AN ETHNOGRAPHIC STUDY OF THE IMPACT OF SERVICE TRANSITION
ON THE WELL-BEING OF NURSES IN TWO NATIONAL HEALTH SERVICE
ACUTE TRUSTS

by

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ABSTRACT

The National Health Service (NHS) continues to go through a period of considerable transition as health services change to meet the needs of a 21st century population. Staff are acknowledged as key to such processes. Staff well-being is a key concept in organisational change literature. For example, levels of staff well-being can be used to measure the success of organisational change. Existing literature has established that a number of different features of change are associated with staff well-being such as levels of control and demand, and social support. The study presented here extends these relationships to focus on how and why staff well-being is influenced during organisational transition. An ethnographic approach was used to observe two surgical units, both of which were undertaking transitions by relocating to new purpose-built facilities. Findings are arranged around three different themes and within each theme a number of aspects of the change were found to be driving effects on well-being: 1) information and communication during transition: the extent to which change-related communications were consultative/participatory, well-scheduled, transparent and incorporated job-related technical information; 2) the nature of the transition: working with 'unsuitable' patients, working in restrictive and disconnected work spaces and the fast-paced nature of work; 3) the impact of the transition on social relationships: the presence of support structures and changes to team dynamics. This investigation contributes to improving understanding of what affects staff well-being during change. A number recommendations for best practice are subsequently formulated.

To my fiancé, Carl, you are an inspiration.

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GLOSSARY

Annual Health Check: the Care Quality Commission's (CQC) method of measuring the performance of all NHS Trusts (in England)

Auxiliary nurse: Lower grade than a staff nurse acting in a supportive capacity. For the purposes of anonymity and consistency all lower grade ward staff are referred to in this thesis as auxiliary nurses.

Bank/Agency staff/shift: Temporary care staff from an external agency or stock of staff the hospital regularly uses (not usually permanent members of hospital staff).

ECG or electrocardiography: measures the activity of the heart.

Obs: a phrase used to abbreviate observations. Observations include taking a patients heart rate and blood pressure.

Sick note: a note provided by your doctor advising of fitness to work.

Sister: Senior member of staff within the ward. More senior to staff and auxiliary nurses.

Staff nurse: A registered/qualified nurse.

Surgical list: the schedule of patients for a given day in a given theatre.

CHAPTER ONE

INTRODUCTION TO THE THESIS

PART ONE: BACKGROUND

The accomplishment of organisational change is a key topic in health services literature (see for example, Pettigrew et al., 1992, Robertson et al., 2010). Major changes within the NHS have been taking place for around four decades (Cox, 1991). At present the NHS is moving through a further phase of substantial change, one that aims to modernise its services to meet the needs of the population it serves. This process involves an exploration of ways in which health services may be delivered in a more efficient and competitive manner (Shapiro et al., 2010). Some hospitals are needing to reinvent themselves to meet these aims. A key part of such change is the staff employed within the organisation (Wilson, 2004).

Below I will explore why staff well-being is a valuable way of considering change before moving on to explain briefly what is known about the relationship between organisational change and staff well-being. I will then summarise how the present research will extend this body of literature. I will finish this section by stating my research questions before moving on to present the structure of the thesis.

Over a sustained period, staff well-being has attracted influential research attention including dedicated reviews and special issues (see for example, Achor, 2012, Danna and Griffin, 1999, Fox, 2012, Morse, 2012, Stearns, 2012). Such momentum

for research, particularly within the NHS, is justified for a number of different reasons. First, the majority of studies show organisational change to have a negative effect on staff (see for example, Noblet et al., 2006, Rafferty and Griffin, 2006). This observation is particularly relevant in light of research that has shown NHS employees to have lower levels of well-being than those employed in other sectors (Wall et al., 1997). Staff well-being within the NHS also affects the performance of organisations. For example, it is thought that, by raising levels of staff well-being in the NHS, efficiency savings made from a reduction in sickness absence could create an extra 3.4 million working days within the service (Boorman, 2009). Staff well-being is also closely linked with patient quality outcomes such as patient safety, patient experience and the effectiveness of patient care (Boorman, 2009).

Research that has considered the relationship between staff well-being and organisational change has identified a number of mediating factors, for example, levels of information about the change (Bordia et al., 2004). The present study will extend the existing literature by examining the relationship between change and well-being by specifically considering how and why these associations emerge. That is, how do NHS staff experience well-being during periods of transition and why do NHS staff experience well-being in this way? The present study will achieve these aims by conducting a context-based investigation that focuses on the experience of staff during the transition period.

Such context-based approaches have been successfully adopted into other related fields. For example, anthropological studies have shown there are many different ways in which well-being is experienced, which vary in terms of context, culture,

location and society (Mathews and Izquierdo, 2009). There is also an established history of context-based work within the health services and particularly within the area of quality and safety in hospitals (Finn and Waring, 2005 Dixon-Woods and Bosk, 2011, Swinglehurst et al 2011, Charles et al 2011).

It is argued here that the use of such methods can provide novel insights 'in understanding people's experiences of wellbeing' (Camfield et al., 2009, p. 5). For example, it will enable the particular stages of the transition to be considered to investigate how particular stages affect well-being. Study of the experience of staff may also lead to new features of well-being being uncovered, both those that staff are aware of and those that may have become so much part of routine as to have become imperceptible.

Well-being and change are important topics within the NHS. A context-based study focused on staff experience will productively extend current understandings of well-being during workplace change. Taking these two points together, the following research questions will be used to develop this project:

1. How do NHS staff experience well-being during periods of transition?
This question seeks to uncover the different ways that periods of transition have an impact upon staff well-being. For example, do staff experience periods of transition as a positive or empowering experience, as a negative or harmful experience or in a neutral or uninterested manner?

2. Why do NHS staff experience well-being in this way?

This question aims to determine the different mechanisms that, from the perspective of staff members, bring about or drive the particular experiences of well-being. For example, if transition is experienced as empowering, do staff attribute this to their levels of participation in decision-making?

3. How does the context enable and/or constrain these mechanisms?

This question seeks to identify the structures, cultural and social norms, and customary practices within the workplaces in transition. In particular, it will seek to describe these contexts, from the perspectives of study participants, and the ways in which these facilitate or restrict the different mechanisms for well-being. For example, in what ways are feelings of empowerment made possible by an open and inclusive culture that facilitates participation in decision-making?

PART TWO: THESIS STRUCTURE

Chapter Two, explores the literature relevant to this project. This narrative review chapter has two overarching aims: to locate the project conceptually and to show where this research will make a contribution. The review is divided into parts structured around three central questions: first, why should we study staff well-being during change? This section identifies relevant literature to justify well-being and organisational change as the main topics of the study. Secondly, how can we study well-being during change? Here I will consider how staff well-being can be defined and operationalised in order to develop a working definition for my research. Finally, what do we know about staff well-being and organisational transition already? This

section establishes what is already known in the area and where this literature will be productively extended by the present research.

Chapter Three details the 'natural history' of the present study, a reflexive way of describing methods and methodology that, with the use of research field notes and journals, aims to describe 'thinking *in process*' (Silverman, 2010, p. 336, his emphasis). The natural history starts with the origins of the research and explores personal motivations before moving on to map why an ethnographic approach was selected. The chapter discusses standout events of the more tangible variety, for example, selection of the case study sites, the process of gaining access and obtaining consent, as well as the softer more subtle processes such as the co-constructed manner in which the fieldwork role was established. The novel methodological aspects or methodological findings of the research are also discussed, including the 'midstage' of observations and how this was an effective means of testing the interpretation and rigour of findings. The chapter ends with a discussion of the stages of analysis, which, as a continuous process based on grounded theory, began with field notes, before moving on to coding and then the writing of analytic memoranda.

Chapter Four describes and compares the two case study hospital trusts (the anonymised Arunwick and Felwater Hospital Trusts) in order to provide the context within which the fieldwork locations operated. The chapter begins by characterising the background of the transitions before moving on to describe broader hospital trusts, including their organisational and regional characteristics. More specific details then follow with the description of the trusts' workforces, detailing the

strategic commitments to their employees as well as the trusts' NHS staff survey results. As the transition studied here involved the move to new purpose-built facilities, the chapter then focuses on the specific fieldwork locations, the hospital wards, starting with the old wards before moving on to the new. The ward routine is also described to provide a 'day in the life' overview of work on the ward. This chapter aims to orientate the reader to the three findings chapters that follow.

The fifth chapter is the first of three findings chapters. The findings chapters are organised thematically, each focusing on a specific part of the transition that affected well-being. Chapter Five details information and communications during the transition. First the chapter sets the context and describes the customary ways in which information and communications are used on the wards. The different mechanisms that brought about effects on staff well-being are then considered. There were four key relevant mechanisms, the extent to which change-related communications were: a) consultative/participatory, b) well-scheduled, c) transparent and d) incorporated job-related technical information. The chapter concludes by considering the ways in which the context enables and/or constrains the different mechanisms.

Chapter Six explores the nature of the transition, that is the particular characteristics of the organisational change. In the present study the transition involved the relocation to new purpose-built premises (work spaces) and changes to work processes (work activities). As a result, the effects on well-being brought out by the nature of the transition are based on changes to work spaces and work activities. Much of the distress caused by changes to work spaces and activities occurred

because such changes were incongruent with the underlying value set of staff. In light of the role staff values played, this chapter first provides contextual details on the nature of staff values. The chapter then goes on to explore the different mechanisms in detail. There were four key mechanisms relevant to work spaces and work activities: a) work activities: the presence of 'unsuitable' patients, b) work spaces: working in restrictive work spaces, c) work spaces: the disconnected ward and d) work activities: the fast-paced nature of work.

Chapter Seven explores the impact of the transition on social structures and how this affected staff well-being. Social structures are important because of the interdependent nature of nursing work and because of the close-knit communities that are established amongst the staff on the wards. Following an exploration of the customary social practices on the ward two key mechanisms are presented. These mechanisms are: a) support structures and b) team dynamics.

Chapter Eight consolidates the central empirical, theoretical and methodological contributions of this study before moving on to consider the implications for policy. The study reported in this thesis comes under the umbrella of one of the *Collaborations for Leadership in Applied Health Research and Care* regional research groups. One of the central aims of these collaborations is to provide 'high-quality applied health research and support the translation of research findings into practice' (Gerrish, 2010, p. 215, Martin et al., 2011). The findings reported in this thesis are synthesised to produce a series of lessons for practice. The applied nature of this study, as will be explored in Chapter Three, represents my own philosophy towards the research endeavour.

CHAPTER TWO

STAFF WELL-BEING AND HEALTH SERVICE TRANSITION: A NARRATIVE

REVIEW OF THE LITERATURE

INTRODUCTION

The successful implementation of change in healthcare organisations is an important theme in the health research literature (Aveling et al., 2012a, Aveling et al., 2012b, Dixon-Woods et al., 2011, Dixon-Woods et al., 2012b, Eccles et al., 2003, Greenhalgh et al., 2012, Greenhalgh et al., 2004, Harrison et al., 1992, Lockett et al., 2012, Macfarlane et al., 2013, Martin et al., 2009, McKee et al., 2010, Nolan, 2007, Pettigrew et al., 1992, Robertson et al., 2010). Of course, organisational change within the British National Health Service (NHS) is not new, with continuous change occurring across many aspects of the NHS over the past forty years (Cox, 1991, Department of Health, 2011b, Department of Health and Social Security, 1972, Department of Health and Social Security, 1979, Department of Health and Social Security, 1983). Employees can both affect and be affected by organisational change (Wilson, 2004). Within this context, staff well-being is a key concept. Managing staff well-being poorly may obstruct future change (McHugh and Brennan, 1994), and indeed staff well-being may be used as an indicator of the success of a change programme (Loretto et al., 2010). I will argue in this chapter that staff well-being is a productive lens through which to enhance the understanding of change within healthcare organisations and, more specifically, that a study which seeks to understand the relationship between well-being and change from the perspective of

employees (i.e. one that documents and analyses the subjectivity of nursing staff), would make an important and original contribution to this field. To this end, I will adopt a narrative literature review strategy. Narrative reviews are common within health services literature (see for example, Say and Thomson, 2006, Waring et al., 2010) and enable the researcher to summarise, critique and synthesise a large volume of literature. The central aim of this type of review 'is to provide the reader with a comprehensive background for understanding current knowledge' and to highlight the 'significance of new research' (Cronin et al., 2008, p. 38). Thus, the narrative style aligns well with the aims of this literature review chapter, within the context of the present study. For an explanation of how the studies were selected for inclusion (see Appendix 1).

The narrative review will be structured around the following key questions:

- Part One: Why should we study staff well-being during change?
- Part Two: How can we study well-being during change?
- Part Three: What do we know about staff well-being and organisational transition already?

Answering these questions will involve, first, identifying existing literature on the well-being of staff during organisational change, in order to demonstrate the basic associations between staff well-being and change. I will also identify the subsidiary effects that staff well-being can have on the patient and the organisation, to justify further the overall topic of the thesis. Second, I will explore in depth the concept of well-being, with three purposes in mind: a) to outline the history and interdisciplinary

nature of the concept of well-being, b) to articulate the theoretical basis for this thesis, by addressing epistemological questions about how it is possible to gain knowledge about well-being (this section will lay the foundation for Chapter Three, where methodological questions about how it is possible to study well-being are addressed), and c) to develop a working definition of well-being for this thesis. Third, I will move on to tackle the concept of change, with a particular focus on the theory of transitions. Finally, I will review the existing literature on staff well-being and change, to identity themes and to explore gaps in knowledge. In this way, I will articulate the gap that my research intends to fill, before describing the study design in Chapter Three.

PART ONE: WHY SHOULD WE STUDY STAFF WELL-BEING DURING CHANGE?

Prior to any in-depth discussion of the definition of well-being, it is important first to concentrate on why research into the general area is worthwhile. Therefore, in the first part of this narrative review I will briefly argue that well-being is a valuable subject to study, and that this is particularly the case within the NHS. This argument centres on three main points. First, that organisational change is consistently found to affect staff well-being. Second, that staff well-being in the NHS remains at low levels. Third, that levels of staff well-being are likely to have consequences for two vital parts of the NHS: organisational performance and the patient experience.

Existing research consistently shows some form of relationship between staff well-being and organisational change. Although some studies report positive effects (see for example, Jimmieson et al., 2003, Loretto et al., 2010) most show that

organisational change has a deleterious effect on well-being. Importantly, this negative relationship has been shown in a range of different settings with a range of different employee types. For example, with elderly care employees (Hansson et al., 2008), UK and Australia based managers (Lindorff et al., 2011), Australian public sector workers (Noblet et al., 2006), Swedish hospital employees (Sverke et al., 2008), community health workers (Noblet et al., 2007), British supermarket staff (Moyle and Parkes, 1999), general practitioners (Sutherland, 1995), and Police officers (Noblet and Rodwell, 2009). The robust nature of the relationship between organisational change and staff well-being shows that it is a valid area of study. However, there are particular reasons why the study of well-being within the NHS is especially important.

Levels of staff well-being within the NHS continue to be problematical. Since being introduced in 2003, the results of the annual NHS staff survey have continued to show that 'levels of bullying, harassment and abuse from other staff (15% of staff in 2010) and work-related stress (29% of staff in 2010) have remained relatively static' (Maben et al., 2012, p. 26-27). It can certainly be assumed that this problem appears to have been present before the introduction of the staff survey. Specifically, research from the 1990s demonstrates that NHS staff suffer more minor psychological problems such as depression, anxiety-based insomnia, strain and an inability to cope, than the general population (Wall and Bolden, 1997). The highest rates of psychiatric morbidity were found in doctors, nurses, managers and professions allied to medicine (Wall and Bolden, 1997).

Taken together, the ongoing staff survey results, and the work from Wall and Bolden (1997), demonstrate that NHS employees show consistently low levels of psychological health. The NHS workforce and their well-being are therefore a topic particularly worthy of further investigation. Indeed, levels of well-being may become a greater concern if, as the organisational-change research described above suggests, levels of well-being drop further during periods of change.

Enhanced staff well-being has also been shown to have a positive influence on organisational performance. The centrality of staff health to the success of the NHS is reflected in the consistent reference to staff well-being within the various NHS strategic plans (Michie and West, 2004). For example, the NHS constitution states that there should be 'support and opportunities for staff to maintain their health, well-being and safety' (Department of Health, 2009b, p. 94). Additionally from the NHS Human Resources performance framework:

> 'a modern NHS must offer employees a better deal in their working lives … The way NHS employers treat employees will in future be part of the core performance measures and linked to the financial resources they receive' (Department of Health, 2000, p. 4).

In addition to recognising that staff are the service's 'most vital resource', the NHS operating framework (guidelines that set out the targets and strategy relating to all areas of the NHS) goes a step further and states the importance of supporting the workforce throughout periods of change as key (Department of Health, 2011b, p. 32).

Other influential papers cite staff well-being as key to the success of an organisation. For example, Michie and West (2004) have developed an evidence-based framework that places the psychological state of employees at the core of organisational performance. The framework shows that contextual features of the organisation (such as the organisational culture) feed into people management practices (such as levels of leadership and support). People management practices then influence the psychological state of staff (such as their well-being, satisfaction and commitment). These psychological states in turn affect employee behaviour, influencing conduct such as absenteeism, errors and near-misses, which in due course influence organisational performance. Going beyond near-misses, the management of employees has also been shown to affect patient mortality in acute hospitals (West et al., 2002). This relationship demonstrates the critical role that people management practices can have in key organisational outcomes, such as mortality rates.

Michie and West's (2004) evidence-based framework suggests that levels of staff well-being are not fixed, that correct management of these could have a positive effect on staff and hence a positive impact on organisational performance. As will be discussed in Part Three of this review, people management practices are key to mitigating the well-being outcomes for staff involved in organisation change.

Michie and West's (2004) framework places the influence of well-being under the broader umbrella of employee psychological consequences. However, other reports have supported the central role that well-being specifically plays in determining

organisational performance. One of the key reports to focus on staff well-being in the NHS is The Boorman Review (Boorman, 2009). This review has further highlighted the connection between well-being and organisational performance by producing a business case specific to the NHS.

A critical aspect of this business case is based on the direct impact staff well-being can have on sickness-related absenteeism. The report suggests that improvements in well-being could lead to an extra 3.4 million working days being created across the NHS (Boorman, 2009). This is a powerful statistic, particularly in light of the widely-reported problems with staffing levels within the health services (BBC, 2013a, BBC, 2013b). Thus, managing the psychological health of staff through transition processes becomes a powerful aid to maintaining performance levels in the organisation.

The final point for consideration here is the impact levels of staff well-being have on the experience of patients. In the early stages of their careers many staff in the heath care sector chose to join the profession because of the values associated with the profession, centring on being altruistic and helping to change the lives of others (Maben et al., 2007, Maben et al., 2012). The assumption that follows such selfless aims is that levels of well-being in health care staff would be derived from providing high quality care. However, evidence suggests that staff well-being should be viewed not as a consequence of high quality patient care, but as an antecedent. That is, staff well-being precedes – and as such influences – the quality of patient care (Maben et al., 2007). This relationship is recognised by NHS staff themselves (Boorman, 2009) and NHS policy makers:

'Improving the working lives of employees contributes directly to better patient care through improved recruitment and retention – and because patients want to be treated by well-motivated, fairly rewarded employees' (Department of Health, 2000, p. 4).

Staff well-being has been shown to influence a number of other elements of patient care, including patient safety and the effectiveness of patient care (Boorman, 2009). Along with the patient experience, these three elements are considered to be indicators of service quality. Links have also been established between 'staff health and well-being and performance on such key issues as patient satisfaction, Annual Health Check ratings (see glossary) and meticillin-resistant Staphylococcus aureus (MRSA) rates' (Maben et al., 2012, p. 8).

It is important to emphasise that patient experience is multidimensional in nature (Murrells et al., 2013). These dimensions include: a) the functional elements of care such as arranging out-patient appointments and medication administration, b) the transactional elements of care such as 'meeting the preferences of the patient as far as timings and locations of appointments are concerned' and c) the relational elements of care, for example, whether 'care is approached as part of an ongoing relationship with the patient' (Murrells et al., 2013, p. 2).

A number of studies support the case for the link between well-being and patient experience. Maben has recently conducted a helpful review of those studies which have investigated a link between staff well-being and NHS patient experience

(Maben et al., 2012). Some of these studies rely on data collected, as Maben et al. (2012) note, from secondary analysis or cross-sectional designs. However, all reported studies show some form of association between the psychological health of staff (for example, in terms of stress and well-being) and the quality of patient care. For example, Firth-Cozens and Greenhalgh (1997) studied doctors' views on the relationship between stress and performance. Just over thirty six per cent of respondents reported incidents that had recently occurred where patient care had been negatively affected because of the stress symptoms the doctors were experiencing. In a further study Firth-Cozens (2001) demonstrates that the majority of incidents of poor care 'are seen by the doctors as being caused by overwork and lack of sleep … this is compounded by the doctors concerned through their suffering guilt and sleepless nights as a result of their poor care, which may influence a cycle of stress and declining quality' (p. 216). This study shows how staff may enter into a downward spiral where work demands and a sense of being 'at fault' leads to higher levels of stress. Importantly within the present context, an increase in work demands is a factor often associated with reduced staff well-being during change (see for example, Noblet et al., 2007, Noblet et al., 2006).

In sum, existing research has found that staff well-being is mostly negatively affected by change. This association is important given that: a) staff well-being is considered to be an antecedent of both patient experience and organisational performance and that b) staff well-being is particularly low within health service employees. Having justified the overarching topic of the thesis I will now move on to consider how we might go about investigating staff well-being during change.

PART TWO: HOW CAN WE STUDY WELL-BEING DURING CHANGE?

In order to explore the concept of well-being in greater depth, this second part of the chapter has three main aims. The first aim is to provide a brief overview of the concept of well-being. To achieve this I will both trace the historical origins of the concept, and consider what the interdisciplinary nature of well-being means for research in this field. This initial discussion will provide a backdrop upon which to develop the second section. Here, I will address epistemological issues regarding how knowledge about well-being can be produced. Specifically, by considering the different ways that well-being is operationalised I will argue that two key features should be taken forward and incorporated into a working definition for this project; the affective and contextual components of well-being. This discussion will enable the provision of a useful working definition of well-being.

a) An overview of the concept of well-being

Definitions of well-being vary within (Camfield et al., 2009) as well as between disciplines. For example, it can refer to both prosperity (i.e. an individual's assessment of his or her happiness and health), or as 'optimal psychological experience and functioning' (Deci and Ryan, 2008, p. 1). Indeed, the broad nature of the concept of well-being has enabled many disciplines to embrace the subject.

Each discipline takes a different view on the core features of well-being and how it should be measured. Although the distinctions that follow are arguably simplistic, they serve to emphasise the ways in which well-being is conceptualised within key social science fields. For example, psychology often takes an individualistic approach and considers the patterns that exist between specific attributes, such as

personality traits and their relationship with subjective well-being (DeNeve and Cooper, 1998, Ryan and Deci, 2001). Within the workplace, literature studies about well-being tend to focus on role and organisational attributes, such as human resources management (Sverke et al., 2008) or job design, and their affects on job satisfaction and anxiety (Holman, 2002).

The cross-disciplinary nature of research into well-being raises the question of whether objective or subjective concepts are more appropriate means of assessing well-being, as well as which unit of assessment is more appropriate, the collective or individual. Such diversity makes the development of a core definition and subsequent operationalisation and measurement of well-being difficult. However, consideration of the philosophical approaches to well-being demonstrates that well-being could be successfully considered as a multidimensional concept.

