, not from any personal deficiency or weakness. One nurse said that “it sends a message that there’s something wrong with you”, while another asserted: “I don’t need counselling.”

Participants also explained that they did not receive any form of supervision, nor had any of them ever been offered a debrief after a patient’s death or another traumatising experience on the ward – this was despite the fact that they often spent 12 hours a day with patients.
Negative effect on patient care
No participant cited frontline care as a significant source of stress. One noted that the patients were “the least of our worries”. However, they recognised that their feelings of hopelessness and their low levels of engagement could have an effect on patient care. One nurse commented: “I tried to make things better at the start, but I’ve given up. I don’t make any effort now – I’m just coasting. That can’t be good for patient care. I’m sure they pick up on it.”

Interpreting the interviews
Individualistic paradigm of mental health
Today NHS managers are directed to refer staff to OH if they report mental health issues or musculoskeletal problems to ensure timely intervention and early treatment of the main causes of sickness absence (NHS Employers, 2016). It is telling that participants described OH referral as a fear-inducing performance management policy, rather than a supportive measure.

As mental distress is framed as a “disordered individual experience” (Ginn, 2008), staff feel compelled to mask their stress for fear that, if disclosed, it could ultimately cost them their job or lead to redeployment. The irony is that this leads to a reduction in self-reported work-related stress, which gives a false picture of the effectiveness of the support that is currently being offered. In that way, the individualistic paradigm of mental health in the NHS is reinforced and perpetuated.

Providing “support and opportunities for staff to maintain their health, well-being and safety” is the third pledge of the NHS Constitution (Department of Health, 2015), but the findings from the interviews indicate that the current model of individual counselling is unhelpful. This model is not unique to the NHS: it reflects our cultural norms, which stem, in part, from the traditional practice of psychiatry in the West. Problems are often seen in isolation, while the individual’s work and social contexts are considered irrelevant or secondary (Ginn, 2008). It is perhaps for that reason that we tend to ask “What’s wrong with you?” rather than “What’s happened to you?” (Dillon, 2013).

Alluding to the compartmentalisation of emotional distress, Cooke and Watts (2016) recently cautioned: “Our society increasingly sees suffering as an individual, psychological issue with a technical fix.”

Absence of an ‘ethic of caring’
Although participants did report going through emotional labour as a consequence of having to cope with incivility, the critical mediating factor was the manager’s failure to support them. Essentially, the manager was not able to cultivate an ‘ethic of caring’ (Northouse, 2010), which is a critical ingredient in the development of trust and cooperation.

Similar themes were uncovered by Johnston et al (2013), who had tracked subjective and physiological ratings of stress in more than 200 nurses over three shifts: both measures of stress were lower when the nurses rated themselves as feeling appreciated, valued and in control of their work. This was found to be more predictive of stress than the type of task performed (Johnston et al, 2013).

Wounded healers
Participants also stressed that the frontline nature of their role meant they were more in need of support than other groups such as allied health professionals yet, paradoxically, they received the least. This lack of support should also be considered in the context of what carers bring with them to the role (Hinshelwood and Skogstad, 2000). An increasing body of evidence suggests that a high level of compassion is born out of threats to an individual’s wellbeing (Stellar et al, 2012).

The experience of adversity (Lim and DeSteno, 2016), socioeconomic hardship (Stellar et al, 2012) and past emotional wounds (Dartington, 1994) have all been linked to the capacity to display ‘compassionate responding’ – defined as “concern for the suffering or wellbeing of others” (Stellar et al, 2012). We also know that adversity can give rise to what has Bentall (2016) termed ‘stress sensitivity’. This may add weight to the ‘wounded healer’ theory (Newcomb et al, 2015), according to which painful life experiences contribute to desirable qualities such as sensitivity and empathy, but also fuel vulnerability (Wheeler, 2007). This would appear to confer special responsibilities on line managers.

Not safe enough to share with colleagues
The HCAs and nurses participating in this study highlighted that support from colleagues was crucial. Similar findings have been reported by Haslam and Reicher (2006) who, in a study of group behaviour, found that a sense of shared identity was associated with higher levels of social support and that this helped individuals “resist the adverse effects of situational stressors.”

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Out of the 11 staff members I had interviewed, 10 also completed the ORES questionnaire. Their results were compared with ORES data collected from 55 staff involved in the Schwartz Rounds (see George (2016) for more information on this group). Notwithstanding the small sample size, clear differences were found between the two groups. Although they rated themselves slightly higher than the Schwartz Round attendees in terms of the level of support shown to colleagues, the interview group rated themselves as feeling less safe to share their feelings with colleagues.

This came as a surprise to me. The nursing and HCA team were ostensibly cohesive. I had assumed that this afforded them some protection against stress. However, their feelings of being unsafe meant that they were not able to trust their colleagues enough to open up to them. Here again, an important mediating factor was that the ward manager did not have the capacity to ‘psychologically present’ (Cardona, 2009). This inability to provide containment for the team appeared to be an important source of stress.

In the second part of my study (George, 2016), I explored how participation in a Schwartz Round can restore a protective mantle until they are themselves provided with supervision to reflect upon and process their own emotions. Clearly, they need support to develop the skills required for addressing stress, anxiety and burnout in their staff. An understanding of psychological defences and group dynamics is an important prerequisite in this regard, but this is not covered by traditional training programmes in leadership or management.

As I argue in my other article (nursingtimes.net/NPMLegacy), these changes should not be led by experts in administration or economics. Policy makers should instead take the lead from professionals with expertise in social and organisational psychology. 

Giving leaders the right expertise

Another implication of the findings is that improvements in staff wellbeing are contingent upon the ability of healthcare leaders to provide emotional containment. This underscores the need for organisations to turn their attention to the specialised support and training that senior healthcare staff need.

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Normalising emotions

This research adds weight to the calls for healthcare leaders to adopt more compassionate leadership styles. However, the results of the interviews with staff also suggest that this will not become commonplace until organisations introduce support systems that normalise emotion.

Eradicating the stigma associated with emotional responses and the expression of emotions would help create a healthier organisational culture. It would also help to address an emerging phenomenon identified in this research, namely that staff have begun to hide their feelings. This is worrying because, in the longer term, this could mask the true extent of stress and burnout among NHS staff.

Implications for the future

Caring but not cared for

One of the implications of the findings is that staff should be managed in the way that they want to work and in the way that the ward manager and the allied health team want to work. This, in turn, will improve the working life of caring for others. However, for this to happen, it will be important to address an emerging phenomenon identified in this research, namely that staff have begun to hide their feelings. This is worrying because, in the longer term, this could mask the true extent of stress and burnout among NHS staff.

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