There are two central philosophical approaches to the concept of well-being: hedonistic and eudaimonic (Ryan and Deci, 2001). Each approach suggests a different means by which well-being can be achieved. The hedonistic approach associates well-being with pleasure (Eid and Larsen, 2008), and its historical origins lie with philosophers such as Aristippus at around the fourth century BC (Ryan and Deci, 2001). Advocates of the hedonistic approach consider that 'the central goal of life is to experience the maximum amount of pleasure, and that happiness is the totality of one's hedonic moments' (Ryan and Deci, 2001, p. 143-144). Most research within this tradition uses subjective well-being as a means of assessment; a combination of high positive and low negative affect, combined with an assessment of the level of individual satisfaction in life (Ryan and Deci, 2001). Research in this

domain has tended to focus on antecedent factors (Ryan and Deci, 2001), such as closeness to parents in childhood (Flouri, 2004). Taking this concept to the workplace, well-being (according to the hedonic approach) would be achieved as the result of a role that enables the employee to achieve maximum enjoyment and satisfaction, and minimum displeasure.

The eudaimonic approach, on the other hand, stems from the work of Aristotle who rejected the idea that happiness came from pleasure-seeking hedonic pursuits. Instead, he viewed it as arising from worthy and meaningful pursuits (Deci and Ryan, 2008). From a eudaimonic approach, a state of well-being occurs when people can live their life fulfilling worthy activities that are in line with their own values. This theory can be extrapolated into the workplace through involvement in meaningful work that, for example, has a wider fulfilling purpose, such as helping people. In this way, individuals would seek out a position where their value set aligns with that of the professional group they are a part of.

The presence of these two historical perspectives has not resulted in either tradition being discredited. Rather, dimensions from both hedonistic and eudaimonic perspectives appear important, suggesting that well-being can be effectively conceived as a multidimensional concept (Ryan and Deci, 2001). For example, as Ryan and Deci (2001) point out, research has utilised principal components analysis (a means of measuring the amount of variance explained by different factors) to examine indicators of mental health and well-being. This analysis showed subjective well-being (a hedonistic trait) and personal growth (a eudaimonic trait) to be partially related (Compton et al., 1996). Additionally, meaning and happiness are considered

as relevant dimensions of the good life (King and Napa, 1998) and of mental health (McGregor and Little, 1998).

In sum, the interdisciplinary nature of well-being means that there are a number of different ways in which well-being can be operationalised. Consideration of the two historical origins of well-being offers a way through this diversity suggesting that well-being can be fruitfully conceptualised as multidimensional. In the section that follows I will explore the potential multidimensional operationalisations of well-being, and how they can be effectively used to study change.

b) Operationalising staff well-being

Staff well-being is operationalised in a number of different ways within the vast body of existing research in the area. Consequently, a key part of any debate on the definition of well-being concerns which particular components or dimensions can combine to form an accurate and usable conceptualisation of well-being. Below, four potential multidimensional models will be presented. The presentation will demonstrate two keys areas upon which a definition of well-being should focus: a) the context in which well-being is studied and b) the use of assessing affective components as key displays of psychological well-being.

Multidimensional models consider well-being to be a structural concept shaped by a number of different components. An early example of such a model comes from Ryff (1989) and Ryff and Keyes (1995) who propose a model of general well-being that draws on six specific dimensions of wellness:

- Autonomy – the extent to which an individual is self-governing and can resist social pressures

- Environmental mastery – the level of capability an individual has in managing his or her world and the activities and everyday aspects within it

- Personal growth – the degree of development and broadening of horizons experienced

- Positive relations with others – the presence of affectionate, trusting and caring relationships with others

- Purpose in life – the presence of goals and direction

- Self acceptance – the degree of positive appraisal attached to the current and past self

The components Ryff (1989) and Ryff and Keyes (1995) propose tap into more meaningful eudaimonic style traits, such as purpose in life and personal growth, as well as affective components including positive relations with others and self acceptance. Importantly for the operationalisation of well-being in the workplace, the model also identifies components that attempt to link the person to his or her environment/context, such as autonomy and environmental mastery, which place the individual within an interactive relationship with a given setting.

Other multidimensional models make a more direct connection between an individual's well-being and specific contexts, acknowledging that well-being can be better understood within specific settings. One of the main contexts in which well-being has been explored in greater detail is the workplace (van Horn et al., 2004).

The rationale is that, rather than appraising it in general, assessment in a particular setting will provide more accurate accounts of well-being (van Horn et al., 2004).

A key context-based model comes from Warr (1994b; 1987) who developed a multidimensional model of well-being in relation to the workplace.

- Affective well-being – assessment of three axes or continuums: depression to enthusiasm, pleased to displeased, and anxiety to comfort.
- Competence – an individual's capacity to manage life's problems 'and act on the environment with at least a moderate amount of success'
- Autonomy – an individual's ability to withstand environmental features, to act and think independently
- Aspiration – assessment of an individual's capability in developing reasonable ambitions and committed attempts at reaching them

(Warr, 1994b, p. 85)

A fifth dimension, integrated functioning, is utilised to draw together the four elements and provide a complete representation of a person. Like that of Ryff (1989) and Ryff and Keyes (1995) this model incorporates elements of the eudaimonic tradition in aspiration as a form of personal growth, as well as the more affective components such as affective well-being. The model also makes direct links with the workplace environment or context with the consideration of competence and autonomy in relation to an individual's particular work setting.

Other multidimensional models have been created within the very specific work context of the NHS. In the NHS, the means by which well-being in staff is most commonly measured is through the NHS staff survey. Much of the seminal work in analysing the staff survey has been conducted by West and colleagues who were charged with interpreting the survey in its first few years of circulation (see for example, Department of Health, 2009a, West et al., 2005, West et al., 2011). West further operationalised staff health and well-being in the NHS into four focal dimensions (West, 2009).

- 'Work-related stress – the proportion of staff who say they have been injured or felt unwell as a result of work-related stress in the previous 12 months

- Work-related injury – the proportion of staff who say they have been injured or felt unwell as a result of moving and handling; needlestick and sharps injuries; slips, trips or falls; or exposure to dangerous substances in the previous 12 months

- Job satisfaction – this is a measure of job-related psychological wellbeing, based on a scale published by Warr, Cook & Wall (1979), and often used as a measure of wellbeing

- Turnover intentions – this is a measure of the extent to which employees are considering leaving their jobs. Although slightly less directly related to health and wellbeing'

(Department of Health, 2009a, p. 15).

Here well-being is operationalised within a very specific workplace rather than work in general. This is helpful because well-being can then be measured using

dimensions that are particularly important to that workplace. Such an approach acknowledges that types of workplaces can be unique, and that the particular workplace context plays a central role in determining how staff well-being should be measured.

Van Horn et al. (2004) have also embraced the consideration of well-being within a work context. This model combines and extends the work of both Ryff (1989) and Warr (1994b), distinguishing five dimensions of well-being:

- Affective well-being – incorporates affect, job satisfaction, organisational commitment and emotional exhaustion
- Professional well-being – includes autonomy, aspiration and professional competence
- Social well-being – covers depersonalisation and social relations in the workplace
- Cognitive well-being – refers to cognitive functioning in the workplace
- Psychosomatic well-being – consists of psychosomatic symptoms such as headaches

This model, like that of Warr (1994b), uses affective well-being as one of the components. Research suggests that affective well-being is related to the other components of the model and as such suggests that it is a key element. For example, features of the psychosomatic dimension such as muscle aches and headaches are related to affective well-being (Taris et al., 2001, Kinunnen et al., 1994). Cognitive well-being is also associated with affective well-being, specifically

error rates, concentration and the ability to make decisions (Broadbent et al., 1982, Goldberg, 1972, Wissing and Van Eeden, 2002).

Given these links, appraisals of affective well-being are considered 'amongst the most important, if not *the* most important, indicators of psychological well-being' (his emphasis, Daniels, 2000, p. 276, Diener and Larsen, 1993, Warr, 1994b). Indeed many survey/questionnaire measures used in the wider literature tap into the affective well-being such as those which focus on job satisfaction as a primary measure of staff well-being in the workplace (van Horn et al., 2004).

Affective well-being is composed of a number of groups or axes of affective experience (van Horn et al., 2004). The groups include anger–placidity, tiredness–vigour, boredom–enthusiasm, depression–pleasure and anxiety–comfort (Daniels, 2000, van Horn et al., 2004). These can be measured by asking questions of employees such as how often their job brings about feelings of enthusiasm or gloom (Warr, 1994a). These different spectrums 'can potentially capture subtleties, complexities and changes in the experience of work' (Daniels, 2000, p. 276, Briner, 1997). Such attributes are particularly important when assessing well-being during periods of complex change in complex workplaces such as the NHS. Assessing well-being in this way can also overcome the problem that well-being is too unwieldy a construct to measure meaningfully. In the present models, such limitations are addressed because the concept is anchored to both a particular setting (work), and a spectrum of different affective (well-being) states within that setting.

The exploration of four multidimensional models of well-being above allows two key conclusions. First, that studying well-being within a particular setting helps to attach the concept to a particular set of circumstances. In doing so, well-being can be more precisely explored amongst people (in this case employees) within their own environment and set of circumstances. Second, that affective well-being, through its links with other dimensions, is perhaps the key component of psychological well-being. The axes upon which well-being can be measured provide a fluid yet structured way of assessing well-being during change. These two conclusions will now be incorporated into a definition of well-being that will be used to develop this project.

c) A proposed definition of staff well-being

The multidimensional models discussed above show a distinct pattern of increasing embeddedness within the context in which well-being is studied, starting from general model of well-being (Ryff and Keyes, 1995), moving through Warr's (1994b) model of workplace well-being and on to West's conceptualisation within the specific context of the NHS. In keeping with this, the present study intends to move a step further and study the well-being of a particular group of staff within a particular ward or unit of the NHS. Such an advance aims to engage more closely with well-being in one specific setting and thereby provide a more precise explanation and analysis of the experience of well-being that occurs within it.

Exploration of the multidimensional models of well-being above showed that all of the models had some form of affective component. Affective well-being is also considered to be related to other dimensions of well-being, and in the form of job

satisfaction is one of the most commonly-used measures of well-being in the workplace. Affective well-being is furthermore considered to be the key indicator of psychological well-being (Daniels, 2000, Warr, 1994b). As such, in this project I will capitalise on this central affective component, incorporating it within the definition used.

In order to synthesise the above, I propose a definition for studying staff well-being during change in the NHS encompassing both affective and contextual components. Specifically, in this project I will define well-being as the common experience of positive affects (such as placidity, vigour, enthusiasm, pleasure and comfort) and the uncommon experience of negative affects (such as anger, tiredness, boredom, depression and anxiety) in a specific workplace setting (Diener & Larsen, 1993, Daniels, 2000).

This definition has several benefits for studying well-being during change. Importantly, it is sufficiently open to enable a number of different affective states to be recorded within the work setting. Further, specific affective states can be noted in reaction to elements of a organisational change, serving to link well-being states to particular parts of change. Finally, the subtle affective changes that occur as part of the process of change can also be encapsulated using this definition.

PART THREE: WHAT DO WE KNOW ABOUT STAFF WELL-BEING AND ORGANISATIONAL TRANSITION ALREADY?

In order to consider how staff well-being is affected by organisational change, first an exploration of organisational change itself needs to be conducted. In view of this, the

first section below will explore the key concepts and terms regarding the ways in which change is conceptualised in the organisational change literature. I will then appraise the existing literature on staff well-being and organisational change, in order to identify the different features of change that affect staff, and identify the gap that my research proposes to address.

a) Types of organisational change

There are several different types of change. For example; planned and emergent change, episodic and continuous change, developmental change, transformational change and transitional change (Iles and Sutherland, 2001). Below I will explore these different types of change, in order to demonstrate that it is the transitional type of change that forms the basis of much of the current research on organisational change. Theories of transition will also be explored to consider how such theory may inform an understanding of staff well-being during a period of such transition.

     i. Planned and emergent change

Planned change is said to be intentional, carefully thought through, with each step forming a calculated part of the process (Iles and Sutherland, 2001). Conversely, emergent change occurs in an unintentional way or as a chance or accidental development; here features of the change are managed as they arise (Iles and Sutherland, 2001). Although both are seemingly distinct forms of change, it is likely that most types of planned change will have some kind of emergent component (Iles and Sutherland, 2001). Indeed, this is particularly the case 'when dealing with large, hierarchical structures often associated with public services' (Esain et al., 2008, p. 25). It has also been suggested that the initiation of change may (or should) be

planned, but then will be eventually superseded by emergent change (Esain et al., 2008).

Importantly, most of the changes reported in the relevant literature appear to be of a planned nature. This may well be because research is unlikely to be organised to capture unplanned or emergent change that may occur. The term 'planned' suggests that preparatory work has occurred, that elements of the change will be anticipated and that there is a degree of certainty.

ii. Episodic and continuous change

Episodic change is 'infrequent, discontinuous, and intentional' and 'tends to occur in distinct periods during which shifts are precipitated by external events such as technology change' (Weick and Quinn, 1999, p. 365). Weick and Quinn (1999) provide a useful representation or set of characteristics of an organisation involved in episodic change:

> '… dense, tightly coupled interdependencies among subunits; efficiency as a core value; a preoccupation with short-run adaptation rather than long-run adaptability; constraints on action in the form of the invisible hand of institutionalization; powerful norms embedded in strong subcultures; and imitation as a major motivation for change' (p. 367).

This extract reflects contextual details that are usually present in hospitals. For example, where there are often a collection of departments that in some way come together, for example, to provide care for a given patient, each of which with its own

strong cultural identity. In this context, 'fire-fighting' can be a common response to change, as organisations may operate work in an externally-led or reactive context. A persistent need to adapt to continuous change could be challenging for staff, requiring them to adjust constantly to external forces. Indeed, during the transition to create a learning organisation, one study found that being in an environment of constant change had a negative effect on staff (McHugh, 1997). The authors concluded that this type of continuous change (that occurred alongside other more episodic style change) was problematic for staff because of the levels of commitment required.

iii. Developmental change

Developmental change serves to develop or improve an existing part of an organisation (Iles and Sutherland, 2001). Developmental change can be either emergent or planned (Iles and Sutherland, 2001), and tends to be incremental in nature. Further, the latter implies a gradual exposure to change within the organisation.

iv. Transformational change

Transformational change is complex in nature (Iles and Sutherland, 2001). A key difference between transformational and other types of change is that transformational change involves a 'shift in assumptions made by the organisation and its members. Transformation can result in an organisation that differs significantly in terms of structure, processes, culture and strategy' (Iles and Sutherland, 2001, p. 16). It is important to note here, however, that the extent to

which organisational culture can be changed is considered by some to be limited (see for example, Meek 1998, Turner, 1990).

Because of the dramatic nature of transformational change, staff are likely to be exposed to novel events in the workplace. Indeed, Rafferty and Griffin (2006) found that, in light of such novelty, employees reflect about their job (in particular whether they still 'fit' within the organisation) and, as a result, turnover intentions rise.

v. Transitional change

Transitional change is episodic, planned and, like transformational change, is significant or fundamental (Iles and Sutherland, 2001). This type of change identifies a new goal state that differs from the organisation's existing state. Transitional change, as Iles and Sutherland (2001) point out, forms the foundation of much of the literature that considers organisational change (see for example, Kanter, 1983, Beckhard and Harris, 1987). The basis of this type of change comes from Lewin's (1951) unfreeze-change-refreeze model. During these three stages the organisation becomes aware of its current stable state and then shifts through a process of change where, for example, new procedures are adopted. Finally, a process of stabilisation occurs where the organisation reaches a new point of equilibrium or a new established state (Iles and Sutherland, 2001).

Given that transition forms the basis of much of the organisational change literature, it is important to explore theories on transition and to consider particularly how transition theory can aid the understanding of well-being during periods of change. In this next section I will address these aims.

b) Theories of transition

Several different transition theories exist, with each attempting to explain the psychological stages passed through, or the trajectory of recovery through a period of change. These theories are relevant for the understanding of transitions, both in terms of how transition progresses, and how transition affects those experiencing it. Perhaps surprisingly, research on the individual transition through bereavement seems to be the most relevant to the development of an understanding of organisational transitions, as seen below.

Generally, transition research focuses on how individuals respond to change, often suggesting the stages individuals go through to return to a non-transitioning state. This broad remit means that the concept of transitions is relevant to a wide range of fields such as education, health, and life events. Work from health services research considers transition, for example, through the movement of patients from pediatric-oriented to adult-oriented care (Reiss and Gibson, 2002) and in adjusting to a chronic illness diagnosis (de Ridder et al., 2008).

Much of the work on transitions in psychology, however, has focused on major life events, and in particular bereavement; the period of grief or loss experienced following the death of a friend or loved one. Seminal work on the transition through bereavement and grief emerged in the 1960s, particularly with the work of Kubler-Ross (1969). Kubler-Ross (1969) explains the stages of grief experienced during the process of bereavement. These stages move through initial rejection, then on to

more tumultuous mid-stages, before the person eventually comes to terms with their loss, as shown below:

1. Denial

2. Anger

3. Bargaining

4. Depression

5. Acceptance

Other researchers have provided models that follow a similar pattern. For example, Fink (1967) identified Shock; Defensive retreat; Acknowledgement; Adaption and Change. Fink's (1967) work (like Kubler-Ross, 1969) shows a similar shape or pattern of stages to the transition process, with a strong initial response that eventually becomes absorbed to form an altered yet acclimatised state. This pattern suggests that the effects of change will not last forever, and thus NHS staff can expect to recover from periods of transition.

This pattern was similarly noted by Adams et al. (1976) whose work considered several different transition types, such as adulthood from childhood, divorce from marriage, and from school into work, to follow this same shape (Ellrodt, 1993). The stages of the model are as follows:

1. Immobilisation

2. Minimisation

3. Depression

4. Acceptance of reality / letting go

5. Testing

6. Search for meaning

7. Internalisation

Exploration of the common features of transition has continued to be a persistent theme in the literature. Levy and Merry (1986) examined the different fields in which transition and change have been studied (Menninger, 1975). They found that the 'fields examined included cultural revolutions, macroeconomics, scientific revolutions, innovative processes, and biological systems' and that each of these followed Lewin's (1951) model 'starting and ending in equilibrium states, with an interim period of transition' (Elrod II and Tippett, 2002, p. 279). This similar trajectory of change suggests that, although the specific psychological states passed through may be dependent on the type of change, a transition within the NHS should follow the same broad curve-like shape.

Other researchers have seen the specific relevance of bereavement research to organisations. Perlman and Takacs (1990) argued that there were strong similarities between those stages put forward by Kubler-Ross (1969), and those experienced during periods of organisational change. Other authors have developed this idea within specific parts of organisations such as teams. For example, Henderson-Loney (1996) noted the parallels between Kubler-Ross's (1969) model (denial, anger, bargaining, depression, acceptance), and Tuckman's (1965) team growth model (forming, norming, storming, performing). Parallels exist; particularly between the

storming and anger stages, where elements of the transition are being worked out before the more concrete and settled performing and acceptance stages emerge.

The theoretical literature on transitions, although originating from a variety of different subject areas, provides four key insights to staff well-being during a transition process. The first regards the sorts of psychological states that are progressed through, for example, distress occurs in the early stages and persists until such point when a sense of familiarity or recovery emerges. Staff may experience similar states with denial in the early stages but more stable acceptance states towards the end of the transition. Second, that a transition process is curve-like in nature with an initial normal state followed by a 'dip' during the acute phase of the transition; these more tumultuous stages will likely have the most impact on staff, before recovery to a new normal stable state occurs. Third, that the great majority of transition models follow the pattern of Lewin's (1951) model, with a basic three stage structure (Elrod II and Tippett, 2002). Finally, that transitions are a passing state, not a permanent one, and as such transition periods or changes are something staff will ultimately recover from and/or adapt to. Taking these points together with the current changing state of the NHS means that consideration of the effects of transition on NHS staff well-being deserves further attention. In the section that follows I will map out what is known about the effects of organisational change/transition on staff well-being, and how this knowledge could be supplemented.

c) Organisational transition and staff well-being

As touched upon briefly in the first part of this chapter, it is a consistent finding in the literature that organisational change affects staff health and well-being (Wilson,

2004). Indeed, this relationship has been found in a number of different settings and with a range of different change types, and almost invariably these effects are negative in nature. For example, specific types of organisational change that have been associated with negative consequences on staff include hard change, for example, cost-cutting and redundancies (Lindorff et al., 2011), personnel change (Rafferty and Griffin, 2006), downsizing (Dragano et al., 2005, Isaksson et al., 1999, Theorell et al., 2003), restructuring (Bourbonnais et al., 2005, Fugate et al., 2005, Hansson et al., 2008, Jimmieson et al., 2003, Litwinenko and Cooper, 1997, Noblet and Rodwell, 2009, Noblet et al., 2006, Wanberg and Banas, 2000), contractual changes (Sutherland, 1995), relocation (Moyle and Parkes, 1999), and mergers (Kavanagh and Ashkanasy, 2006). However, although less frequently reported, some organisational change affects staff health and well-being in a more positive sense, through, for example, staff participation in organisational change (Sverke et al., 2008). Such effects are thought to occur because the workforce participates in the change to more transparent roles and responsibilities (Platt et al., 1998), more challenging and varied work (Desombre et al., 2006) or increased job security, promotion and training (Loretto et al., 2010).

The existence of many of these effects is of course dependent on the nature of the organisational transition. The nature of the transition is important because different kinds of transition processes are likely to have different kinds of effects on staff well-being. In light of this, the section that follows will distinguish what these different processes might be in order to provide an insight into the different features of change that may impact upon staff. It is through exploration of these processes that I will

identify gaps in the current body of research and articulate where this research will contribute.

Current empirical evidence suggests that six key components of the change process affect staff well-being outcomes. These components are (i) information and communication, participation and involvement, (iii) control and demand, (iv) social support, (v) coping strategies and (vi) the appraisal of change.

i. Information and communication

Information, that is the details provided about the organisational change, and also how they are communicated to staff, has a robust relationship with well-being. For example, a survey study by Rafferty and Jimmieson (2010) demonstrated that levels of information have a negative relationship with distress, and a positive relationship with quality of work life. Research that seeks to pick apart the reasons for this relationship has sought to identify further associations that may be relevant.

The key mediators implicated in the relationship between information and well-being are the levels of uncertainty and self-efficacy amongst staff. Jimmieson et al. (2004) caution that, due to the non-linear way that organisational change occurs, uncertainty is the most common psychological state experienced (Begley, 1998, Bordia et al., 2004, Nelson et al., 1995, Sagie and Koslowsky, 1994). The role of uncertainty is based on the notion that the presence of change-related information reduces apprehension amongst staff. In the presence of information, staff are more knowledgeable about the circumstances of the change, and such a transparent approach can also support feelings of trust within the organisation, in turn improving

levels of job motivation (Jimmieson et al., 2004, Tan, 2005, Wanberg and Banas, 2000). Similarly, information is considered as a means of enabling employees to predict aspects of the change, understand the reasons behind them, and as such make sense of the change (Sutton and Kahn, 1986). However, if official communications are lacking and have not met the needs of staff, unofficial rumour processes can emerge (Bordia et al., 2004). In this way, information acts as a means of circumventing uncertainty.

On the other hand, self-efficacy describes the extent to which an individual feels capable, competent or able in a given set of circumstances (Bandura, 1977). Jimmieson et al. (2004) narrowed this concept further to change-related self-efficacy, the 'employee's perceived ability to function well on the job, despite the demands of a changing work environment' (p. 13). The authors found (using self-report measures) that employees who felt they had received higher levels of change-related information and rated themselves as higher in change-related self-efficacy also reported higher levels of psychological well-being. In this way, information seems to act as a capability or confidence builder, allowing staff to feel competent in circumstances of change.

It is also important to note that the social networks within an organisation have an important role to play in communicating information about changes. Social networks affect the 'diffusion of innovations … because they form the channels through which interpersonal communication takes place' (Greenhalgh et al., 2004, p. 167). The meaning behind an innovation (i.e. some form of change) is considered to be socially constructed (Greenhalgh et al., 2004). Therefore negotiations between group

members can articulate any perceived advantages that an innovation might bring (Greenhalgh et al., 2004). This finding suggests that interpersonal communications about change may determine how such changes are received and/or adopted by staff.

ii. Control and demand

Control and demand refer to the level of power or influence an employee has within the change process, and the extent to which the employee receives a more challenging workload because of it. Much of the research into control is carried out using Karasek's demand-control-support (DCS) model as a theoretical framework (Karasek and Theorell, 1990). The DCS model proposes that adverse employee outcomes emerge from circumstances that are high in demand, low in control and low in support, or in other words high-strain roles stem from 'situations where the demands are not matched by adequate levels of decision-making authority and/or support from supervisors and colleagues' (Noblet et al., 2006, p .336).

Levels of control are cited as a key factor in determining the effects of change on staff. For example, Noblet et al. (2006) found a significant positive correlation between job control and both job satisfaction and psychological health. Noblet et al. (2007) found similar results in a study looking at Australian community health workers as levels of job control had a close relationship with psychological health and job satisfaction. Noblet and Rodwell (2009) found that job control has also been shown to have a significant positive relationship with both intrinsic and extrinsic satisfaction, and employee well-being. Similarly, Moyle and Parkes (1999) found that perception of control buffered the negative effects of organisational change when

employees relocated to a new supermarket branch. The rationale behind this relationship is that feelings of control amongst staff enable them to feel in command of themselves and the decisions being made during change. Such control then makes change feel more as if it is being done *with* them than *to* them, and as a result change is less likely to negatively effect their well-being.

Work demands are also key factors implicated in the relationship between organisational change and staff well-being. Again, as with control, the relationship between demands and staff well-being is regularly present in research. For example, one study surveyed police officers and state government authority employees who had gone through large scale organisational change, and found a significant relationship between job demands and reduced well-being (Noblet and Rodwell, 2009). Sutherland (1995) also looked at large-scale change in the form of a new GP contract and compared results from two surveys taken three years apart. The research found that job demands were a key predictor of job dissatisfaction and low levels of psychological well-being.

iii. Participation and involvement

Another dimension highlighted as a mediating factor in the relationship between aspects of well-being and transition are the levels of participation and involvement with the change. That is, the degree to which staff are able to contribute and take part in the decisions about the process of any change (Caplan et al., 1980). For example, Tan (2005) tested participation as a predictor variable and found a strong significant positive correlation with psychological well-being. In addition, a 'lack of consultation during decision-making steps' was found by Gutierrrez and Dyson

(2009) to have a negative impact on staff during change. Isaksson et al. (1999) have shown that a lack of participation in organisational change is a key predictor of distress levels in staff. The rationale for the positive relationship between participation and distress is similar to the function of control as changes occur *with* rather than *to* staff.

Measuring levels of employee participation has also demonstrated other important causal relationships. For example, staff participation has been measured and demonstrated to have a positive relationship with feelings of change readiness amongst staff (Terry and Jimmieson, 2003) and quality of work life (Rafferty and Jimmieson, 2010). A further strand of research tested participation in terms of either proactive or reactive implementation of organisational change (Sverke et al., 2008). A proactive approach would engender more positive feelings towards organisational change due to perceptions of fair treatment and staff involvement in key decisions (Heller et al., 1998, Kozlowski et al., 1993). Sverke et al. (2008) found that 'participation in decision-making was associated with more positive work attitudes and fewer health problems' at both the proactive and reactive sites (p. 124). The authors found that a proactive strategy, as compared to a reactive one, had a number of positive influences on staff, such as lower feelings of job insecurity, role conflict, and role ambiguity, as well as more positive attitudes towards the change process.

iv. Social support

Social support is considered to be an important aspect in times of change in terms of staff well-being, but one that can unfortunately be lacking during such periods. This

is because heightened workloads and fewer available resources reduce the capacity of those who can provide support to do so (Noblet et al., 2006). Swanson and Power (2001) studied the role of social support during organisational change in a retrospective study that used a self-report questionnaire. They found that lower levels of reported social support were associated with higher levels of change-related role stress, namely role conflict, role ambiguity and role overload.

Noblet and Rodwell (2009) also looked at the role of social support and measured it, again using a self-report measure. Here, they found that work-based social support had a significant positive relationship with both job satisfaction and staff well-being. Interestingly, social support was the only variable tested that was found to be associated with all of the outcome measures. It can therefore be considered that the predictive value of social support is a robust finding, as has been demonstrated by other researchers (De Lange et al., 2004, Leong et al., 1996, Noblet et al., 2007, Tan, 2005). One study carried out within a health services setting came from Sutherland (1995) who conducted a questionnaire study with General Practitioners (GPs) going through a change in their contractual arrangements. Here, a lack of social support was again found to predict poor psychological well-being (Sutherland, 1995).

Social support is clearly an important component of the causal chain from organisational change to staff well-being. However, it is important to note that the social relationships in a workplace, and the support that is obtained from them, are often complex and can be fragmented or involve conflict (Quine, 1999). This observation warns of the potentially hazardous nature of social relationships.

Further, such problems may be intensified during change if, for example, staff positions are perceived as under threat.

v. Coping strategies

As may be drawn from the previous discussion, much of the literature that has considered organisational change has focused on the notion of coping. Coping describes the strategies utilised by individuals (either cognitive or behavioural) which enable them to circumvent stressful situations (Parkes, 1990). Coping has routinely been noted as an important factor in determining levels of staff adjustment to change (Terry and Jimmieson, 2003). Coping strategies can be further specified as either problem- or emotion-focused. Problem-focused coping strategies seek to 'modify or manage the source of the stress', while emotion-focused strategies seek to 'regulate the heightened emotions that result from exposure to threatening stimuli, while also avoiding direct confrontation with those threats' (Noblet et al., 2006, p. 337).

Survey research found that emotion-focused coping was negatively correlated with well-being but problem-focused coping had a positive relationship with well-being (Noblet et al., 2006). To mitigate these effects, Noblet et al. (2006) suggested that employees who rely more on emotion coping should be helped to adopt more problem-based strategies. These effects mirror those findings already outlined regarding participation and involvement, where proactive change implementation strategies had better staff outcomes. In this way, addressing the issues associated with change can have more positive results for staff.

Further research on coping strategies comes from Tan (2005) who investigated two different types, active and avoidance coping. These classifications were adopted from Holahan and Moos (1987) and can be divided further in order to specify whether they are behavioural, emotional or cognitive. For example, active coping strategies include members of staff embracing organisational change as an opportunity rather than as a threat, an active behavioural strategy could involve 'making plans of action in times of stress' whereas an active emotional strategy might include 'sharing worries with others to reduce tension' (Tan, 2005, p. 28). With regards to avoidance coping, staff may forget 'about organizational change until it happens' as a avoidance-cognitive strategy, use 'drinking or eating more in times of stress' as an avoidance-behavioural strategy, or keep 'anxious feelings to oneself' as an avoidance-emotional strategy (Tan, 2005, p. 29).

Tan (2005) found that those who utilised active-behavioural strategies during times of organisational change had an enhanced sense of well-being. In addition, those who adopted active-cognitive approaches to coping were less stressed at times of change. Studies on coping have generally highlighted that coping and particularly coping of an active nature tends to have positive well-being outcomes for staff.

vi. Appraisal of change

A further focus of the literature is on the role of appraisal, that is, how employees have judged or assessed aspects of the change process. For example, one cross-sectional survey study found that those organisational changes appraised by participants as threatening had a negative relationship with both job satisfaction and eustress (stress that is considered healthy), and conversely had a positive

relationship with sickness absence and distress (Verhaeghe et al., 2006). However those organisational changes viewed by staff as a challenge had a positive relationship with job satisfaction and eustress (Verhaeghe et al., 2006). These findings suggests that those who view the appraisal of change as stimulating rather than as a potential hazard can expect better well-being outcomes. Similarly, levels of job satisfaction and well-being have been found to be higher, and absenteeism and turnover intentions lower when staff appraised the organisation and environment more positively (Martin et al., 2005).

Lattuch and Young (2011) followed similar research aims to those of Martin et al. (2005) and Verhaeghe et al. (2006), but targeted a young working population. Results suggested that staff were satisfied in their roles when both the degree and frequency of change were high. The authors proposed that younger workers could be more willing to accept the circumstances of change than an older age group (Lattuch and Young, 2011). Thus younger employees who may be more familiar with change may also be better able to cope.

Other research has linked the concepts of coping (discussed above) and the appraisal of change. For example, Fugate et al. (2005) tested Lazarus's (1991) process model of coping within an organisational change setting, and found that emotions and coping mediated the relationship between 'the appraisal of stressors and individuals' psychological well-being' (p. L5). This finding suggests that the appraisal of change generates cognitive coping strategies that in turn affect an individual's level of well-being (Fugate et al., 2005).

In this section I have mapped out the different influencing factors in the relationship between organisational change and transition. Through this exploration of the literature I have identified the six main features of change that affect staff. Now that I have established what is known about the area I will go on to discuss how this knowledge can be enhanced with further work.

d) Studying well-being *in situ* with a focus on the experience of staff

The previous section has shown that well-being is mediated by a number of different elements. These social, operational, cultural and perceptual mediators are robust findings in the literature, and as such invite a nuanced consideration of their features. Such a investigation would involve answering questions of *how,* that is in what ways, well-being is experienced by staff, and *why*, i.e. for what reasons does well-being materialise during the process of transition. Below I will argue that critical to compiling such an account is the study of well-being *in situ*, with a focus on the experience of staff. Such an account will enable new features or refined accounts of well-being to emerge.

Other fields within the social sciences domain, and in particular anthropology, have made a convincing case for developing the study of well-being in this way (Camfield et al., 2009). There is also a long tradition of this type of work in the field of quality and safety in hospitals (see for example, Dixon-Woods et al., 2011, Dixon-Woods et al., 2009, Finn and Waring, 2005, Hassell et al., 1998, Swinglehurst et al., 2011). In the section that follows I will discuss what can be gained from investigations that focus on the experience of staff within their own environment. To do this I will draw

on empirical evidence that shows how focusing on such, often interlocking, elements will produce a detailed picture of well-being during transition.

i. The study of staff well-being *in situ*

As discussed in Part Two of this chapter, current understandings of well-being in the workplace will benefit from a consideration of well-being *in situ*, that is in the context or natural setting in which the phenomenon occurs. Such an approach is indeed advocated by seminal organisational change texts (Pettigrew et al., 1992). This type of contextual study takes into consideration the backdrop or circumstances of a given location, and includes details such as the organisational culture, climate and relations between group members (Michie and West, 2004). The culture of an organisation consists of members' beliefs, attitudes and their collective or shared meanings regarding the organisation itself, and working within it (Schein, 1992). Expressions of culture include 'hierarchy, job descriptions, informal practices and norms, espoused values and rituals, stories and jokes and jargon' (Michie and West, 2004, p. 93). The climate of an organisation has characteristics in common with culture and describes how the workforce experience the organisation, how they 'attach shared meanings to their perceptions of it, focusing on the processes, practices and behaviours which are rewarded and supported in an organization' (Michie and West, 2004, p. 93, James et al., 1990).

The rationale for considering these elements of context is 'that people's experiences and evaluations of their lives are shaped by their perception of their environment and themselves, in the context of what they value and aspire to' (Camfield et al., 2009, p. 8). Thus, it is important when trying to create detailed depictions of well-being in the

workplace to ensure that those studied are not separated from their own particular setting. An exemplar study from anthropology provides a clear illustration of how context can influence well-being.

Adelson (2000) studied the well-being of the Cree, a group indigenous to Quebec, Canada, and showed how their well-being was closely linked to the land. As Adelson explains, the 'landscape … has changed over the decades and so too have the Cree people and the ways that well-being is articulated as part of their relationship with that land' (2009, p. 109). Here we can see that the Cree's sense of well-being is very closely related to the current condition of the land; as the land changes so does the well-being experienced by those working on it.

Building such a nuanced picture of well-being requires information to be gathered in a manner that can absorb the rituals, stories, jokes, jargon, shared meanings, and the circumstances in which these occur. Such depictions can be achieved by using what is known as thick description, an approach for recording human behaviours that

> '... does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard' (Denzin, 1989, p. 83).

In this way, thick description builds a 'clear picture of the individuals and groups in the context of their culture and the setting in which they live' (Holloway, 1997, p. 154). Also, as the empirical evidence suggests that well-being is mediated by a number of different components, thick description aids the explanation of such processes by providing contextual information that accounts for particular outcomes. This method of describing the setting is particularly helpful for investigating change, as a description can be formed which incorporates *why* certain circumstances that bring about effects on well-being do so, and furthermore *how* this occurs.

A helpful way of thinking about the interplay between the why and the how can be borrowed from Pawson and Tilley's (2006) realist evaluation model, a model that has been utilised to evaluate, amongst other things, organisational change within the NHS (Greenhalgh et al., 2009). In short, realist evaluation has four linked parts, two of which are relevant and adopted in the present study: mechanisms and contexts. Mechanisms are considered to produce the effects of a programme or intervention. In this way, mechanisms can be viewed as the cogs or working parts of interventions (Pawson and Tilley, 1997). Context, on the other hand, refers to the relevant features of the environment, conditions or circumstances in which the mechanisms work (Pawson and Tilley, 1997). The concept of mechanisms can be used to understand what it is about change that drives any effects on staff well-being. Different moderators and mediators of change discussed above (coping strategies, appraisal of change, participation and involvement etc.) would, within a realist framework, be considered as mechanisms. Context then forms those features, circumstances and conditions of the transition that enable or constrain these mechanisms. A similar

concept comes from Pettigrew et al. (1992), who refers to settings as receptive and non-receptive contexts. Receptive contexts include a supportive organisational culture and the simplicity and clarity of goals and priorities within the change agenda.

An aspect of the context that may be of importance to staff is the particular stage of the transition they are passing through. Transition processes tend to unfold as a change curve, with the curve describing the movement of an organisation from one fixed state, through an unstable state, to a new fixed state (Lewin, 1951). By creating an account that builds in the particular stage of organisational change, we can start to understand what elements of the given stage influence staff well-being. In addition, as the transition progresses, a later stage can be understood within the context of earlier stages.

Such a consideration can aid the understanding of why staff approach particular stages of change in a particular way, and whether previous or anticipated events have influenced their views of this transition stage. For example, participation may not occur across all aspects of the change; staff may have been involved in communicating news about changes to processes but not in the earlier planning stages when decisions were made about how such a process could work.

Nevertheless, despite the benefits that contextual investigations can bring to the understanding of well-being, there is a central criticism that is often levelled at such studies. Specifically, in light of the detailed consideration of one or (perhaps at most) a handful of particular contexts, such work can lack generalisability to wider groups or populations (see for example, Symon and Cassell, 2011). Thus, it is important that

this potential limitation of context-based work is managed throughout the research. In view of this, the context/generalisability debate will be referred to in a number of places in this thesis. In the methodology chapter I will provide an explanation of how the criticism will be mitigated within the research process itself. How this mitigation process is conducted will then be demonstrated in, for example, the thick descriptions provided both in the setting the scene chapter (Chapter Four) and the three data chapters that follow it (Chapters Five, Six and Seven). The extent to which the mitigation was successful will be explored within the discussion chapter (Chapter Eight).

In this section I have described several different benefits that can be realised from the study of well-being *in situ*. These include taking into account particular features of the organisation and how these influence staff well-being during change as well as being able to take into account the sequential nature of transition periods. I have also described how, by using thick description, these benefits can be realised. In the section that follows I will explore how study of the staff experience of transition can also help to extend current knowledge of staff well-being during transition.

ii. Study of the staff experience of well-being

The understanding of staff well-being during transition will also benefit from privileging the participant experience, producing accounts that inductively record how staff articulate their experience (Rojas, 2007). Taking such an approach allows for those elements of well-being that may have been overlooked in prior work to emerge. These may be features that staff were aware of but had not had the

opportunity to disclose, or elements that may be deeply internalised, and so assimilated into their behaviour as to have become imperceptible to the individual.

Part of the rationale for focusing on the participant experience is to align research and research findings more closely with practice. To achieve such alignment, research should focus on 'how practitioners act, what work they do, with whom they interact, and what practical reasoning they apply in their own localized experience ...' (Jarzabkowsky, 2005, p. 8). In this way, the research concentrates on the routines of staff, and uses this to build a picture of what matters within that particular setting.

Key to focusing on this localised experience is paying particular attention to the subjective meaning of participants (Popay et al., 1998). Reflection of participants' voices will lead to understanding about how and why particular processes or elements within the transition occurred as they did. The focus on this type of knowledge or experience will position staff as the central provider of expertise on their well-being, rather than as recipients of guidance on what is *thought to be* significant for staff. Importantly, taking such an approach may provide new or novel insights to tackle issues that have evaded efforts thus far (Popay et al., 1998).

Focus on the staff experience may also help to clarify elements of well-being that are apparent to staff but not captured by current measures. As Camfield et al. (2009) puts it, concentrating 'on people's resources and agency … can encompass areas of people's lives that are influential and important but rarely measured' (p. 7). Such resources could include those that are concrete, such as access to goods (equipment, space) within the work space, and those that are less tangible, such as

expertise or assistance. Elements like these may change during the transition process, including becoming obsolete, inaccessible or even growing in significance.

Alongside the above is the potential to capture new information that may not be apparent even to those inside the setting. This process is also spoken of in terms of making the mundane obvious, or the ordinary extraordinary (Dixon-Woods, 2003, Jarzabkowsky, 2005). These may be elements that have become so assimilated into the normal way of working that staff are now unaware of them. By attempting (as far as possible) to capture an insider's perspective, new parts of the social, perceptual, cultural and/or operational elements that may underpin well-being can come to light.

Importantly information that privileges the participant voice may be able to uncover factors regarding staff well-being that are more relevant to staff themselves. Hearing their own voices within the data may be a powerful means of demonstrating that staff have been understood. This will be helpful for policy makers who can then develop policy regarding the care of staff during change that more closely aligns with the voices of those who have experienced that change. Such an account may also benefit future research by providing information that can develop and refine existing measures of well-being in the workplace. Indeed it may challenge the use of a number of measures in particular working contexts.

PART FOUR: CONCLUSION AND RESEARCH QUESTIONS

In distinct yet interlocking parts, this narrative literature review chapter has tackled three important questions about staff well-being and change: Why should we study staff well-being during change? How can we study well-being during change? What

do we know about staff well-being and change already? The key messages that should be taken forward from this review are that, first, staff well-being is a valuable area of study not only for the staff but also because staff well-being affects both organisational performance and the patient experience. Second, adopting an affective and contextual definition of well-being will allow for well-being states that occur in reaction to specific elements of the transition process to be documented. Third, the existing literature consistently shows that staff well-being is influenced by a number of different social, operational, cultural and perceptual elements. Research that has established these relationships will benefit from an investigation that extends current knowledge by exploring beyond the causal, to consider the *how* and *why* of staff well-being during change. That is how is staff well-being experienced and why do these different states of well-being emerge during the process of transition? The essential components of compiling such an account lie in a consideration of well-being *in situ* that centres on the experience of staff. With these points in mind, the following research questions will be used to develop this project:

1. How do NHS staff experience well-being during periods of transition?

This question seeks to uncover the different ways that periods of transition impact upon staff well-being. For example, do staff experience periods of transition as a positive or empowering experience, as a negative or harmful experience, or in a neutral or uninterested manner?

2. Why do NHS staff experience well-being in this way?

This question aims to determine the different mechanisms that, from the perspective of staff members, bring about or drive their particular experiences of well-being. For

example, if transition is experienced as empowering, do staff attribute this to their levels of participation in decision-making?

3. How does the context enable and/or constrain these mechanisms?

This question seeks to identify the structures, cultural and social norms, and customary practices within the workplaces in transition. In particular it will seek to describe these contexts from the perspectives of study participants, and the ways in which they facilitate or restrict the different mechanisms to well-being. For example, in what ways are feelings of empowerment made possible by an open and inclusive culture that facilitates participation in decision-making?

CHAPTER THREE

RESEARCHING STAFF WELL-BEING DURING HEALTH SERVICE

TRANSITION: A METHODOLOGICAL ACCOUNT

'The accomplishment of fieldwork is not a passive activity.'

(Coffey, 1999, p. 26)

INTRODUCTION

This chapter details the 'natural history' of my research, a style of methodological writing recommended by Silverman (2005) that aims to describe 'thinking *in process*' (p. 306, his emphasis). This reflexive method involves the use of research field notes and journals to enable the reader to feel more like an 'insider', the commentary focuses on how the project develops and the challenges encountered during the research. It also recommends accepting that qualitative research is often a 'messy' process and advocates the researcher starting with the personal context of the research, for example, with the researcher's motivation in the choice of subject matter. By incorporating these elements, 'natural history' chapters embrace two fundamental aspects of rigorous qualitative research, reflexivity and transparency (Popay et al., 1998, Horsburgh, 2003), from the outset.

The motivation and the starting point for this research came from a personal interest in workers' experiences and particularly their well-being in relation to the workplace. I have worked in a variety of roles ranging from a Divemaster (a scuba diving professional), a conservationist in the Bornean jungle through to stacking shelves in

Sainsbury's. Some of these jobs were tedious and others fulfilling. I am interested in the nature of what made them so. In addition, work is an important part of our socialisation: where we form relationships, where we learn and display skills, where we can climb career ladders or remain, where some of us attach all of our self-worth and some of us very little. I also feel (as an academic in training) that the academic's role is a somewhat privileged one. Generally academics have considerable freedom to pursue their own personal agenda, be it research or otherwise (see for example, Furnham, 2011). In this way my choice of a research career enables me to use the workplace as a resource, somewhere from which I can draw personal development and fulfilment, not merely something that draws from me (in terms of time and effort). I agree with authors such as Lewis (2010) who consider researching 'employee wellbeing at work as an ethical endeavour' and that 'anything we can do … to help that experience be life-enhancing rather than spirit-demeaning for people is a good thing' (p. 947).

Using my personal context as a starting point, this chapter will now detail why I selected ethnography as a research approach and the value that this approach brings to the subject matter (Part One) before moving on to discuss the data collection and analysis phases (Part Two). The theme of what demonstrates rigour in qualitative research (starting with reflexivity and transparency) and how these contribute to transferable (generalisable) findings will continue throughout this chapter. This theme known as criteriology, refers to the debate regarding what standards should be used to judge qualitative research (see for example, Guba and Lincoln, 1985, Horsburgh, 2003, Johnson et al., 2006). In this chapter I will draw on a

range of different criteria such as credibility and transferability to demonstrate how excellence in qualitative research can be demonstrated and assessed.

PART ONE: SELECTING AN APPROACH

My decision to carry out an ethnographic study can be traced back to the early literature reviewing stage of the research process. Here, I argue that existing research has highlighted the importance of a number of different mediating/moderating factors in the relationship between organisational change and well-being. These factors include levels of participation, information, colleague support and the use of coping strategies (Tan, 2005). Yet there is a paucity of research on understanding *how* and *why* such associations are present.

To meet my research aims, I sought a method that would enable me to access the meanings behind staff behaviour, particularly in relation to well-being. It was also imperative that the context of staff well-being could be taken into account, particularly in relation to the stage of transition in which the staff were involved. In order to gain this level of understanding, the need to adopt a naturalistic methodology became apparent. Taking such an approach is particularly valuable as there is a 'growing recognition that enlargement of our theoretical understanding of phenomena depends on the collection and interpretation of richer and deeper forms of data' (Popay et al., 1998, p. 341). Of the naturalistic approaches it was ethnography that met these needs most. As Brewer (2000) puts it,

> 'Ethnography is the study of people in naturally occurring settings … by means of methods which capture social meanings and ordinary activities …' (p. 10)

To impart a brief history, ethnography originates in social anthropology (Hammersley and Atkinson, 2007) where early and now classic works such as Margaret Mead's *Coming of Age in Samoa* (1928) emerged. At that time the focus of ethnographic work was on small, non-Western cultures. Some authors (Said, 1994) were sceptical of this work as it was produced at a time of Western dominance (Savage, 2000). Around the same time a similar approach, often referred to as the 'Chicago School', was being developed by sociology and journalism scholars who focused their work on local urban areas (Hammersley and Atkinson, 2007, Lutters and Ackerman, 1996). This focus spread to the field of social anthropology where research began to focus on 'at home' settings (Savage, 2000).

Some authors suggest, because the definition of ethnography is contested, that describing what it involves provides a clearer representation of the approach (Hammersley and Atkinson, 2007). Hamersley and Atkinson (2007) describe data collection in ethnography as an iterative process focused on describing and analysing people's actions in everyday contexts. The process usually involves a small group of participants and range of methods. These methods include document analysis, interviewing, and most frequently, participant observation and informal interviews (Hammersley and Atkinson, 2007). Participant observation and informal interviews were the methods I chose to use, as they were the most appropriate in addressing my research questions, particularly regarding: a) the need to remain

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open, b) the importance of context and process in answering my research questions and c) the analysis process. These features are now explored in turn.

a) The need to remain open

The 'need to remain open', as Baszanger and Dodier (2004, p. 11) put it, was an important aspect of this study with regards to three main elements: the research questions, knowledge production and flexibility. Being open means being ready to recognise the social meanings, practices, norms and values of a culture in a given context, whatever they may be, without reference to any *a priori* expectations or hypotheses. This openness should continue throughout ethnographic work to ensure that the study, whilst iteratively developing a focus, remains adaptable to unforeseen elements that may occur during the course of the research (Baszanger and Dodier, 2004). Here, the research questions provided the focus of staff well-being but deliberately remained sufficiently broad to enable other elements affecting staff well-being to emerge.

Remaining open was also important in terms of the knowledge production in this study. Both in terms of acknowledging my own limitations and privileging the knowledge of my participants. Prior to embarking upon this research I was a lay person with regard to health care settings and the work that was carried out within them. Consequently, adopting an interview or survey-based method would have been problematic, particularly in identifying appropriate questions and prompts, and to whom it would be best to direct these. Thus, with regard to my background, an open iterative approach meant that my position as a lay person would not restrict or misdirect the scope of the study. This study design was flexible, responsive and

could adapt to circumstances as they presented themselves. According to Popay et al. (1998) such flexibility, rather than standardised design, is a mark of excellence in qualitative research.

Remaining open also privileges the knowledge of others involved in research, something that Popay et al. (1998) refer to as 'the primary marker of standards in qualitative research' (p. 344). Privileging the knowledge of others instead of 'expert' knowledge in the field is particularly valuable as 'more innovative ways of dealing with persistent policy failures or challenges' may emerge (Popay et al., 1998, p. 345). Giving a voice to the group also aligned with my ethical standpoint as I felt it was important to ensure that this piece of research reflected as closely as possible the experience of the staff. In return for participants granting me access to this part of their world, the very least I could do was to go through the process of transition with the staff.

b) The importance of context and process in answering the research questions

Recording context was central to my research questions and an ethnographic approach addressed this need. This process of 'placing observations into a larger perspective' was particularly important as I wanted to observe the ebbs and flows of normal working life (Fetterman, 1998, p. 19). That is, to be there for 'on' and 'off' days and to be aware of the 'bigger picture' in order to understand what affected people's daily experience. Horsburgh (2003) refers to the importance of documenting

> '… background information about the overall structures, settings and frameworks within which participants were situated. Active

acknowledgement of the effect which these may have in facilitating, or inhibiting participants' actions is required, in order to place the data which is obtained from them within a wider context' (p. 311).

The use of alternative methods such as interviews or questionnaires would therefore have been less suitable. Such methods may have provided a comparatively static view and/or just been the product of an 'on' or 'off' day. Contextualising data is also a strategy for enhancing the dependability and reliability of the data produced (Silverman, 2006), something that will be covered in more detail later in the chapter. Using an ethnographic approach would enable me to document and analyse this process in a more holistic manner.

Although phases such as 'before', 'during' and 'after' did exist, they were not rigid. Organisational transition is a process of interlinked stages with a 'build up', the actual change event (in this case relocation) and subsequent adjustment period. In the new wards, some of the tasks had changed or were new to staff, for example, patients from surgical specialties that were unfamiliar to the nurses were being treated on the wards. More minor changes included stock and equipment being stored in different or unfamiliar locations. Consequently, the nurses were often problem-solving as several of the tasks which made up their working day were different and needed clarification or a whole new approach. It was as the number of these new tasks declined and staff became adjusted to the ward and its workings that the so-called 'during' period seemed to be coming to a close. Without the information on context afforded by an ethnographic approach, accurately timing interviews or questionnaires to capture the process of change would have been problematic. As

health care organisations are complex, adopting an approach that can take such complexities into account by contextualising is particularly valuable. Indeed, ethnography is a frequently adopted method within health services research (Dixon-Woods, 2010, Dixon-Woods et al., 2012a, Tranter et al., 2009).

c) The process of analysis

The process of analysis also motivated my choice of ethnography for this research project. As someone who was new to taking such an open and iterative approach, the initial data analysis running in parallel with the data collection itself was reassuring. This process enabled me to recognise, albeit with an open mind, areas to focus on while in the field as well as to check that the research was 'working'. Also, knowing that data would come from a range of different sources (such as observations in the ward itself, informal conversations and meetings) meant there were several arenas (some private, some public) from which I could draw during analysis to support or refute emerging theories. I have termed this 'triangulation-by-context' and argue later that it is a key aspect of assessing the validity or credibility of research.

PART TWO: DEVELOPING AND DELIVERING CREDIBLE RESEARCH

As discussed in Chapter Two, one of the key criticisms levied on ethnography is that, through its focus on a specific context, the findings lack generalisability. However, this criticism is often applied when qualitative research is being assessed using quantitative parameters, such as population size and the statistical generalisability of findings. Scholars such as Seale (1999) argue that qualitative research cannot be assessed by the same criteria that are used to assess quantitative research because

the methodologies are so different (Symon and Cassell, 2011). This criteriology debate is concerned with answering 'what constitutes good qualitative research?' (Symon and Cassell, 2011, p. 1). Many authors have sought to answer this question including Horsburgh (2003), Popay et al. (1998) and Tracy (2010).

Horsburgh (2003) argues that the concept of generalisability in qualitative research is 'situational, rather than demographic' (p. 311). Situational representativeness or transferability refers to the extent that 'theory developed within one study may be exported'; thus the aim becomes to make logical generalisations to a similar class of phenomenon (Horsburgh, 2003, p. 311). Polit and Beck (2010) recommend methods for enhancing the transferability of research such as using thick description and knowing the data set in detail. I additionally argue that achieving transferable findings occurs as a result of the careful planning and execution of research, and rigorous analysis of research findings. The sections that follow consider seven main aspects of the research process: a) selecting case study sites, b) gaining access to the case study sites c) my fieldwork role, d) consent, e) observing well-being f) the methodological findings and g) the analysis process. In these sections I will draw upon a range of different criteria such as credibility, transferability and dependability to show how excellence in qualitative research can be achieved. By demonstrating qualitative research is credible, trustworthy and dependable researchers can provide rigorous data for transfer (generalisation) to other settings.

a) Selecting case study sites

The hospitals from which I could select my case study sites were predetermined. These were the three partner trusts of the regional CLAHRC centre under which this

research was housed (see Chapter One). My long list of case study sites was therefore any of the departments/units within these three trusts. My selection of sites from within this pool was motivated by the principles of theoretical sampling. Selection is made 'on the basis of their relevance to your research questions, your theoretical position and analytical framework, your analytical practice, and most importantly the argument or explanation that you are developing' (Mason, 2002, p. 124). The case study sites need to have the relevant characteristics to 'help to develop and test your theory' (Mason, 2002, p. 124). Morse (1999) sees this as a vital step in ensuring the transferability (generalisability) of research as:

'It is this selecting that ensures that the theory is comprehensive, complete, saturated, and accounts for negative cases. The knowledge gained from the theory should fit all scenarios that may be identified in the larger population' (p. 5).

There were four key stages to my case study site selection. First, the trust needed to be embarking on a period of transition within the time frame of my doctoral studies, this requirement shortened the number of viable trusts from three to two (one had a transition planned but this was to be much further in the future). Second, the short list was created by identifying those departments that were similar in terms of the type of service provided, for example, two endoscopy wards or two human resources departments. A similar service was required as the two remaining hospitals were so different. The hospital known as the anonymised 'Arunwick Hospital' is a very large organisation providing tertiary services nationally, whereas the hospital known as the anonymised 'Felwater Hospital' is much smaller and focuses on its local population

(see Chapter Four for a detailed description of the case study sites). Thirdly, the chosen departments/units needed to be going though a period of transition during the timeframe of this research. As the transitions/relocations were staggered at each trust, some occurring over a year apart, this reduced the number of viable sites considerably. Finally, to enhance the transferability of findings, the case study sites were chosen because of their relationship to a wider population (Mason, 2002). This only left one viable pair of sites and as a result the Day Case and Short Stay Unit (DCSSU) at each hospital trust were selected.

The DCSSUs were both embarking on a transition that comprised of the relocation to new purpose-built premises and changes to work processes. The sites represent a wider population in two main ways. Firstly, the majority of the participants were nurses, whose profession forms a large group of over 300,000 across the UK (NHS, 2012a). Also, the NHS has the largest number of employees of any organisation in Europe and of the professionally qualified clinical staff, nurses form the biggest occupational group (NHS, 2012a, NHS, 2012b). In addition, the sample was taken from a health services setting specifically from acute hospital trusts which is a sector that forms a large population of organisations that appear within 'the wider universe' (Mason, 2002, p. 124).

b) Gaining access to the case study sites

The process of gaining access to my chosen case study sites began directly after their selection. Gaining access has been described as often coming as a rude awakening to researchers (Feldman et al., 2003). However, having been privy to several horror stories from fellow postgraduate students regarding difficult access

procedures, my experience was quite the opposite. I was worried and almost ready for battle, but in fact gaining access to the DCSSUs followed a similar and straightforward path at each hospital. Oddly, however, the ease with which the access was gained then became a point of concern for me regarding the possibility that power imbalances might emerge.

There are many different ways in which a researcher can access the field (Brewer, 2000). At first I had hoped that I would be able to gain access by taking a bottom-up approach, where I could contact the DCSSUs directly. However, such an approach was not suitable both because of the sort of organisations I was trying to gain access to i.e. NHS hospital trusts and because of the collaborative partnership that already existed between the university and the hospital trusts. This partnership (see Chapter One) meant that intermediaries were in place to assist with the process of gaining access. The intermediaries were senior staff that were both part of the extended research team and the relevant hospital trusts. It was the intermediaries who introduced me to the DCSSU managers.

By taking more of a top-down approach (via senior staff) to enter the field, I was concerned that a bad first impression or power imbalance may be created with the participants. That the means of entry would (falsely) position me as an ally to higher levels in the organisation or as some kind of 'management spy' (Simmons, 2007, p. 13). In this way, instead of being considered by staff as a neutral researcher I would be considered as someone who was brought in by senior management to assess their work in some way. I feared my presence would influence the frontline staff causing them to, for example, inhibit their behaviour in some way. Indeed, as Mulhall

(2003) warns, gaining access using a top-down method is 'a pragmatic solution, but one that may override those further down the hierarchy' (p. 310). This concern was particularly worrying as much of the credibility (i.e. validity) of ethnographic research rests on the relationship between the researcher and the participants. However, for the most part my concerns were unfounded, this was largely owing to the care I took in developing my role within the field (discussed later in the chapter).

The process of gaining access began by contacting ward managers to arrange initial meetings. Although it was frustrating that some these meetings failed owing to the lack of availability of necessary staff, I had to accept that a researcher is simply not a priority in a busy hospital. At both hospitals those who attended access meetings were gracious and welcoming. It was clear that the meetings were successful as gatekeeper access was granted to me. However, the process of setting up the access meeting at Felwater Hospital (the first hospital within which I observed) did affect how I managed the one at Arunwick Hospital. The Felwater Hospital access meeting stands out more for me probably because at that stage I was still quite new to the ethnographic research process. Despite gaining access permission from the meeting, I felt two conflicting emotions afterwards. Firstly, I felt overwhelmed, incredibly happy that the study was supported by the hospital and secondly disappointed because I felt that I was perhaps 'giving the hard sell', so desperate was I for the meeting to result in a favourable outcome for my research. For the next access meeting, however, this time at Arunwick Hospital, I created a fact sheet about the project and so the meeting was much more of an information exchange. This kind of exchange was also possible because by this stage I had had around two months' experience in the field and knew what parts of that experience were relevant

for those at the hospital. The meeting therefore felt more businesslike and I felt more professional.

These initial meetings also enabled me to be introduced to members of staff who worked on the ward. These were introductions that I could build into relationships once the fieldwork began in earnest and gave me the opportunity to converse with the nurse and/or sisters in charge of each ward in a separate room where I could explain my research to them. It was helpful that the nurses I met at this introduction were full-time, permanent members of staff. In my first few days there was always someone I had met previously who could facilitate my introduction to other members of staff whom I had not yet met. Naïvely, I thought that meeting the rest of the staff would occur all at once in one go. In fact, the knowledge of my presence was spread in a more diffuse manner, particularly by word of mouth. In some ways, again, the introductions were more top-down than I had hoped for and I was once again concerned that this could have an impact on the way I was perceived. I made the following note just before I started on my first day at Felwater Hospital (for a key to the punctuation/symbols used in my field notes see Appendix 2). Lily was one of the two staff nurses (see glossary) in charge I had met previously:

> I saw Lily (nurse in charge) by the escalator and smiled at her. She smiled back and carried on walking. {I wondered why Lily did not take me to the ward. I was not sure whether she was shy or could not remember who I was. I wondered whether this was a signal that she did not want me there.}
>
> [Felwater field notes, week -7]

However, much of my interpretation was anxiety on my part, as later on that morning,

> Lily (nurse in charge) asked me when I was taking my break and I replied I did not mind and could go in the 'whenever' category. She told me to write my name up on the board and then said "you're part of the team now". {This felt very inclusive, warm and welcoming. Lily is lovely.}
>
> [Felwater field notes, week -7]

Being introduced to only one staff nurse in each ward at Felwater Hospital did make it harder to ensure all the staff on the ward knew the reasons for my presence and the substance of my research. I would have preferred to have been able to present my work at for instance a ward meeting. However, such events where all the staff came together were extremely rare. I was only aware of two such examples at each hospital during my entire period of observation.

c) My fieldwork role

Establishing a role on the ward was an important part of the process of gaining access. The researcher may have the necessary permissions physically to enter the research setting but I feel it is through carefully negotiating a social role that access is granted to the rich data ethnographers seek. Several authors have suggested typologies of the various fieldwork roles. For example, Spadley's (1980) work refers to five different types of participation along a scale ranging from high involvement to

no involvement. At the high end, complete participation is often used by researchers who already live/work in the situation they wish to study and at the low end researchers merely observe. Such roles did not fit with my experience on the ward as complete participation was not possible due to my lack of experience/qualification in nursing, yet I did feel that being part of the group was still possible. Fieldwork often involves unusual work (see for example, van Maanen, 2011). My fieldwork involved conversations with staff, joining in on breaks with others and attending staff social events. I attended nursing handovers, nurses' group dinners and tea breaks, ward parties and ward meetings. In this way I participated socially but not in the work the ward staff carried out. Wind (2008) proposes a rethink of the concept of participant observation. She suggests 'negotiated interactive observation' as a more accurate description of the sort of fieldwork that occurs during ethnographic studies in health care (p. 79). This is because:

> 'In the best of ethnographic worlds the ethnographer locates a place from where she can participate in the lives of the people studied; she finds a credible role that gives her the best opportunity for building trust and rapport so that she can join in different situation and activities' (Wind, 2008, p. 82).

Similarly, Jordan (2006) reflected on her shifting roles as a researcher, as student, person, guest and negative agent, adding that 'researchers must negotiate their presence … [and] that role must be simultaneously balanced between acceptable social science practice and comfortable interactional behaviors' (p. 172). Establishing such a balance with participants is an intangible process. However,

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thinking back it was the different ways in which the staff normalised the presence of a researcher, reflected in their attitudes towards me, that guided the relationships I had with participants. For example, at Felwater Hospital the staff seemed unaccustomed to the presence of a researcher, even the concept of research or having someone on the ward who was not completing clinical work was strange to them. Because of this unfamiliarity it was difficult at first to 'find a way in'. However, our meeting or cross-over points were conversations on personal or social matters (as opposed to work), such as television programmes and shopping; also, once the staff knew about my study aims I became 'a shoulder to cry on'. In this way staff normalised me, viewing me as a friend or confidante, they called me 'Raunchy Rowena' (for no reason other than the alliteration!). I was someone who hung out in the ward, ate toast, chatted, drank coffee with them and helped them locate and carry things.

At Arunwick Hospital, staff seemed much more accustomed to the presence of a researcher. When I explained I was conducting a study with the trust, I became a colleague who simply did a different job on the ward. In turn, my relationship with staff felt more professional in nature. In this way, similarly to Jordan (2006), my role at both hospitals was co-constructed. Being both flexible and guided by the participants, rather than forcing upon them the role of a rigid observational researcher, made my social role feel authentic to me. This authenticity aided my immersion in the setting and ultimately the dependability and credibility of the data I collected.

Despite my integration there is no doubt that a stranger, in this case a researcher, entering a setting will affect that setting, and it would be naïve to assume otherwise. As touched upon earlier, participants can be suspicious, believing the researcher to be some kind of spy or official (Simmons, 2007, Burawoy et al., 2000). I found Watson's (2010) writing on the 'emotional resilience' required to conduct ethnographic research particularly relevant at this stage. One of the most important ways of facilitating integration was to be in the setting as much as possible in the early days of the study (Hammersley and Atkinson, 2007). This attendance helped me to demonstrate to participants that I was committed and that I could start to build a trusting relationship with them. It also meant that my presence on the ward became 'normal' instead of unexpected or new. In the early stages of data collection there were times when I wondered whether my participants were giving a 'polished performance'. However, if this was the case in the early days in an intensely busy surgical ward it was very difficult for participants to keep up any kind of performance and my concerns about this soon dissipated.

d) Consent

I obtained written informed consent from most of the staff who worked on the two units (see Appendix 3 for the consent and Appendix 4 for the participant information forms). Those I was unable to obtain consent from were for the following reasons: a) long-term sickness, b) for some part-time staff our paths did not cross until much later on in the project and, c) as the majority of bank and agency staff (see glossary) changed from day to day, going through the process of consent when they often would not return to the unit and go through the relocation felt like an inappropriate request given their fleeting time with the unit. One participant who did consent to the

study asked for her responses not to be included; all other participants gave full consent (for a list of participants see Appendix 5 and 6).

The traditional notion of prior informed consent was 'developed in relation to the discrete episodic interventions typical of clinical trials or biomedical experimentation' (Murphy and Dingwall, 2007, p. 2225). This kind of model is very difficult to implement on a busy ward. In my case, the nurses' time was very much in demand and it was difficult to find some time when I could provide the level of information needed for them to give me informed consent. On a few occasions, I reluctantly interrupted staff breaks to gain the space required to explain my research and their role within it. Also, on a few occasions I went through the process with groups of three or four staff. The process of gaining consent from participants was often an unexpected launch pad for beginning a discussion about staff well-being. Several members of staff used this opportunity to think about and tell me what it was that was important to them in terms of their well-being or 'what made them tick'.

> Whilst obtaining informed consent from Sharda (an auxiliary nurse, see glossary) she went on to inform me that lower level staff do not get enough respect and are not as valued as they should be … She also commented that the junior doctors get treated badly: humiliated and undermined … [she] said that the uniform was an issue as patients know what grade they are dealing with and they sometimes will not speak to a clinical support worker or student nurses as they think they are 'clueless'.

> [Felwater field notes, week -7]

This is just part of the conversation I had with Sharda and is similar to other conversations with staff when obtaining consent. This process seemed to give staff a platform to vocalise their frustrations with work and brought to my attention areas to keep under review.

At Arunwick Hospital, the staff group relocated into a new ward to join an existing staff cohort that had been in place for around five months. This situation meant that when the group I was observing moved across to the new unit, a new round of introductions and explanations about my research was required for the staff who were already in place. This group appeared to have mixed feelings about my study; some seemed pleased that the focus was on the other group of staff but others expressed the view that they would have benefited from such research when they moved into the ward five months previously. As this existing staff group were not the focus of my study I did not obtain written consent from them. However, each time I observed on the ward I obtained verbal consent from those closest to where I was observing and took the opportunity (if I had not done so already) to introduce my study and provide more detail if necessary.

e) Observing well-being

As discussed in the literature review chapter, the definition used in this research is based on an affective and context-based conceptualisation of well-being. Affective well-being comprises a number of groups or axes of affective experience (van Horn et al., 2004). The groups include anger–placidity, tiredness–vigour, boredom–enthusiasm, depression–pleasure and anxiety–comfort (Daniels, 2000, van Horn et

al., 2004). However the depression – pleasure axis is considered to account for the majority of the variance in well-being. This axis was used as a guide to observe manifestations of well-being in the field, to ensure that the data collected was credible (i.e. valid). Those affective states observed towards the pleasure end of the spectrum included joy, happiness, laughter, excitement, vitality, passion/eagerness and were considered to be positive manifestations of well-being. Those affective states observed towards the depression end of the spectrum included sadness, crying, anger, irritation, annoyance, worry, concern were considered to be negative manifestations of well-being. Neutral affective states were noted when staff did not show a particular affective response, when neither of the affective ends of the axes were displayed by staff. For example, when staff were simply discussing aspects of their work or getting on with tasks, it was common that staff displayed neutral affective states.

These accounts of well-being were then linked to the transition process by recording affective reactions to particular aspects of the transition. These affective states occurred in reaction to a number of parts of the unfolding transition and in a number of different ways. For example, affective states were recorded in reaction to tasks directly related to the transition such as moving, sorting or cleaning items on the ward ready for the move. Affective states were noted in response to (expected or unexpected) stages of the transition such as the nervous moments just after the wards were opened or in angry reactions to the unexpected merger at Felwater (see Chapter Five). Reactions were also recorded amongst staff whist conversations were being had about the transition. Staff discussed, for example, how it would work, what the ward would be like afterwards and any rumours they had heard. Staff expressed

their feelings about these different elements of the transition either directly (by stating how they felt) or indirectly (through tone of voice or body language).

Of course much of the data collected was not related to the transition; for example, it was concerned with day to day tasks like handovers, drug rounds, or linen changes. However this information served to set the scene of the ward and to establish what customary practices, values and social norms were present rather than to explore what affected staff well-being during change.

I found that having the notion of positive and negative affect in my mind for those initial observation sessions provided a scaffold to move on to the more context-specific formulations of staff well-being. Indeed, as my time in the field developed I learnt about the complex parts of observing well-being such as the atmosphere of the wards, the patterns of behaviour surrounding certain events and the subtle gestures such as facial expressions and looks/glances between members of staff.

f) Methodological findings

Once my fieldwork had begun I conducted all of my observation in staff or communal/public areas, specifically at the nurses' stations, in the staffroom, and in the ward corridors and doorways. For several reasons I rarely went onto the patient bays: firstly, the decision was an ethical one. Stepping out of the staff areas and into a patient bay or cubicle felt like an invasion of the patient's privacy and as patients were not the focus of this study it seemed an unnecessary invasion. In addition, as a researcher, it is important to recognise the impact both on the population you are studying as well as those who, although not the focus of the study, are still present in

the setting. The bays and patient cubicles seemed to be where most of the routine nursing tasks were carried out and where the nurses conducted their 'customer facing' role.

Goffman (2010) describes this as a frontstage or front region performance. Here 'the performance of an individual in the front region may be seen as an effort to give the appearance that his activity in the region maintains and embodies certain standards' (Goffman, 2010, p. 203). In areas that 'belonged' to staff the performance was much more backstage in nature for 'the performer can relax; he can drop his front, forgo speaking his lines, and step out of character' (Goffman, 1959, p. 115). If the patient bays were frontstage and the staffroom backstage, I found that the nursing stations corresponded to a further 'midstage'. This finding emerged because the nurses' stations seemed to come somewhere in-between; the stations were backstage in a sense that staff were away from patient bays but still frontstage as many of the nurses' stations were in visual and audible range of the patient areas. Here nurses carried out professional aspects of their role, such as completing patient notes, speaking to patients and doctors, demonstrating the frontstage nature of the location but also spoke about their personal lives and gossiped amongst themselves. The midstage nature of the nurses' stations was made particularly salient when nurses spoke in hushed voices or were caught doing things there that they should have been doing in the staffroom, such as reading the paper or internet shopping.

The notion of 'stages' leads to a novel means of assessing validity and credibility that is 'triangulation-by-context'. Triangulation involves a particular aspect/element of a study being investigated from a variety of different angles to see whether a

congruence between findings occurs (Denzin, 2009). There are several different types of triangulation, for example, by method or by measure (see for example, Addicott et al., 2006). I observed my participants in their front- (to some extent), mid- and backstage performances and in doing so conducted what could be referred to as a triangulation by 'stage' or context. I occasionally found that the behaviour I observed was mediated by the setting so that, for instance, behavioural responses were more intense and expressive in the staffroom and more discreet in patient-facing roles on the ward. Thus, I was offered different viewpoints from which to collect my data. However, it is important to avoid making the erroneous assumption that 'the aggregation of data from different sources will unproblematically add up to produce a more accurate or complete picture' (Hammersley and Atkinson, 2007, p. 184). Instead, triangulation provides a means of adding rigour to an inquiry (Brewer, 2000, Denzin and Lincoln, 2000). For example, events on the ward were often expanded in the staffroom and explained in greater detail, and this provided an effective way for me to check my interpretation of events.

One of the main tools I used alongside participant observation was the use of informal interviews (Taylor, 2005). These were generally spontaneous conversations (see for example, Williamson et al., 2012), usually referred to as informal conversations in my notes, held with staff while they worked or during breaks. I used these to build rapport with my participants but also to explore issues and events in the unit that I could not fully understand through observation alone. Informal conversations also allowed staff to approach me with information that they felt was important for my study. This interaction made the research much more of a two-way

process as I observed the scene in front of me and received feedback from the participants within it.

g) The analysis process

Brewer advises 'the first thing to note about analysis is that it is a continuous process' (Brewer, 2000, p. 107). This iterative type of analysis is based on grounded theory, 'a general methodology for developing theory that is grounded in data systematically gathered and analysed. Theory evolves during actual research and it does this through continuous interplay between analysis and data collection' (Stauss and Corbin, 1998, p. 158). I conducted three broad stages of analysis that built upon and informed the next level. These were field notes, coding and analytical memos. At times this was a 'messy' process that involved much to-ing and fro-ing between the data, however it is important to report these details as transparently as possible to ensure the dependability of the research (Shenton, 2004, Thomas and Magilvy, 2011). However, for clarity the stages presented below are ordered to show how each stage fed into the next, the decisions that I made about the process and how the analysis evolved on the basis of these. Conducting such a thorough analysis enabled me to become heavily engaged with my data, a further strategy recommended for enhancing the transferability of findings (Polit and Beck, 2010).

    i. Field notes

Data was recorded solely using field notes made in a spiral-bound notebook. The nurses' station, a place where I conducted much of my observation, was a location where staff were frequently writing in some form of document, be it patients' notes or some kind of administrative document. It felt more natural to be writing notes than

not and so it seemed acceptable to make notes openly, in a non-covert way. I noted on my first day at Felwater Hospital,

> … I stood or sat at the nurses' station or adjacent to the nurses' station to make my observations. I had a notebook that I was writing notes in on occasion. This did not seem out of place because many staff members were writing on different pieces of paper, either in notebooks, on patient notes, etc. I felt more self conscious if I just stood there.
>
> [Felwater field notes, week -7]

I also did not feel that my memory was reliable enough to provide the detail required to do the subject justice without written notes. The field notes were made initially in a condensed format before being turned into an expanded account as Spradley (1980) suggests.

The condensed field notes were taken 'at the scene' and as well as both brief and detailed descriptions included single words, my own abbreviations, and sometimes single letters or symbols. The shorthand nature of condensed notes lent themselves particularly well to recording the large number of things happening in the ward quickly. Sometimes events occurred that only 'appeared' after a few occurrences. An example of this was staff mentioning the temperature on the ward as being too hot or too cold several times before it seemed to become audible to me. In those early stages I also found that my values occasionally affected the initial interpretation of my observations. Particularly during my first week when I looked back on the first set of field notes, there were indications in my analysis/interpretation section that I was

comparing what was happening in the field to what I would expect in my normal working life, for example:

> The hospital was very much waking up. I noted on my way through that the café was not open until 8am. {The opening times of the café surprised me as lots of staff start their shifts before 8am, this seems like a) a missed opportunity and b) not very staff orientated.}
>
> [Felwater field notes, week -7]

In this way, I was producing *etic* and not an *emic* interpretation (Fetterman, 1998). Etic analysis is 'based on the researcher's concepts' whereas emic analysis derives 'from the conceptual framework of those being studied' (Silverman, 2006, p. 284). Although this is a reasonable starting point for a researcher in an entirely strange setting by working reflexively I could highlight that a personal comparison was happening and that I needed to work very closely with Spradley's (1980) principles outlined below to achieve the *emic* perspective. This early reflection also taught me to challenge my views, to ask myself why I was interpreting data in a particular way and to include evidence such as facial expressions and tone of voice.

The language used in my field notes changed as my project progressed. I started by writing out phonetically the terms I heard on the ward, things like operation or procedure names and not understanding nicknames given to illnesses or procedures such as a "TWOC". This was a term I heard frequently in Felwater Hospital, and initially I had no idea about what it referred to but soon learned this meant Trial Without Catheter. As my understanding developed, so the groups' nomenclature

became normal; I now shared this language and began to 'speak' it in my field notes. As time went on I found I understood what was going on in the setting more and more, fewer things needed explaining and because of this I was able to respond in appropriate ways to events rather than in the beginning when it was much more 'nodding and smiling'. Understanding events and language seems to have a snowball effect as I was then able to find, for example, contextual jokes funny and as such my rapport with the staff grew stronger and stronger (Gale, 2010). As well as my own sense of feeling immersed in the setting, I was able to draw upon staff reactions to me as a gauge of how immersed they thought I was in the setting. These reactions were both implicit and explicit. For example, implicitly staff brought me into conversations about gossip and personal matters as well as members of staff telling me explicitly that I was part of the team.

The methods used to create field notes are an important way of helping to ensure the data recorded is reliable. Within the ethnographic approach reliability (also known as dependability) refers to whether or not the same findings would emerge if the study was attempted again (Shenton, 2004, Thomas and Magilvy, 2011). To 'address the dependability issue more directly, the processes within the study should be reported in detail, thereby enabling a future researcher to repeat the work' (Shenton, 2004, p. 71). I believe I have conducted and reported my 'research strategy and data analysis methods in a sufficiently detailed manner' as recommended by Silverman (2006), in order to make the 'research process transparent' (p. 282). I used several strategies to ensure this. First of all I recorded my field notes in accordance with Spradley's (1980) guidelines, which are very similar to what Seale (1999) refers to as low inference descriptors.

Spradley's (1980) three principles for making an ethnographic record are the language identification principle, the verbatim principle and the concrete principle (see for example, Suzuki et al., 2007). The language identification principle is similar to adding the kind of detail found in the script of a stage production, where speakers, tone and location are recorded. For example, I used speech marks ("…") when quotations I had written down were word for word what a participant said. However, when I recorded a quotation that was not exact I used inverted commas ('…') to indicate this (see Appendix 2 for a key to my field notes). The verbatim principle stresses the importance of recording direct quotations and is based on the assumption that summarising what people say may close off areas of investigation, whereas recording speech word for word leads to further questions. The concrete principle advocates using concrete language in the field notes to describe events. By adopting this approach to creating field notes the researcher can create low inference descriptors; that is what the participants said/did rather than the researcher's reconstruction of it.

Spradley (1980) also suggests that researchers take four different types of field notes: condensed notes, expanded notes, a fieldwork journal and a set of notes focused on analysis/interpretation in order to systematise the process of note taking (see for example, Parke and Griffiths, 2008). I systematised my field notes in the same way using the four different types but also co-located these types in my expanded field notes. I chose not to separate them as I wanted to make sure that my interpretations/analysis and journal were all alongside the expanded field notes.

I felt that separating the notes gave the opportunity for detail and connections/relationships between sections of data to be lost. Instead, after each section of data or event in the data I wrote a section (marked out using definite brackets ({…})) that included my interpretations and analysis as well as my more cumulative journal-like thoughts. It is using techniques such as these that enable a distinction to be made between emic and etic analysis. Kirk and Miller (1986) also argue that the relevant context of an observation needs to be recorded. I found it particularly useful to start each observation by spending five or ten minutes taking the 'temperature' of the ward: recording the context, how busy the ward was and what the mood was like. This preparation enabled me to immerse myself within an observation session; it also felt that describing the basic contextual elements in a concrete manner acted as a kind of introduction to each new set of field notes. It is using these techniques that enable field notes to be produced in a methodical, consistent and therefore rigorous way. In addition, by making the means by which data was recorded transparent the data can be shown to be a reliable source.

The expanded account formed the second stage of the recording process. Having had first-hand experience in previous research projects of the detail that can be lost as memory fades, I always (without fail) expanded my condensed notes by typing them up immediately (0-2 hours) following the observation sessions. With everything fresh in my mind this often resulted in the expanded notes exceeding 4,500 words per day. The volume of notes I took varied from day to day and could depend on factors such as the level of activity on the ward. However, this was not always the case, as quieter days gave me the chance to have more informal conversations with participants, which also resulted in large volumes of notes.

Once away from the field, the process of expansion allowed me to document more fully what I had seen and heard during the observation session as well as giving me time to think about what was really going on. This process enabled the compilation of a thick description of the setting (Geertz, 1973). That is a description with enough detail that those reading the work can make sense of both the context and the participants of the study (Polit and Beck, 2010). Constructing a thick description is considered to be a key way of enabling other readers to judge how transferable (generalisable) the findings are to their own context (Polit and Beck, 2010). In addition to the thick description offered within the data chapters, Chapter Four focuses on the background and process of the transitions as well as offers a description of the case study trusts.

Compiling this thick description or expanded account often triggered memories that I had not recorded in my condensed notes, so while retaining the chronological order of the notes, expanding the notes helped me to reflect on the day as a coherent whole. This procedure allowed me to notice patterns, themes and connections. When the expanded accounts were written up, initial analytic notes, memoranda, hunches and ideas were recorded alongside the observations (Hammer and Champy, 1995). For me, these initial analytic notes were my research diary, often taken at the scene and developed during the expansion phase when (as mentioned) I could comment on the day as a coherent whole. Within the expanded field notes the source of the event was also noted, be it an observation such as overhearing a conversation, a meeting such as the daily handovers or during an informal conversation.

ii. Coding

I conducted three phases of coding on the expanded field notes. The first of these phases was more descriptive and was conducted continuously when I was in the field. This approach is based on grounded theory where analysis develops theory and this theory directs subsequent data collection (Charmaz, 2006). The second and third phases were conducted after data collection was complete.

- Phase one: in the field

The aim of this phase of analysis was to discern the descriptive concepts that would be explored (with an open mind) in greater detail in the more focused phase that followed (see for example, Fallona, 2000). To conduct this analysis I read and re-read the expanded accounts several times. This allowed me to become familiar with and eventually absorbed in the data. Such comprehensive knowledge of a data set is considered to be key in 'providing the thick descriptions upon which transferability depends' (Polit and Beck, 2010, p. 1456). I will now explore the different ways that enabled me to (as part of the analysis process) become immersed within the data.

The field notes were tagged with emerging descriptive concepts (Spradley, 1980). The aim was to identify stable features within the dataset to enable observations to become more focused and eventually selective in subsequent phases of data collection (Spradley, 1980). The concepts emerged in different ways, for example, spontaneously from unusual participant vernacular, from my own identification, or from the need to devise a new expression to characterise a pattern (Hammersley and Atkinson, 2007).

At this point my descriptive concepts were sensitising concepts that provide a set of guidelines for inclusion (Bowen, 2006). By carrying out more focused observation to clarify their meaning and analysis to explore their relationships with other categories, more definitive concepts with precise inclusion criteria were developed (Bowen, 2006).

- Phase two: after fieldwork was complete

When the data collection was complete, all of the expanded field notes were coded using three different types of codes: descriptive coding, mechanism coding and magnitude coding (Saldana, 2009). This coding built upon the concepts developed in the first phase.

Descriptive coding 'summarises in a word or short phrase … the basic topic of a passage of qualitative data' (Saldana, 2009, p. 70). In order to provide the descriptive codes I read each section of the data (sometimes several times over) and assigned the code as if I was giving that section a title. Descriptive codes included patient care, cancellations, managers and bank/agency staff. The purpose of using descriptive coding was to capture the main subjects covered by the data (Saldana, 2009) and the broad contexts/circumstances in which well-being was being disrupted.

The second type of coding, mechanism coding, was similar to what Saldana (2009) refers to as process coding. However, instead of focusing on actions this coding was concerned with the mechanisms in the data. As was discussed in Chapter Two

mechanisms are considered to produce the effects of a programme or intervention (Pawson and Tilley, 1997). Thus, in the present context, mechanisms are used to understand what it is about transition that drives any effects on staff well-being. In order to provide mechanism codes I once again read each section of data and assigned codes according to my perception of the underlying reason(s) driving the event. Mechanism codes included nursing values, workload, communication and work ethics.

The purpose of using mechanism coding was to answer my second research question that focuses on why staff well-being is experienced in particular ways (see Chapter Two for the research questions). For example, when speaking about an obstructive patient a nurse said: 'Doctors go mad at the nurses not him (i.e. the patient)' [Felwater field notes, week +3]. This excerpt was given a descriptive code of *Patient behaviour* and the mechanism code of *Unfair*. The descriptive code was given because the nurse was talking about patient behaviour. The mechanism code was given because she was talking about the injustice of blame being directed at nurses when they did not consider the situation to be their fault. This perceived unfairness caused a negative reaction from the staff nurse. Where possible I noted the reasons behind actions alongside the affective state of the participant(s) to explain why I made particular judgements in the field.

Magnitude coding was used when coding for well-being (Saldana, 2009). A set of magnitude codes were developed by openly reading through the field notes and developing codes that encapsulated the levels of well-being expressed in data. The codes went from categorising strongly negative expressions such as crying, through

codes for when people appeared neutral and to very positive expressions of well-being such as laughter. These magnitude codes reflect the axes of affective well-being discussed earlier in this chapter. A code was also used for anomalous instances, such as people laughing at an apparently negative experience.

Although the three cycles of coding (descriptive, magnitude and mechanism) were completed on the same data set, it was the coding structure from the mechanism phase that had the most analytical utility for my research aims. The mechanism codes enabled me to explore what was driving or what was the source of effects on staff well-being such as unfairness.

- Phase three: Constant comparative method

The data once coded was then examined further using the constant comparative method to identify the 'properties of the codes' and to continually refine them by adding, merging, dividing and removing codes where necessary. Conducting a constant comparative analysis is an important way of developing the validity or credibility of one's findings (Silverman, 2006). In conducting this process 'categories emerge from the data that constitute explanatory propositions to account for the patterns and regularities represented by the categories'; in this way the theory that emerges is grounded in the data (Brewer, 2000, p. 152). Once this constant comparative phase was complete the number of categories had reduced considerably. Many changes and swaps were made during this period, which made the data clearer in my mind and developed the structure of the categories in to what felt like a more fitting representation of the data.

The constant comparative phase is important because during the coding period itself one cannot yet be certain of the final parameters, edges or shape of the data. Once coding is complete and the boundaries of the data are known, the conceptual 'tightening' of the themes can begin. After hours creating the field notes I found that I was very conscious of trying to capture all the rich detail within them. This caused my initial set of codes to be overly detailed and specific. I also noticed that some of my codes were either synonyms or very close to each other and so they could be collapsed to build larger categories. This process of coding, then comparing and tightening enabled me to develop conceptual categories or, an in-process theory (Locke, 2001). Application of the constant comparative method enabled a tighter set of 21 categories within three broader themes to be taken forward.

iii. Analytic memos

Once the constant comparative stage was complete I further analysed the data by writing analytical memos for the categories. I found this gave me a starting point or framework for a qualitative description of the data, where I could establish and record patterns in the data, develop classifications and examine negative cases (Brewer, 2000). The analytical memos included sections on, for example, a summary of the data, a summary of how the data in a category changed over the transition process, a section for any initial thoughts that arose while I was compiling the memo, a section for documenting deviant cases, one for describing other categories to which it linked, and how it did so, as well as a section on the 'bigger picture', i.e. whether there were any unifying themes. As the focus of my project is on well-being, deviant cases usually involved a strange or abnormal reaction to an event or also a non-reaction to something that had previously been upsetting. There was also an

area for documenting and considering recommendations that could be made on the basis of the category.

During this stage of analysis I also went through the process of 'delimiting the theory' (p. 52). This requires the researcher to 'clarify the story they have to tell about the phenomenon…' (Locke, 2001, p. 52). For me this was greatly helped by concentrating on my research questions and so I focused on those parts of the data set that were relevant or related in some way to the transition (rather than data that encapsulated general ward life). Until this point the analysis process had enabled me to consider in detail the categories in their broader sense. This was essential for considering the context of the wards and as a result exploring how the transition worked, or indeed did not work, within this context.

One of the things I also found particularly useful throughout the analysis process was to continue reading around the subject area of the study. It is very tempting at the analysis stage to bury oneself within the data and not emerge until this process has come to a close. However, it was through reading that I was able to keep my mind open and entertain new explanatory ideas. For me it was reading the work of others particularly regarding the conflicting demands placed upon clinicians that gave the data a voice. Until this point I felt I could explain *what* was affecting staff well-being but was having difficulty expressing *how* or *why*. Considering notions of demands and the conflicts these could place upon staff provided me with new insight particularly regarding the role of dissonance or incongruence that staff may experience as a result. This reading helped me to think more clearly about the data and the possibilities within it.

The complete process of field note writing through to applying the constant comparative method to looking more broadly across the data set required me to live the situation, focus in on the minutiae of my field notes, and then draw out and back away from the data to think about it in its entirety and the messages that could be distilled from this. As Hammersley and Atkinson (2007) put it, 'we develop analyses by making connections among conceptual categories of our local data and also by relating them explicitly to generic ideas that transcend them' (p. 189).

The full analysis process enabled me to establish three key themes regarding what affected staff well-being during transition. These are: a) information and communications during the transition, b) the nature of the transition and c) the impact of the transition on social structures. These central themes form the subject matter for the three findings chapters presented in this thesis (Chapters Five, Six and Seven).

CONCLUSION

At the start of this project my experience of hospitals and ethnographic methods was very limited. Reading back through my early field notes makes how far I have come apparent to me. This chapter has provided a reflexive account of conducting ethnographic research in two short stay surgical units. In it I have provided an account of why I chose ethnography as the research approach. Conducting an ethnography has enabled me: a) to embrace the multifaceted nature of health service transition by contextualising data, b) to privilege the knowledge of others and

c) to obtain deeper, richer forms of data in order to understand complex behaviours such as those associated with well-being.

A further central aim of this chapter was to engage with the criticism that ethnography does not provide generalisable findings. However, it is argued here that ethnographic research is not aiming for statistical generalisability but for transferability. Indeed, it was shown in this chapter that by appropriate management of the research process (such as transparent reporting of the analysis phase etc.), the credibility and dependability (that is validity and reliability) of qualitative work can be demonstrated. By showing the ways that qualitative research can produce rigorous findings readers and users of this research can then make judgements regarding the suitability of transferring or exporting the findings to other relevant situations and hence overcome this central critique.

CHAPTER FOUR

SETTING THE SCENE: THE CASE STUDY SITES

INTRODUCTION

This chapter describes the two case study hospital trusts (the anonymised Arunwick and Felwater Hospital Trusts) and in doing so has two broad aims. First, to provide the context within which the fieldwork locations operated. Secondly, to provide sufficient information to enable the reader to make judgements about whether the findings presented here are transferable to their own context (Polit and Beck, 2010).

The chapter is divided into three main parts. Part One characterises the broader hospital trusts, specifically focusing on their organisational and regional characteristics. This section will describe the trusts' workforce, detailing strategic commitments to their employees as well as their NHS staff survey results, particularly relevant as the survey was conducted during the fieldwork period. Part Two will detail the background of the transitions at each trust and will particularly consider the national and local drivers for change. Finally, in Part Three, the chapter focuses in on the specific fieldwork locations, starting with the pre-transition wards at the two hospitals before moving on to the post-transition wards. This latter section provides an overview of what the transition involved for staff, i.e. a relocation to new purpose-built premises and subsequent changes to work processes.

PART ONE: THE CASE STUDY SITES

a) The hospital trusts

The case study sites were both acute hospital trusts. This type of hospital forms a large group of around 170 organisations found across the UK (NHS, 2012c). As organisations, Felwater and Arunwick Hospital Trusts differ in many ways, most notably regarding their size, foundation trust status, purpose and income of the organisation as well as the demographics of the populations they serve. Felwater Hospital, located in a British town, is a traditional district general hospital. It employs around 2,500 staff and is the only provider of acute care in the local area (Felwater NHS Trust, 2011). The trust mainly offers typical secondary care services such as cardiology, general surgery and maternity services.

Arunwick Hospital, unlike Felwater Hospital, holds Foundation Trust status. It is located in a large English city and is a much bigger organisation employing around 6,900 staff. In terms of geographical area, Arunwick Hospital casts its net much more widely and as well as providing secondary services is a 'major tertiary centre within the region' (Shapiro et al., 2010, p. 11); Arunwick Hospital Trust offers specialist services such as organ transplants. The difference in size between the organisations is reflected in their income figures, which for the 2010-2011 period were £180 million and £535.7 million for Felwater and Arunwick Hospital respectively (Felwater NHS Trust, 2011, Arunwick NHS Foundation Trust, 2011).

b) Staff in the trusts

Both hospital trusts made strategic pledges in their 2010-2011 annual reports regarding their workforce. Felwater Hospital stated that improving the trust as a place of work was a priority while creating a fit-for-purpose workforce was one of Arunwick Hospital's strategic pledges (Arunwick NHS Foundation Trust, 2011, Felwater NHS Trust, 2011). One of the best known means of assessing the attitudes of NHS staff towards their work is through the annual National NHS staff survey (see Chapter Two for a full explanation of the survey). The survey structure is based on four pledges made to all NHS staff by the NHS constitution (Department of Health, 2009b), along with the addition of two themes focusing on staff satisfaction and, equality and diversity (see Table 4.1).

Table 4.1: Four pledges to staff from the NHS Constitution for England (2009) and two additional themes upon which the NHS Staff Survey (2010) is based.

Pledge 1	To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities
Pledge 2	To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed
Pledge 3	To provide support and opportunities for staff to maintain their health, well-being and safety
Pledge 4	To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
Additional theme 1	Staff satisfaction
Additional theme 2	Equality and diversity

Each section includes between two and fourteen statements that ask staff to rate different aspects of their work, for example, levels of satisfaction with their work and

the extent to which staff feel supported by managers. The table below (see Table 4.2) shows how many statements achieved scores from staff that were above the national average (better than) and below the national average (worse than), and the same as the national average at Felwater and Arunwick Hospital Trust. The table shows that Arunwick Hospital scores above average more frequently and below average less frequently than Felwater Hospital in all areas except the equality and diversity theme. This suggests that staff at Arunwick Hospital had higher levels of staff satisfaction than those at Felwater Hospital.

Table 4.2: Overview of the NHS staff survey results at Felwater and Arunwick Hospital Trust. This table shows the number of statements within each pledge/additional theme that scored (A) above the national average, (B) fell below the national average and (C) were the same as the national average.

	(A) No of scores above average		(B) No of scores below average		(C) No of average scores	
	Felwater	Arunwick	Felwater	Arunwick	Felwater	Arunwick
Pledge 1 statements – Roles (out of 9)	3	8	4	1	2	0
Pledge 2 statements – Development (out of 6)	5	6	1	0	0	0
Pledge 3 statements – Well-being (out of 14)	3	10	7	1	4	3
Pledge 4 statements – Engagement (out of 2)	0	2	1	0	1	0
Additional theme 1 statements – Staff satisfaction (out of 4)	0	4	4	0	0	0
Additional theme 2 statements – Equality and diversity (out of 3)	1	0	2	2	0	1
Total (out of 38)	12	30	19	4	7	4

PART TWO: BACKGROUND ON THE TRANSITIONS

In order to understand the reasons behind the transitions it is important to detail the circumstances that led to their inception. Exploring these drivers for change sets the background scene and as such provides a more detailed account of the service transition.

It is difficult to present the precise drivers for the transitions, for example, those laid out in a business case or in funding applications, without compromising the anonymity of each trust. However, the information provided here derives from two main sources. First, a research report written about the trusts prior to them embarking on their organisational transitions. This report served to provide a baseline or starting point before the physical transition began in earnest at each organisation and in doing so presents an exploration of the drivers for such change. Secondly, a personal communication from a key stakeholder in the transition process (the source of which has been anonymised).

I will first focus on the national drivers for change before moving on to explore the local drivers. As I will go on to demonstrate, the influences on service transition are often multiple, complex and politically or pragmatically motivated.

a) National drivers for change

Heath care services are continually changing to keep up with developments in health technologies and the understanding of health and illness (Shapiro et al., 2010). As this body of knowledge grows so do the societal expectations of health care (Department of Health, 2008). Developments in health care affect the way that such care is delivered, for example, in terms of reducing the length of stay for patients in hospital (Anonymised Hospitals NHS Trust, 2009) and moving particular services into community settings (Shapiro et al., 2010). To keep inline with these shifts requires acute trusts to modify or in some cases transform the way they operate (Shapiro et al., 2010).

The shift towards a more patient-focused health care system is a major political trigger for change (Shapiro et al., 2010). This shift is reflected in various changes to the health service. For example, both the results of individual trusts and information collected by the Care Quality Commission (CQC) are accessible to service users. This transparency enables users to make considered decisions about where they wish to be treated (Shapiro et al., 2010). Evaluating the success of treatment also reflects a patient-focused shift in the health service (Shapiro et al., 2010). Patient-reported outcome measures (PROMs) are a form of service evaluation that focuses on the patient's quality of life before and after an operation or treatment. This measure changes the focus away from the success of a procedure in medical terms alone (Shapiro et al., 2010). A move is also reflected in strategic level changes to the heath service as approximately 10% of a trust's income will be (as of 2010-2011) connected to levels of patient experience and quality reported in that trust. These shifts require hospitals to change how they deliver their services and also what services they deliver in order to stay ahead in an increasingly competitive market (Shapiro et al., 2010).

There were also financial triggers for change such as the forthcoming government spending review (Appleby et al., 2009). Although at the time the wider health service was uncertain of where exactly the budgetary restrictions would fall, the impending arrival of such cutbacks was a certainty. As a result, there was an increased need for health care organisations to develop productivity and efficiency gains (Martin et al., 2006). Trusts were already adapting to deal with these issues by, for example, working to reduce the length of stay (Ham et al., 2003) and adapting particular care

models (Shapiro et al., 2010). The sense at that time was that cutbacks would be lasting; as a result acute trusts had the opportunity to develop longer term plans about how they might operate within a relative period of austerity (Shapiro et al., 2010).

b) Local drivers for change

Local pressures additionally drove the need for organisational transition. For Felwater Hospital, to ward off concerns about takeovers from a neighbouring health care organisation, its continued existence depended the presence of newly-built facilities (Shapiro et al., 2010). A large new wing to the hospital was considered to secure the hospital's future as the primary health care provider for the locality (Shapiro et al., 2010). However, such a large scale investment is also the hospital's most significant hazard to its financial survival (Shapiro et al., 2010).

The pressure at Arunwick was centred on appropriate growth and development. In addition, changing 'commissioning to a more open and competitive market … had a significant effect on [Arunwick Hospital's] ability to strengthen its position in the tertiary market' (Shapiro et al., 2010, p. 40). So, unlike Felwater, the drive for securing a new hospital for Arunwick was not to merely survive but to grow and flourish into a leader within the sector.

c) Organisational drivers for change

Prior to the transition, Arunwick Hospital Trust was spilt across two sites operating from one old hospital and one very old hospital (Shapiro et al., 2010). The old hospital suffered from asbestos and the very old was unsound in places (Anon,

2013). Additionally, the two hospital sites were an inefficient way of running a tertiary centre. Arunwick Hospital Trust needed a new, modern, fit-for-purpose facility and somewhere in to which the trust could grow.

At Felwater Hospital the organisational triggers for change also stemmed from the need to up-date old building stock. Some of the hospital buildings had been condemned as a result of fire and some of the buildings dated back to the turn of the last century or before (Anon, 2013). For both hospital trusts, the only realistic means of raising the funds for the new buildings was through a Private Finance Initiative (PFI), a system procurement carried out in collaboration with the private sector which has some characteristics of a repayment mortgage (Anon, 2013).

The Arunwick Hospital Trust building project involved a vast new main hospital costing around £550 million. At Felwater Hospital Trust the project was a new and large hospital wing costing around £170 million. Both new sites were originally designed around the requirements of the services they provided (Anon, 2013). In this way, function (activities) determined form (spaces). However, both building projects developed in an iterative manner where time, money and the practicalities of geography meant the original aims were constantly being diluted (Anon, 2013).

PART THREE: THE FIELDWORK LOCATIONS

Fieldwork was carried out in the Day Case and Short Stay Unit (DCSSU) at each hospital. These units dealt with low risk surgical procedures that had a high chance of the patient being discharged on that or the next day. This type of work meant that the wards should close at the weekend, when the theatres would also close. The

units were staffed mainly by ward sisters (see glossary), staff and auxiliary nurses, but other staff came on to the ward, such as doctors, cleaners, porters and housekeepers. To cover all of the wards that comprised the DCSSUs at both hospital sites resulted in observation being carried out in five separate locations (the names of which have been anonymised, see Table 4.3). The descriptions that follow focus on two key features of the wards, the environment and the routine.

Table 4.3: Fieldwork sites before and after the relocation.

	DCSSU Wards before the relocation (old)	DCSSU Wards after the relocation (new)
Felwater Hospital	Carson Ward Crawley Ward	Grantham Ward
Arunwick Hospital	Darcy Ward	Bennett Ward

The fieldwork was conducted during the relocations to capture the process of transition as it unfolded. Fieldwork at each hospital lasted approximately five months and owing to the dates of the two relocations was staggered. Fieldwork began first at Felwater Hospital on Monday, 2 August 2010, and continued until Wednesday, 1 December 2010 before moving on to Arunwick Hospital between Monday, 25 October 2010, and Friday, 11 March 2011.

a) Pre-relocation Wards

i. Carson Ward (Felwater Hospital, pre-relocation)

Carson Ward formed one of the two halves of the old DCSSU at Felwater Hospital (the other, Crawley Ward is discussed below). Due to the transition, the staff from both units relocated and merged into the completely newly built and unopened DCSSU, Grantham Ward.

- Environment

Carson Ward was a 20-bedded ward with two male patient bays and one female (see Figure 4.1). Two single rooms held patients of either sex and were generally saved for high-risk patients. Each of the three bays had six bed spaces in constant use that were arranged in 'Nightingale ward style' with beds positioned in two rows opposite each other.
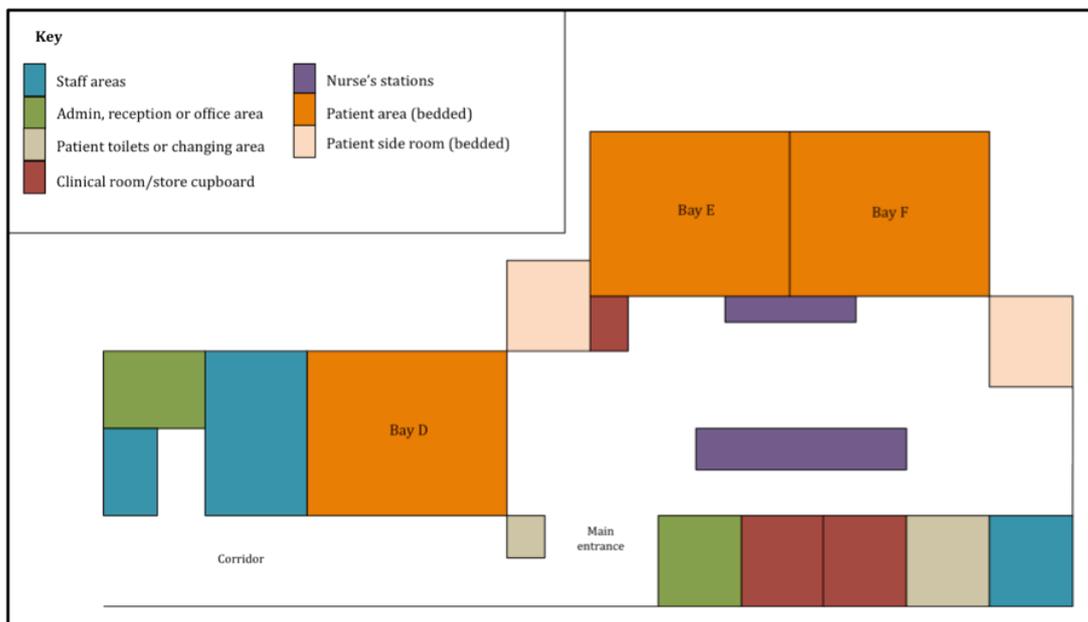
Figure 4.1: Layout of Carson Ward

The Carson Ward environment was old-fashioned and the area around the nurses' station felt claustrophobic. It was small, the ceiling felt unusually low, it lacked natural light and became quite hot at times. Switching on a desktop fan was often one of the first things that nurses did when they arrived at the nurses' station at the start of their shift. At busy times, such as doctors' ward rounds, mealtimes and when patients were getting up and washing, the lack of space made the area feel hectic. The 'hub' of the ward was the nurses' station. The staff walked and sometimes ran around the ward, often using the nurses' station as an 'interchange' to check patient notes or add to them, make calls, chat to other staff and pass through on the way to the clinical room to collect drugs and other equipment.

- Routine

Carson Ward was supposed to be a 'minus 47 hour' surgical ward. A ward for patients having surgery with a good prospect of discharge within 47 hours. The reality was different. Carson Ward cared for many 'all care' patients, including those patients needing help with most tasks including washing and going to the toilet, many of whom stayed on the ward for weeks (this issue is discussed in detail in Chapter Six). This wide variety of work inevitably influenced the ward routine.

The shifts on Carson Ward ran from 7am - 3pm (an 'early') and 1pm – 9pm (a 'late'). Some staff (included in this study) occasionally did what was known as the 'long day', which could stretch from 7am – 9pm. Night shifts were covered by a separate group of staff who did not work during the day. Each 'early' and 'late' shift began with a handover, where staff on the earlier shift would inform those coming on to the next shift what patients were on the ward, their procedures, medical history and any tasks

that were outstanding, such as arranging an outpatient's appointment. The handovers were usually very methodical, working through the ward zone by zone, bed by bed. Most staff would have a hot drink at this time and chat about both their personal and working lives. At the end of the handover the nurse in charge would allocate the bays amongst the staff, usually with one qualified staff nurse and around two auxiliary nurses per bay. This handover process occurred at Carson Ward and Crawley Ward and continued more or less unchanged in the new hospital. On completion of the handover at around 7.30am, nurses came out of the staff areas (where the handover was usually held) on to the ward, the sheets on the beds were changed and patients started to get up and wash, many requiring assistance to do so. Tasks such as contacting doctors to review patients, accompanying doctors on ward rounds, managing the discharges/admissions, changing dressings, administering drugs and getting patients to appointments such as X-rays in the hospital then took up most of the rest of the day.

ii. Crawley Ward (Felwater Hospital, pre-relocation)

Crawley Ward was the other half of the old DCSSU at Felwater Hospital and was located in a different part of the hospital, approximately five minutes walk away from Carson Ward.

- Environment

Although Crawley Ward also had a dated interior it was a much more spacious ward (see Figure 4.2). The area in front of the nurses' station was large and there seemed to be more natural light filtering in. The ward was mostly painted in light colours and

so felt brighter. However, the ward could become cold and draughty, and had a hole in the ceiling.
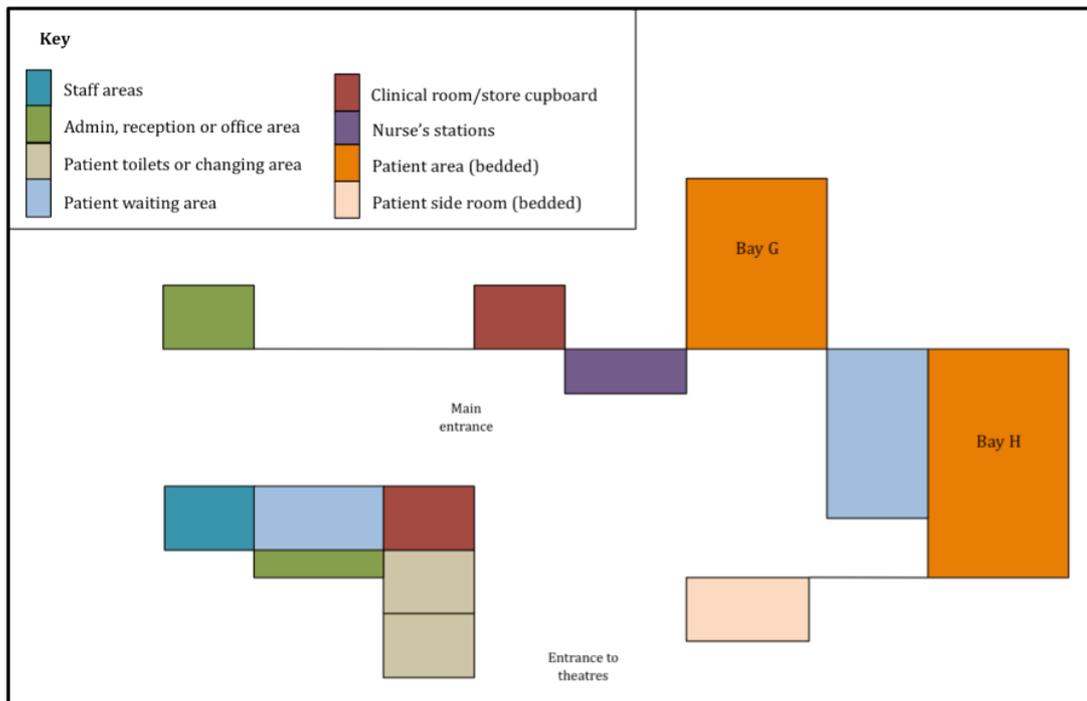
Figure 4.2: Layout of Crawley Ward

Like Carson Ward it was a tired and old facility. Bay G (the smaller of the two bays on the ward) had four bed spaces and Bay H (the larger bay) had 10 bed spaces. Along with the single room, Crawley Ward was a 15-bedded ward. The beds were in constant use except occasionally in the early morning when patients had not yet arrived or when there had been no patient transfers into the ward overnight.

- Routine

Crawley Ward did receive 'unsuitable' patient transfers (those patients deemed to be outside of the DCSSU remit), it functioned more as a DCSSU than Carson Ward. The day usually began with a handover of those patients who had been on the ward

overnight and a discussion of what beds that day's surgical patients were to use. Once the handover was finished staff changed the linen on the beds and started admitting and readying the day case surgery patients for theatre. When patients had been to theatre, staff provided care and prepared patients for discharge, doing tasks such as obtaining drugs from the pharmacy and asking the doctors to approve the patient's discharge.

iii. Darcy Ward (Arunwick Hospital, pre-relocation)

At Arunwick Hospital the DCSSU consisted of two separate wards. One of these wards (Darcy) was housed in an old hospital building. While the other ward was in the new hospital building and had been operational for approximately five months. The group that I observed relocated from the old Darcy Ward to join the new Bennett Ward (see Table 4.3).

- Environment

Darcy Ward had two bays, one for males (Bay A) and one for females (Bay B), with beds around the edge and a central nurses' station in each section (see Figure 4.3). The ward had room for approximately 30 beds, although around a third of this space was not in use.
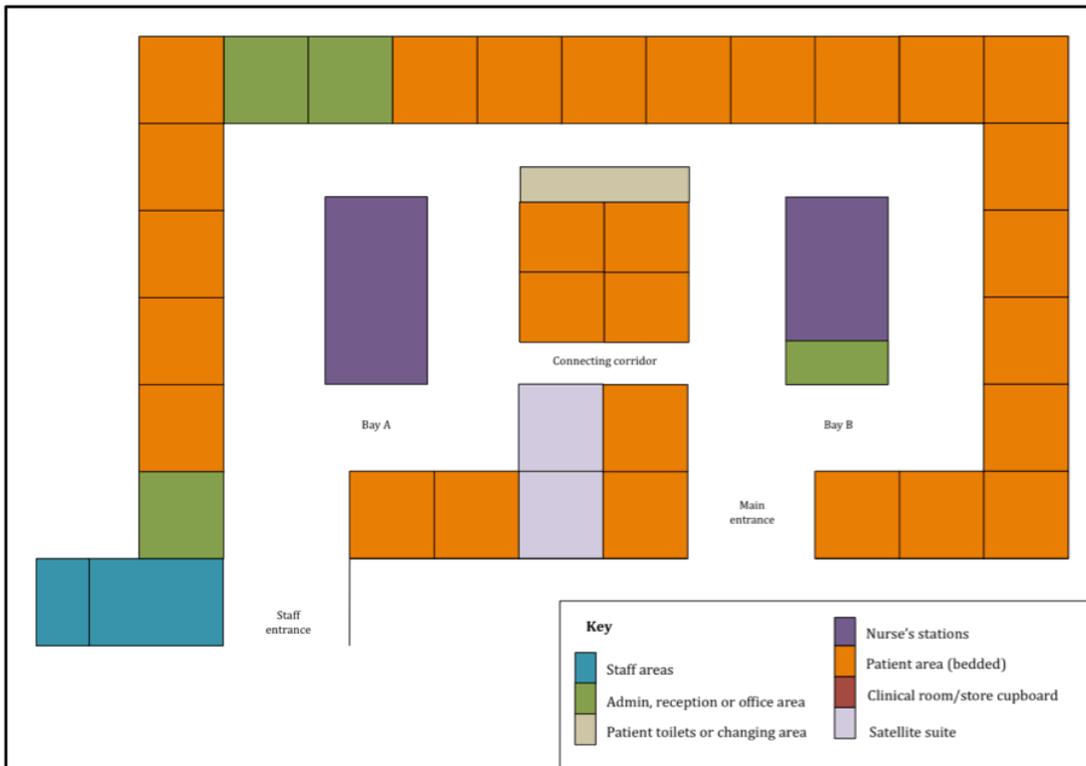
Figure 4.3: Layout of Darcy Ward

The ward was very spacious due to its original purpose which required room to house several machines/monitors around each bed. It was light and bright with lots of windows. However, the ward felt oversized, much too big for the number of staff and patients it housed and so was very quiet with no real 'buzz'. Staff tended to gather at the nurses' station more than in other locations but there did not seem to be a hub or central location to which everyone returned to chat between tasks, for example.

- Routine

On Darcy Ward the day began with a handover between 7.30 and 8am. Once the handover was complete staff prepared patients for theatre and then, post-operatively, readied them for discharge or transfer to a more suitable unit. The shifts

at Arunwick Hospital ran from 7.30am – 3.30pm (an 'early') and 1.30pm – 9.30pm (a 'late'). As at Felwater Hospital, some staff also did the 'long day', which again usually ran from the very beginning to the very end of the day. The handover occurred in Darcy Ward in much the same way as at Felwater Hospital.

b) The relocations

At each trust, once the buildings were handed over by the contractors to the trusts, a series of planned relocations began. At Felwater Hospital the relocation and opening of the hospital wing had three main phases. The unit observed in this fieldwork (DCSSU) moved during the third phase of the project on Saturday, 25 September 2010 (Felwater NHS Trust, 2011). Staff were asked to come in and help on the day of the relocation and as this was a Saturday staff came in on their day off. Once all the equipment had been taken from the old wards, the teams congregated in the new unit (Grantham Ward) and began to unpack and generally ready the ward for opening on Monday, 27 September.

At Arunwick Hospital the relocation and opening of the new hospital was on a much larger scale with six separate relocation phases across a period of 16 months (Arunwick NHS Foundation Trust, 2012). The staff from Darcy Ward moved on the second of the relocation phases on Tuesday, 16 November 2010 with the first working day on Wednesday, 17 November. Darcy Ward nursing staff played a less active role in the relocation than staff at Felwater Hospital. On the day of the relocation the ward was still open and patients were being cared for by the nurses. The packing was mostly organised and carried out by sisters and the hired removal

firm. In the new wards at both hospital trusts staff experienced a range of changes, such as new facilities, procedures, workflow and equipment.

c) The 'new' wards

i. Grantham Ward (Felwater Hospital, post-relocation)

The new DCSSU at Felwater Hospital, Grantham Ward, was located on the second floor of the outpatients department in the new wing of the hospital.

- Environment

It was divided into three zones: Zone N and L were for patients on trolleys (those going home that day) and Zone M was a bedded area for those staying overnight (see Figure 4.4).
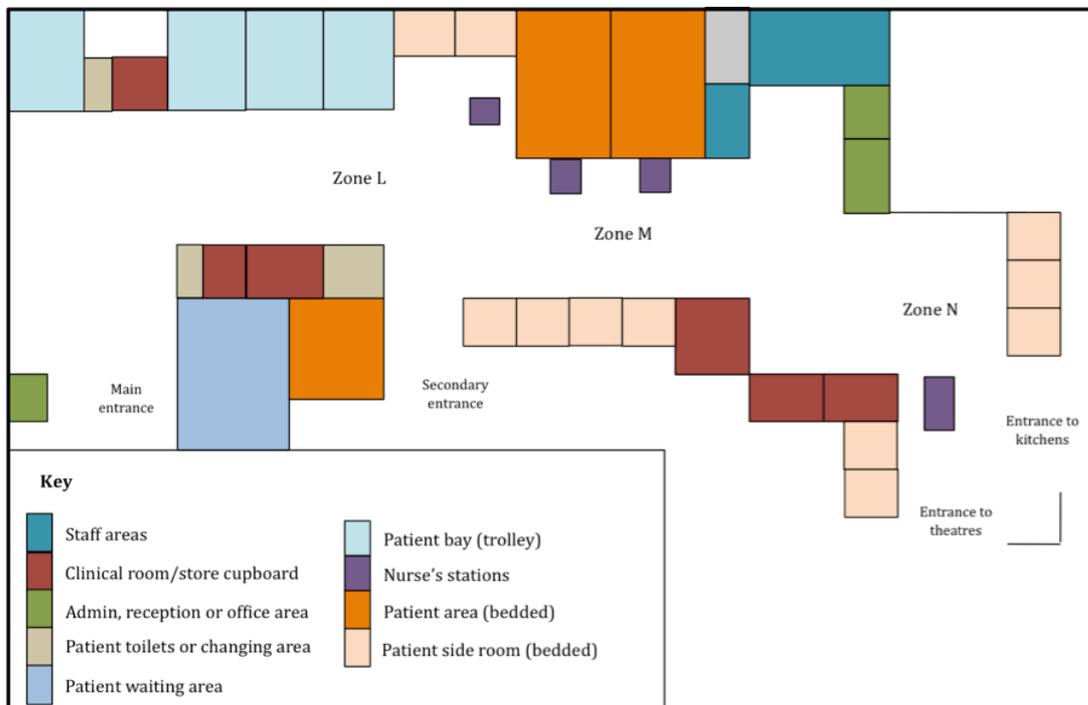
Figure 4.4: Layout of Grantham Ward

Grantham Ward was completely new, to the point that on moving day there was still dust in some of the rooms left by the builders. The ward was light, bright and spacious: a very modern health care facility. Most of the rooms had very large windows, almost floor to ceiling. All the fittings in the hospital from the floor to the door handles, toilets and signage were all shiny plastic; it had a 'new' smell to it. The ward felt like an environment in which it would be much easier to deliver health care hygiene and accessibility standards. The ward was substantially larger with frequent walking required to reach the different areas. The new ward seemed much tidier than the old wards; everything had a place and it was very much the rule to keep everything in its place.

- Routine

A typical day on the new Grantham Ward began with a handover of all the patients who had stayed overnight in Zone M. Once the handover was complete most of the staff then went to Zone M to change the bed linen of overnight patients and to serve breakfast; some staff would also admit the day case patients. At around 10am the first day case patients would come to the receiving area (Zone N) post-operatively and would then be taken on to the bedded or trolley area, depending on whether or not they were staying overnight. Patients were generally sent through to the ward from theatres until around 6pm when the theatres finished their working day. The nurses would then care for patients and work towards getting patients discharged or making sure there was room in the bedded area for them to stay. Shift times remained the same and night shifts continued to be covered by a separate group of staff.

ii. Bennett Ward (Arunwick Hospital, post-relocation)

The new DCSSU at Arunwick Hospital, Bennett Ward, was much larger with a much more complex layout than the old Darcy Ward. The ward was divided into a recliner zone (Zone C), a trolley zone (Zone B) and a bedded zone (Zone A) with a central command centre where all the beds were managed and allocated (see Figure 4.5). The recliner zone (Zone C) was the smallest area on the ward and was designed for patients who did not require a trolley or a bed, such as patients receiving an infusion treatment. However, the recliners were replaced with trolleys and this area was then lacking in space (see Chapter Six for a detailed discussion on this issue).
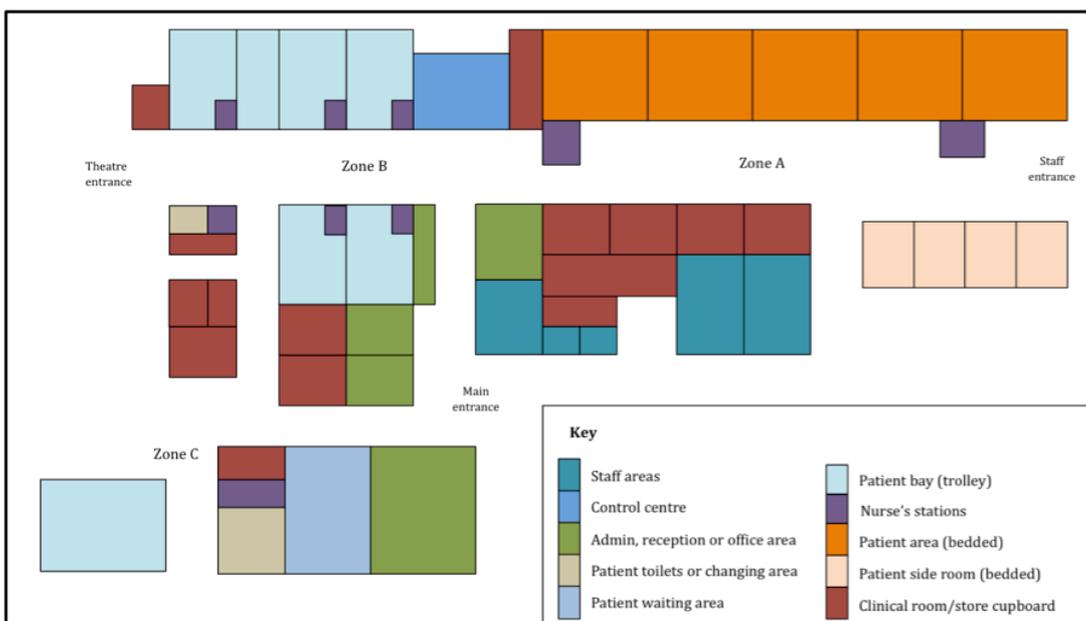
Figure 4.5: Layout of Bennett Ward

- Environment

Bennett Ward was a modern, fresh and bright environment. With an emphasis on high patient numbers (i.e. volume), the ward design enabled the patients to be

effectively moved through the system. However, all space was accounted for and Bennett Ward felt considerably busier and more cramped than Darcy Ward. The central corridor running though Zones A and B constantly had different staff such as nurses, porters and doctors busy with their work. The nurses' stations, although greater in number, were considerably smaller than those they replaced and nurses worked in cramped conditions when at the station. The proximity of the patients to the nursing stations meant that confidential conversations often needed to be whispered.

- Routine

On Bennett Ward the staff came on to the ward immediately when their shift began. They went straight to the control centre and found out what zone they were working on. The majority of Bennett Ward did not require a handover as a new group of patients came in every day. It was only the bedded zone (Zone A) that required a handover of patients who had stayed in overnight or were on the ward when the late shift came on. The handover was usually conducted at the Zone A nurses' station with nurses leaning on the accessible desk space or in a treatment room, again with nurses leaning on the available space. Those who were working on Zones B and C (the trolley zones) gathered the notes for their patients and waited for the welcoming staff (usually two auxiliary nurses) to bring the patients to the zone before the nurses then formally admitted the patients and prepared them for theatre. Again, once the patient had had his or her procedure, the main tasks for staff were to care for patients, to work towards having the patient discharged or, if staying overnight, to move him or her into the bedded area.

CONCLUSION

This chapter provides background information on Arunwick and Felwater Hospitals with the purpose of describing the circumstances in which the wards operate. This account was achieved by considering the characteristics of each trust, the trust's strategic commitments to its workforce and the NHS staff survey results. A description of the background to the transition, which included the old wards and the subsequent relocation to the new wards was provided before day-to-day life and ward environments were described. It is intended that through this detailed account of the context enough information has been provided to enable other researchers or practitioners to decide whether the findings presented in the three following chapters are relevant (that is transferrable) to their own circumstances. The thesis will move on to present the findings from this project starting with a focus on information and communication and how this affected the well-being of staff during the transitions.

CHAPTER FIVE

INFORMATION AND COMMUNICATION DURING THE TRANSITION

INTRODUCTION

This chapter and the two that follow present the findings from fieldwork conducted at Felwater and Arunwick Hospital Trusts. Each chapter focuses on a central part of the transition that affected staff well-being. Chapter Six (that follows this) presents findings on the nature of the transition. That is, what the specific characteristics of the transition were (in this case relocating to new work spaces and the new work activities associated with this relocation) and how these characteristics affected staff. Chapter Seven puts forward findings on the impact of the transition on the social relationships within the ward units. The present findings chapter focuses on information and communications during the transition.

Change-related information, that is information specifically related to the transition (rather than information on the ward or unit in general) and the communication of such information is relevant to the transition process for a variety of reasons. Information provides staff with knowledge about what is happening during transition, both in terms of the progression of the transition (process) and what the transition will mean for staff roles once it is complete (content). Communications about the process of transition can include, for example, information on when the transition will happen, what the transition will involve, who it will involve, who will assist the process and how the transition will work in relation to other departments. In light of

the centrality of information to keeping staff up to date about the transition process this information needs to arrive in a timely, transparent fashion, one that enables staff to participate in or be consulted on the process of transition in some meaningful way. In addition, communications on the content of the transition were important for staff, such as information about what work would be like following the transition.

This chapter, like the other two that follow it, has a specific structure. In Part One the contextual information from both case study sites is presented in relation to the theme of the chapter. This information is presented to provide the reader with a sense of the relevant collective or shared meanings, informal practices and norms or any values pertinent to the topic under discussion (Michie and West, 2004, Schein, 1992). The chapter will then move on in Part Two to consider the different mechanisms i.e. those aspects of the transition that brought about different effects on well-being. This use of the concepts of contexts and mechanisms is borrowed from Pawson and Tilley's (1997) realist evaluation (see Chapter Two for an explanation of this approach). The conclusion of each chapter is then used to summarise the ways in which the context of the case study site may have constrained or enabled the presence of the mechanisms.

PART ONE: CONTEXTUAL DETAILS

INFORMATION AND COMMUNICATION AT THE CASE STUDY SITES

This section of the chapter aims to provide a sense of some of the customary practices with regards to information and communications on the hospital wards. The staff at both sites experienced the transfer of information with predominantly operational or goal-orientated intentions, that is, to facilitate the routine functioning of

the ward. Examples included discussing which duties were outstanding and which had been completed, assisting and updating doctors, coordinating the use of equipment and informing other departments of patient requirements such as arranging a phlebotomist to come to the ward. In this way, communication was a facilitator of activity on the wards and ultimately acted to enable staff to move through their workload.

> Grace (a ward administrator) whilst flicking through a ring binder was checking with Baldeep (a staff nurse) what patients were still on the ward and who had been discharged. She phrased the question 'Is [a patient] still here?' and 'What about [another patient]?' … 'Who?' Baldeep replied and walked over to Grace to look at the ring binder.
>
> [Felwater field notes, week -7]

> Katie (a staff nurse) explained what Isobel (a staff nurse) and Faith (an auxiliary nurse) were doing to a member of staff (I did not write down who but maybe Ella (a senior sister)) and then said, "I'm going to get a drink – is that all right?". The member of staff said, "Yeah – that's fine." {Staff are kept in the loop, this is communication.}
>
> [Arunwick field notes, week -4]

In addition, staff at both hospital sites regularly experienced both informal and formal communications. The informal communication centred on conversations between staff discussing both work and personal topics. On the other hand, more formal transfers included handovers, where usually the nurse in charge would methodically

deliver relevant patient information to those nurses starting a shift. Patient notes, where patient care was recorded, were used by staff as a means of accessing basic information. Additionally staff used a whiteboard (usually placed in central positions), where patient location and procedure status (pre-, post-, during) were noted.

Despite this similarity the characteristics of communication at the sites had two key differences. First, there was a more obvious lack of information at Felwater Hospital. That is, there was a greater sense that information did not get through or was unavailable to frontline staff:

> The nurses at the nurses' station were discussing rumours that Section Two forms (see below) need to be completed on the computer. {A lack of communications?}
>
> > [Felwater field notes, week -7]

> Lily (the nurse in charge) discusses the new 'fit note'. Lily is not sure how to fill it out as the form has changed. It is decided just to tick that the patient is unfit for work for a week and that the GP is to review. {It seems that staff are just expected to know and work it out for themselves.}
>
> > [Felwater field notes, week -6]

The presence of rumours suggests that staff were not informed about some work-related issues. As demonstrated above the experience of rumours arose in the more administrative aspects of nursing work. For example, a Section Two form was often

used by nurses to indicate that social services should become involved to assess a patient's needs. Staff lacked information regarding changes to these and other frequently used forms such as the new 'fit note', the document that replaced the decommissioned 'sick note' (see glossary). Such occurrences gave the impression that the general experience of ward life was one with low levels of information, that staff needed either to get by on minimum amounts of information, use their initiative or seek confirmation from other areas of the hospital. Circumstances such as these were rarer at Arunwick Hospital and as a result staff seemed much more 'in the know' about their work.

A second dimension of communications present at Arunwick Hospital but not noted at Felwater Hospital was the role communications played in the nurses' demonstration of professionalism. In this way, the effective relaying of information was seen as part of the nurses' credibility and part of how they demonstrated (to patients, staff and visitors to the ward) that they were proficient in their work. This effect occurred because obtaining up-to-date information meant nurses could better order and plan their work, which in turn allowed nurses to show they were thorough in their practice, organised and competent. For example, during an informal conversation Kate (a ward sister) explained one of the reasons why she felt keeping staff informed was important:

> I have no idea why but [the handover breaking up/finishing] reminded
> me of a time when Kate mentioned to me one of the reasons why
> communication was important. She said it's not very nice if, when
> people [patients, staff or visitors] come on the ward and ask for

someone they are told that the person is on the other bay [in the ward] and is not given any more help. If they [the staff] all know what is going on in both bays this should not happen. {communication is important on this ward.}

[Arunwick field notes, week -1]

Kate is explaining that by keeping everyone informed each staff member is equally able to help a visitor who comes to the ward rather than just sending the visitor to look elsewhere. As the ward was separated into two bays (one for male and one for female patients), not knowing what was happening on both sides could result in a delay while an informed staff member was located and became available to assist. Transferring information in the ward keeps staff up to date and allows them to address visitors thoroughly and quickly. This activity reflects the nurses' adherence to maintaining professional practice. Staff at Arunwick Hospital also attached importance to the way they delivered information and could become uncomfortable if they gave partial information. For example, one senior sister, Ella, during a lengthy telephone conversation with a colleague had become embarrassed when she could not answer a question asked by a colleague because she could not remember the response, adding that it was particularly bad as she 'was only told 5 seconds ago' [Arunwick field notes, week -4].

Delivering information effectively was an important demonstration of the nurses' professionalism because nursing work is not a solitary practice; nurses work in teams and are all links in that team. By obtaining and passing on thorough updates, staff are aware of the status of work activities and can approach tasks in a more

informed fashion, for example, knowing what tasks have already been accomplished and what is outstanding. This method enables staff to approach their work in a more straightforward manner and can in turn be an implicit means of demonstrating that they are a strong and effective part of that team. Similarly, communication of information was a source from which nurses were able to achieve a sense of self-belief:

> Annabelle (a staff nurse) commented on staff just having been given all the discharge information used over on the new ward. She said it was fantastic because you did not have to go round asking people; it was there in black and white how they (the patients) should care for themselves. Annabelle said this gave you confidence in what you were telling patients.
>
> [Arunwick field notes, week 4]

Here the communications offered the nurse reassurance in the accuracy of information she was passing on to patients. Having the information in 'black and white' meant there was no ambiguity. The desire to avoid asking colleagues was touched upon by another staff nurse, Isobel, who cautioned during a conversation in relation to their arrival on the new ward 'that they [the Darcy Ward staff] will be the annoying ones asking lots of questions' [Arunwick field notes, week -4]. This attitude may stem from staff wanting to avoid appearing inexperienced or avoid being a burden to others.

In sum, customary practices with regards to information and communications were based on the ward working in a task-orientated manner, a process that was enabled by the communication of different types of information. In this way, information was very much an operational enabler, allowing nurses to move through their workload quickly and effectively. There were appropriate situations for formal and informal communications; for example, nursing handovers at the beginning of the shift were more formal in nature whereas those carried out throughout the shift were more informal and *ad hoc*. Customary practices also differed between the hospital sites. First, instances in which staff lacked information were more frequent at Felwater Hospital. Second, the use of communication as a means of demonstrating professionalism among nurses was a more dominant feature of ward life at Arunwick Hospital. At Arunwick staff used communication to show credibility and proficiency in their work. The chapter will now move on to explore information and communication mechanisms during the transition.

PART TWO: INFORMATION AND COMMUNICATION MECHANISMS DURING THE TRANSITION

There are several different strategies that can be adopted when communicating information. In the present study, both systematic and unsystematic approaches were observed. A systematic approach to communicating change-related information maintained levels of well-being amongst staff. An unsystematic approach to communicating change-related information affected staff well-being negatively. Communicating information about the transition process showed that both the process of communicating (how the communications were delivered), as well as the content (what the communications covered), were important for staff well-being.

This chapter will now turn to consider the different mechanisms that were relevant to change-related information during the transition. The delivery of change-related information differed at each case study site and these will be explored separately first (sections a and b), before moving on to consider the content of change-related information jointly (section c). Part Two is divided into three parts: a) Felwater Hospital - Delivering change-related information and communications, b) Arunwick Hospital - Delivering change-related information and communications and c) The content of change-related information and communication at both case study trusts.

a) Felwater Hospital - Delivering change-related information and communications

The approach to delivering change-related communications at Felwater Hospital was unsystematic in nature. There did not appear to be a fixed plan or system in place and as a result communications were lacking in the extent to which they were consultative/participatory, adequately scheduled and transparent. The ways in which these three mechanisms brought about effects on staff well-being during the transition will now be explored.

For ward staff at Felwater Hospital, levels of involvement and participation in the transition were low. This feature was particularly striking when, an additional unexpected stage of the transition occurred. This unexpected stage was a merger (that appeared to be in progress) between Grantham Ward (the new DCSSU) and Hughes Ward (a different specialty unit in another part of the hospital). The details of

this potential merger were uncertain and, despite rumours, staff were uncertain about the merger and what it would entail:

> Baldeep (a staff nurse), [talking about the merger], said that they (the staff group) are not supposed to know. Baldeep added that they have not been told officially yet. The merger is due to occur at the beginning of December. At this point Naveen (an auxiliary nurse) added that we (the staff group) will be told the week before as always. {Poor communication seems normal here.}
>
> [Felwater field notes, week +5]

In this same informal conversation, Baldeep advised that the Grantham/Hughes Ward merger was likely to mean a fundamental change to staff working hours and shift patterns, such as working weekends and Christmas. Baldeep became very upset during this informal conversation as she was worried about the impact this change would have on her personal life. However, at the same time Naveen's words demonstrated that staff expected to be informed late in the process and that this delay was commonplace. This example highlights firstly a lack of commitment to involving staff, and secondly that the failure had become standard practice. The concept of habituation, where reactions to an event are weakened with repeated exposure (Domjan, 2010), is relevant here as the more staff experience poor communication (it is reasonable to infer), the more poor communication will become accepted practice. However, interestingly, although staff are used to receiving information in this way, they do not appear to be habituated to these circumstances. Thus any effect on staff well-being has not been weakened with repeated exposure.

Consequently, it appears poor communication has a persistent effect on staff well-being. Low levels of consultation with staff regarding the potential Grantham/Hughes Ward merger continued to have a detrimental effect on staff well-being in the weeks to come:

> The majority of the group leave the [staff]room to start their shifts. A few of the nurses are left behind. Cecelia (a staff nurse) has been talking about calling the union today as (the staff) think they (the union) should be involved and she wants to seek their advice. Cecelia says that she would not have minded all these [new types of specialty patients] coming and the change to the working hours if they [possibly the management] had come and told us and consulted us first.
>
> [Felwater field notes, week +7]

Again, staff were angered by the lack of consultation from management. This extract was recorded 'backstage' in the staffroom, an enclosed area where staff could be more open and vocal about their feelings than they could on the more public-facing ward. The lack of consultation is cited as the central problem here, not the changes to work that the merger will bring. The situation suggests that it is the manner in which change is approached rather than the changes themselves that affect staff. A little while later, however, the course of the Grantham/Hughes Ward merger changed again:

> I am about to leave the ward and go into the staffroom to collect my things. Information has filtered through to the ward that the move is on

hold until the new year. From this news Eve (an auxiliary nurse) says to Cecelia that she (Cecelia) does not need to stress anymore, not until the new year anyway. Cecelia said that this is why people should not talk about, act on or worry about rumours as it was just a waste of time. Cecelia also said that it was pointless worrying about things as they had no control over the situation. The other staff in the room seemed to agree with nods and grunts.

[Felwater field notes, week +7]

Cecelia's comment that staff have no control suggests that their views have little influence at the management level. Cecelia was disappointed that her colleagues went along with rumours. I noted after this conversation that, although Cecelia had commented on worry being pointless, she did still concern herself with these matters. This is interesting because Cecelia's aim to portray an image of someone who is unconcerned also works to conceal her inner feelings. Thus a tension exists where caring is denied within a role built on placing care at the core of professional practice.

On the wards at Felwater Hospital rumours were common. Instances included speculation about whether the transition would still occur after the new building suffered floods and regarding further specialty units joining the ward. These speculations arose because staff were often unsure about upcoming arrangements or plans made by higher levels of the organisation (such as the plan to merge wards) until such plans were in the fruition stage. The presence of rumours also served to highlight the low levels of information available. It is within the context of such

circumstances (low levels or insufficient information from management) that rumours tend to emerge (Bordia et al., 2004). Literature also suggests that these rumour processes materialise (despite being damaging in themselves) to reduce the occurrence of other harmful states among staff, such as uncertainty (Rosnow, 1991; DiFonzo, Bordia et al., 1994). In this way, rumours can act as a coping mechanism by reducing the gap that exists between the levels of information staff have, and the levels of information staff feel they require.

A further dimension of the communication process was the schedule of the change-related communications. At Felwater Hospital information about the transition often did not reach frontline staff in a timely manner; this negatively affected staff well-being. This set of circumstances occurred because there was rarely enough time to implement the requirements detailed within such communications. This delay usually resulted in extra pressure being placed upon staff to meet such demands. For example, just prior to the relocation at Felwater Hospital, staff on Carson Ward were informed that they needed to re-house all surgical patients as, upon their departure, the unit was going to become a ward specialising only in medical patients:

> I come on the ward and begin blowing up balloons for the party this afternoon and, as I walk out of the senior sister's office, Baldeep (a staff nurse) says to me, "I hope your book is full of the stress we are under getting these beds sorted". Lily (the nurse in charge) adds in an

overly calm and dreamy voice "We're not stressed". {Baldeep is clearly

stressed by something that is going on with the beds. Lily is playing up

to Baldeep}.

<div align="center">[Felwater field notes, week -1]</div>

A little later during an informal interview Naveen (an auxiliary nurse) and Alison (a staff nurse) explained why getting the beds sorted was stressful at this point in the transition process:

> Naveen added, the one thing I will tell you is that it is a bit late for us to
>
> be told that the beds need to be sorted. We should have been told this
>
> at the beginning of the week. Naveen then went on to explain that this
>
> ward will now only have medical patients on it. He says this adds a lot
>
> of stress to the nurses who are now trying to sort out transfers. This
>
> information should have come earlier, preferably at the beginning of the
>
> week.

<div align="center">[Felwater field notes, week -1]</div>

Last-minute information that requested the ward type to be changed (from surgical to medical) resulted in a lot of extra logistical work for the nurses. For example, Lily (the nurse in charge) went on to make a succession of pleading telephone calls to other wards in the hospital to ensure that all the surgical patients were re-housed ready for the relocation. This workload, coupled with the preparation required for the transition, resulted in the ward being put under pressure to meet the needs of both aims. The situation placed conflicting demands on staff as they were required to work in a

manner that was uncomfortable for them, and as a result had a negative impact on their well-being. Communications about the Grantham/Hughes Ward merger (discussed earlier) also resulted in further instances where information arrived late on to the ward:

> Alison tells me that the Grantham Ward and Hughes Ward [are merging]. I look over at Kavita (auxiliary nurse) and she pulls a sad face. Alison says there have been rumours it would happen for weeks … Alison went on to advise that "it means we have to work with new staff and a new boss" and that they [ward staff] get so much stuff "thrown at them" and that "it's water off a duck's back, been through so many changes over the past few years, don't care anymore". {Kavita is not happy. It seems that rumour is the first source of information. There are more changes coming.}
>
> [Felwater field notes, week +5]

Alison's comment that the Grantham/Hughes Ward merger was 'water off a duck's back' was made using an angry tone that made her comment feel false, as if she was using her words to deny that the merger had upset her. Indeed, I wrote in my fieldnotes that her anger made it feel as if she cared and that she did not truly mean what she was saying. Alison's comment mirrors Cecelia's earlier objection to paying attention to rumours. Again, by portraying an unconcerned image Alison's inner response is concealed. Thus, a conflict occurs between showing herself to be uncaring and care being a fundamental part of her role. Alison also highlights the multifaceted or 'hard' nature of the merger by making reference to its abrupt onset

and the new team members staff will need to become accustomed to. This instance demonstrates that despite the rumours, information that the merger will go ahead is sudden and that the level of adjustment is a significant concern for staff. Alison's use of the term 'thrown' has a number of implicit inferences, such as the communicative relationship being one-directional, a lack of participation and respect, and highlights that management level staff did not consult the frontline. I also noted at the time that the term 'thrown' suggested that the merger was sudden and that there was a lack of agreement and information about it.

Interestingly, some staff did not appear as concerned with the change itself as with the way in which it had come about. As Naveen (an auxiliary nurse) put it during a handover meeting, "it's not that it is happening - it's the late notice … people have plans" [Felwater field notes, week +7]. Naveen's comment alludes to a further problem regarding the late notice of the merger, as at this time the Christmas break was only a short time away. This circumstance potentially meant that staff would be expected to work over the Christmas period (something that was not required at that time). Here Naveen feels that the staff group have been poorly treated. The general feeling about the timing of the Grantham/Hughes Ward merger, however, was summed up by Grace (one of the ward administrators) at the end of a handover meeting with, "It's just a nightmare isn't it. It's just another hassle you don't need." [field notes, week +7]. The merger was an unanticipated feature of the transition and caused additional pressure at an already demanding time.

A further dimension of change-related communications was the extent to which such communications were transparent, both in terms of dissemination hierarchies and in

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terms of the clarity of the message being conveyed. At Felwater Hospital, when communication was attempted channels of information transfer were often unrehearsed and as a result were blurred. Ambiguous hierarchies of dissemination meant the passing on of information could be ineffective. For example, on the day before the relocation ineffective communication was causing confusion among the staff. This final day was an important opportunity for the staff to get their ward ready and organised for the transition.

> Daphne (a ward administrator) comes to the [nurses' station] and says that the patients are asking her what is happening. Cecelia (a staff nurse) then says that she does not know who is doing the beds at the moment (i.e. managing the beds) and listed [a range of staff members] (all of whom were getting involved). Cecelia has a stressed tone. [A few minutes later] Cecelia said aloud: 'Doing me head in, so many people are involved in the beds.'"
>
> [Felwater field notes, week -1]

As part of this extract I noted that there was a hectic five-minute period for Cecelia as she continually fielded questions from the theatre, reception and management level. Cecelia was annoyed that so many people had become involved with the bed management, as it made the already blurred lines of communication even worse. This unstructured way of communicating again forced conflicting demands onto staff as Cecelia had to work in a manner that was uncomfortable for her. The extract above highlights that the effect of unstructured information transfer does not stop at the staff level because patients are also uninformed as a result. This situation at

times created frustration and anger among patients and made staff members apprehensive about updating them, whether they had information for the patients or not. The next section will focus on the delivery of change-related information and communications at Arunwick Hospital.

b) Arunwick Hospital - Delivering change-related information and communications

At Arunwick Hospital a more systematic approach was taken to information transfer. Generally staff were more involved in the process, the schedule of the communications was gradual and communications were considered to be transparent. These three mechanisms enabled staff to feel more informed, as such they were generally unperturbed about the transition and were therefore more comfortable about the changes. Although occasionally staff wanted more information, this was very much the exception rather than the rule.

Prior to the transition at Arunwick Hospital, the managerial team were active in passing on information about the move and thus a variety of accessible sources were made available. I noted that information was available in various different formats; for example, screen-savers were shown on computers asking, "Do you want to know more about the move? There are a number of ways staff can access information about the move …" [Arunwick field notes, week -4]. Other communications included leaflets entitled "Big Move", countdown screen-savers stated how many weeks were left until the move, and a large booklet about the move was available to staff. There was also a flipchart easel in the staffroom stating: "Any questions/queries write them below and we will try to answer them" [Arunwick field

notes, week -3]. Here staff had asked questions about both staff and patient matters. This multi-pronged approach meant that staff had a large quantity of information upon which they could build a more complete representation of what the transition would involve. The importance of such communication was highlighted by Annabelle (a staff nurse) who during a longer conversation spoke about the role of information in more detail:

> Annabelle talked about generally being "'unfazed'" by the move. Annabelle said that she did not think anyone was. I asked her what had happened for her to feel unfazed. She said it was because there had been so much information available about it. They had had compulsory visits. Annabelle added that she had been when it was just an empty shell, when the curtains had been put up and when the trolleys were put in. Annabelle said this removed the shock factor as you saw it from being a blank canvas onwards. Annabelle also said that there was always information on the internet, in magazines and journals. Annabelle also added that it felt like Ella (a senior sister) and others had given them information as and when they got it. {Staff have not been shut out. Information has been key and is definitely seen as a positive thing. There is no sense of 'ignorance is bliss' amongst the staff.}
>
> [Arunwick field notes, week -1]

As demonstrated by the above extract, the quantity of accessible information provided by higher levels of the organisation (for example, senior staff) contributed to

staff feeling unfazed. Annabelle's awareness of the amount of information available about the transition suggests that information transfer was successfully communicated to frontline staff. The timely nature in which the nurses had been updated by their senior sisters helped staff to feel that information had not been concealed from them. This approach appeared to have built a level of trust between management and frontline level staff, a transparency recognised by Annabelle. Various reasons why the information received from management had been instrumental in preventing the negative effects of change are described by Annabelle. The visits to the new ward had enabled staff to gain experience, adapt and become comfortable with the area. Having the visits organised by management in this gradual manner allowed staff to see the ward grow to completion rather than experiencing alarm that may have been associated with only being exposed to the finished product. Staff could therefore adjust to the new ward in a gradual and informed manner. This approach could prevent the new ward from seeming overwhelming to staff and reduce the impact of a 'reality shock' that may be experienced when individuals go through change (Kramer and Schmalenberg, 1977).

As well as visits to the ward prior to the transition, staff also completed a rotation of taster shifts on the new unit:

> While I was obtaining informed consent from Uma (a staff nurse), I told her to come and tell me if she felt that there was anything affecting her well-being. Off the back of this Uma mentioned that she had worked on the new unit before. She knows the procedures. She said that working

over there had really helped. She has done a few shifts on the new unit and been on a 6-week rotation with them (I think). {This experience does seem to have really helped get nurses comfortable with what is happening.}

<div align="center">[Arunwick field notes, week -4]</div>

Uma describes a thorough taster shift experience that helped her to feel more comfortable with the changes ahead. However, Katie (a staff nurse) had mentioned earlier in the week that despite acknowledging that this process had been useful it was now "not so much fear of the unknown as fear of the known" [Arunwick field notes, week -4]. Here, Katie explains that the rotation of shifts had achieved two outcomes: they had been beneficial to staff but they had also served to change the subject of staff concerns. By providing information about the new ward through taster shifts, staff expectations are primed for what lies ahead. However, for others the reality of the new workplace does not appear to fit what they feel comfortable with.

Interestingly, transferring information in this gradual, accessible and transparent way had not had an overtly positive effect on staff; rather, the approach left staff well-being unperturbed by the relocation. Similarly, at Felwater Hospital during a long conversation I asked Layla (an auxiliary nurse) whether she would feel okay about the relocation if she had received all the information she felt she required. Layla replied that instead of being worried she would just be concerned [Felwater field notes, week -2]. This response suggests that although information can be helpful in times of change it cannot act as a cure.

c) The content of change-related information and communication at both case study trusts

This chapter has, until now, focused on the process of delivering change-related information. However, the content of information is also an important component of a systematic approach. Content information was a dimension that some staff at both Felwater and Arunwick Hospitals were lacking in, specifically with regards to what is identified here as job-related technical information. This type of information refers to technical or practical knowledge relating to the new responsibilities within the new wards. A lack of such information had a negative effect on well-being and as such acted as a mechanism. Of course, the vast majority of relocated staff had many years' experience as health care professionals. However, the changes to the operational processes and types of patients they were caring for meant that new job-related technical information was required. The lack of such information will now be explored first at Felwater Hospital before moving on to Arunwick.

The perceived lack of job-related technical information placed conflicting demands on staff. This conflict occurred because, in some cases, staff did not have sufficient information to enable them to conduct their work in a manner they felt comfortable with. This situation could cause confusion and have a negative impact on staff well-being. The need for this information was most striking just after the transition when several aspects of the nurses' work had changed. Fear regarding these uncertainties was present before the relocation but became more obvious in the early stages after the wards had moved. At Felwater Hospital, despite tours of the ward (and some knowledge of the layout of the ward) and wider hospital, on the first day of the newly

opened Grantham Ward when staff were beginning to work with the new patient flow, the uncertainty regarding how the flow would work was clear:

> None of the ward staff seem to know where they are going right now. People are walking about trying to busy themselves with things but not really knowing what to do, it seems. {There is still quite a lot of preparation going on.}
>
> [Felwater field notes, week +1]

Staff were making themselves busy with no clear purpose or understanding of how the new ward should work. Some staff were excited yet before staff left the staffroom to begin their first shift others were very nervous:

> [Staff] in the staffroom drink their drinks and then go outside of the room. Baldeep (a staff nurse) is left in the room with Naveen (an auxiliary nurse) and me. Baldeep pours herself some squash and says, "I feel sick". {She is nervous.}
>
> [Felwater field notes, week +1]

Baldeep was suffering from nerves on that first morning as were many other members of staff. Both the ward sister and the rest of the staff group were trying to compose themselves by taking deep breaths and busying themselves. Staff were eager for the patients to enter the ward to enable the staff to begin rather than waiting apprehensively:

Layla (an auxiliary nurse) comments that she "needs a cage for these butterflies". Both Layla and Lily (the ward sister) just want the patients to start coming through now. Layla adds that she has never worked on short stay before and she is nervous because of this. {I forgot that not all staff have worked in this [day case] environment before. It is extra stressful for those for whom it was [totally] new.}

[Felwater field notes week +1]

At Arunwick Hospital (as mentioned earlier) the staff had received taster shifts which had helped some to feel comfortable (as in the example from Uma (a staff nurse) discussed earlier) when they started on the ward:

Faith (an auxiliary nurse) walks past me and I ask her how she is. She says she is fine but she keeps going in the wrong rooms for things. I ask her how she is finding it [referring to the new ward]. Faith says it's fine - I've worked on here before so... (indicating she knows what she is doing). Did that help? I ask. If she had not she says she would have been a fish out of water, following someone around. I can do my own things, she says. {She thinks it is amusing and does not mind that she keeps going in the wrong rooms. The previous shifts have given her control}.

[Arunwick field notes, week +1]

However a lack of job-related technical information was also present:

> Katie (a staff nurse) is standing awkwardly near the desk. She does not look as if she is sure what to do. Katie turns to me and says, "It's horrible when you don't know what to do ... I'm not even sure if I should be here". She goes on to tell me that her name was not down so perhaps she should have been in on the late. She jokes that she is going to hide in the bin. She does not want to leave and have to come back, I think. {Katie does not like being uncertain of what to do and where to go.}
>
> [Arunwick field notes, week +2]

The problem of being unsure of what to do differed in a number of ways between the two hospital trusts. First, at Arunwick Hospital the new ward into which staff had moved had already been operative for approximately the last four months. As a result, those nurses new to the ward could shadow the more established nurses and question them on elements they were uncertain about; at Felwater Hospital however, all staff were new to the ward. Secondly, as noted above, staff at Arunwick Hospital had completed a rotation of 'taster' shifts so had worked on the new ward (albeit for a short time) before they had taken up a permanent position there and hence knew more of what to expect. However, some staff were experiencing uncertainty because they lacked the information and experience they felt they needed to be sure and feel comfortable with the work they had to do. This imposed conflicting demands on staff and as a result had a negative effect on their well-being.

In addition, however, at Arunwick some staff (despite the taster shifts) also felt uninformed about aspects of nursing work on the new ward. These staff had little or no experience in, for example, caring for patients who had had particular operations, such as hand operations, and this lack of experience became a focus of concern for staff:

> I look at Isobel (a staff nurse) and she lets out a whine which means help me. She says that it is "the Ear Nose and Throat stuff and the hands" meaning that are concerning her.
>
> [Arunwick field notes, week +1]

This concern about new procedures continued at Arunwick Hospital when new specialty patients joined the ward:

> The phone is ringing on the new specialty station. Laura (a staff nurse) is doing paperwork, not answering the phone. A few moments later Laura seems to realise that she has to answer it. It is not going away and there is no one else around. She answers it and says "DCSSU, staff nurse… Ok…. Yeah, she's gone… Yep… (patient name)… Yeah, she is. She's here… (laughs) Yep… (patient name) Let me just check… Bear with me… Just taking one off… He's definitely still on it, just completed… his bed rest". Laura then tells the person on the other end of the phone the patient number and the bed number he/she is in. Laura then looks in the notes trolley and then goes into [a patient] bay having placed the phone on the desk. A couple of moments later Laura

comes back to the phone and says, "Hello. He's had [a procedure]",

(Laura lets out a small laugh), says "Bye" and then hangs up the

phone. She walks away from the phone and lets out a [long

exasperated and] frustrated sigh. Laura then turns to me and says

"[new specialty] – it's just completely alien"… 'and they're 'yeah just go

on here'' (she does an impression of someone in a silly voice being

blasé about going on the new specialty section).

[Arunwick field notes, week +12]

Laura was finding the new specialty difficult because it was foreign to her and this

set of circumstances frustrated her. She did not appear to feel comfortable managing

the care of patients in this area. Laura's cuttingly ironic impression served to

emphasise that it was not understood (possibly by management) how problematic it

was working with patients when she felt uncertain about what to do. This lack of

knowledge places conflicting demands on Laura because she is required to work in a

specialty about which she feels ill-informed and, as a result, she feels uncomfortable

with this requirement. Additionally, there was a sense among staff that the new

specialty patients were involved a higher risk, and perhaps because of this may have

placed a greater responsibility on nurses.

Concerns relating to staff feeling uninformed about new patient procedures were

initially confined to Arunwick Hospital, as staff there dealt with a wider range of new

procedures. Yet Felwater Hospital staff also suffered concern relating to a lack of

information about procedures when the possibility of the Grantham/Hughes Ward

merger (discussed above) arose:

Naveen (an auxiliary nurse) says he is worried about the prospect of the [new specialty] patients coming here as people are not trained. I asked Naveen whether he thought they would get training and he said no.

[Felwater field notes, week +5]

During this informal conversation Naveen clearly states his concern regarding the levels of information staff had received and considers them insufficiently trained to deal with new types of specialty patients. Again a tension exists between the levels of information staff feel are adequate to conduct their work and the levels of information they have received. The new specialty patients at Felwater were complex: they needed longer in hospital to recover from their operations and required a specific care regime. Staff at Arunwick Hospital held a similar opinion regarding their new specialty patients. These patients were a different type of patient from the normal 'low risk' procedures that most commonly came through the DCSSUs, highlighting the importance of having specific technical knowledge of their care.

CONCLUSION

This chapter has explored the different contextual backdrops of the case study sites and the different mechanisms in relation to information and communications during the transition. Exploration of the context at Felwater Hospital suggests that there was a general lack of information and communication on the ward. Communication did not appear to be a priority or that resources that could have provided information in a

more organised manner were diverted elsewhere. This context appeared to facilitate the lack of a systematic approach to communications at Felwater which in turn led to reduced levels of well-being. At Arunwick Hospital, communication appeared to be a means by which staff could demonstrate their professionalism, in that, communicating in a thorough manner seemed to be important to staff. This context seemed to facilitate the presence of a systematic approach to communications on the unit and as a result staff well-being was better maintained. The presence of job-related technical information as a mechanism at both trusts suggests that a period of instability of some kind following a transition may be difficult to avoid despite the levels of information available. The chapter that follows will explore the nature of the transition and how this affected staff well-being.

CHAPTER SIX

THE NATURE OF THE TRANSITION

INTRODUCTION

Findings from this research show that the nature of an organisational change affects the ways in which the change is experienced by staff. The nature of a change refers to the characteristics of the transition, that is what the main features of the change are and what it involves. As is explained in Chapter Four, the present transition was based on the relocation to new facilities and the new types of work activities that would be carried out in these new spaces. There are four key areas in which the nature of the transition affected staff well-being. These were regarding the presence of 'incorrect' patients, restrictive work spaces, disconnected work spaces and the fast-paced nature of work. These four mechanisms (explored in Part Two) caused conflicts amongst staff as they were required to work in spaces and carry out work activities that were incompatible with their underlying value set.

Part One of this chapter will explore some of the professional values observed at the hospital trusts. This section will provide contextual information to the reader regarding the norms and customary practices that existed at the two hospitals in relation to staff values. For the purposes of this project staff values are considered, as Maben et al. (2007) have argued, to be 'core values held by members of the nursing profession. They are not 'ideals' in the sense that they are unachievable' (p. 99) or a type of visionary speculation. As will be explored below the values displayed

by staff are based on a strong work ethic and commitment to patient-focused care. The chapter will close with a conclusion that will consider the ways in which the contexts of the two hospitals constrained or enabled the presence of the mechanisms.

PART ONE: CONTEXTUAL DETAILS

STAFF VALUES AT THE CASE STUDY SITES

The manner in which staff went about their work reflected a collection of ideals that guided their behaviour. This often implicit value set underpinned their approach to work, laying out both what was considered comfortable and appropriate, and the expectations staff had of others and themselves. The key features of these ideals, present at both hospital trusts, included a strong work ethic and a patient-centred approach to care. It is important to note that these values can be interlinked as, for example, a keen work ethic feeds into the care staff provide.

The nurses at both hospital trusts had a robust work ethic, in that they worked hard to contribute to the workload and complete tasks. This approach to their work was displayed in a number of different ways: for example, when staff found they had come to the end of a set of tasks they regularly sought information from their colleagues regarding whether anything was outstanding. Also, when staff were idle or missed something there was a sense of guilt or surprise. The extracts below provide some examples of this work ethic:

> Sharda (an auxiliary nurse) was sitting behind the front desk. She
> noticed that the patient in the side room had been discharged and said,

"Oh God. Better get that bed changed." {Sharda is shocked she did not notice the bed needed doing and jumps to do it.}

<div align="center">[Felwater field notes, week -5]</div>

During an informal interview with Kavita (an auxiliary nurse), I ask her how it is going in O'Brien Ward (a ward adjacent to the new Grantham Ward), as she has been working there as a runner, taking the patients to and from O'Brien Ward and into [the DCSSU]. I ask her this particularly as it is such an unpopular role. Kavita said that she felt guilty that she was not doing very much. Kavita added that she spent two hours on Friday doing nothing just sitting in [one of the sections of the ward] by herself. Kavita said it was like a ghost town as no one was around.

<div align="center">[Felwater field notes, week +2]</div>

Katie (a staff nurse) asks, "Are you all right, Faith?" "Yeah," says Faith (an auxiliary nurse). "Have you had your little break?" Faith replies, "I'll wait till this is done." {Staff are keen for tasks to be finished before leaving for breaks – she is conscientious.}

<div align="center">[Arunwick field notes, week -4]</div>

During a longer informal conversation with Isobel (a staff nurse), she says that the ward is not normally like this. [She said to me], "You must think that we don't do anything." {It was exceptionally quiet}. Katie (a staff nurse) adds that it may be quiet because it is half term.

[Arunwick field notes, week -4]

Annabelle (a staff nurse) comes over to the station and asks the nurses who are sitting behind it whether there is any paperwork they would like her to do. {It seems that she does not have anything to do now she has got the refreshments, she does not want to appear lazy, which is a cultural matter, as no one ever wants to appear lazy here.}

[Arunwick field notes, week +7]

The above extracts indicate that staff at both hospital trusts were a keen and hard-working group. Behaviours such as guilt reactions and the need to cajole other staff into having breaks gave the impression that laziness or cutting corners would not have been tolerated or would produce negative reactions from other members of the group.

Although the ward teams at both trusts worked hard there were limits to what they felt was acceptable in terms of demand. If staff felt they were under too much pressure they could become distressed. However, as the examples that follow demonstrate, staff also disliked overly quiet periods; a steady pace was preferred:

Kavita (an auxiliary nurse) spoke about not liking the quietness on the ward. She talked about her previous jobs in retail management and in a call centre – she talked about thinking that clock-watching was bad.

[Felwater field notes, week -6]

Lily (the ward sister) turns and says to me, "You know what I don't like about this is there is a lull and then everything comes together." {The ward is quiet and then hectic. There is a preference for a steady pace.}

[Felwater field notes, week +3]

Layla (an auxiliary nurse) advised me that she thinks 'lates' are a better shift because they are a busier shift as patients tend to come back from theatre at this time.

[Felwater field notes, week -7]

A group of staff are sitting round the table discussing what it is like out there (in the ward). They seem to think it is going along at a steady pace and that this is good. Katie (a staff nurse) says, "Ticking along, that's what we like. No frenzy." Isobel (a staff nurse) seems to agree with this. {They all like an even steady pace.}

[Arunwick field notes, week +8]

> Annabelle (a staff nurse) says aloud that it is "better when patients are admitted [first rather] than sent for straight away". She adds that this (being sent for immediately) "creates more of a panic".
>
> [Arunwick field notes, week +7]

An even pace was preferred because it enabled staff to work in a manner that was not so busy that they felt they were rushing (and possibly were worried that mistakes could be made) and not so slow they became bored. This issue of pace interlinks with ideals around patient-centred care as staff recognise that too frantic a pace is an unsuitable environment for treating patients.

Approaching work in a patient-centred manner is an overriding (yet again often implicit) feature of daily life on the wards. Nurses displayed the patient-centredness of their care in a number of different ways, from putting their own interests last to being pleased when they had solved a patient's problem:

> Cecelia (nurse in charge) is about to leave the ward to get ready for her job interview but she is 'unsure about what to do with the last man' (i.e. the last male patient who is without a bed). Cecelia says, "We have still got one man to get in." {Her concern over getting people in beds is apparent, even over her own issues of her pending job interview. She does not want to leave until it is resolved, cutting into her interview preparation time.}
>
> [Felwater field notes, week -5]

Layla (an auxiliary nurse) is talking to the patients on bay 1 still. {Maybe it is more important to her to be out on the wards with patients. I have noticed this before.} [A little while later I noted that] Layla seems to spend most of her time in Bay 1.

[Felwater field notes, week -5]

Alison (a staff nurse) says that she is wearing her black watch today because she is in mourning. This seems to jog Lily's (a staff nurse) memory as she says to me that yesterday was a sad day because a patient who had been on the ward for approximately seven weeks had died. {Death does affect the staff.}

[Felwater field notes, week -1]

Isobel (a staff nurse) comes off the phone and goes to speak to a patient. As she does so Faith says there is a phone call for her and Isobel goes to take the call. Isobel says down the phone, "That's absolutely brilliant. Thank you." (She is very happy now.) It seems that Isobel has sorted something out for the patient. {She is extremely pleased when it is sorted out.}

[Arunwick field notes, week -4]

Kate (a sister) says that she does not want to move a patient twice. {This may happen if the patient does not go home tomorrow as the ward will close and they will need to find somewhere else.}

[Arunwick field notes, week -2]

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This range of examples shows the numerous ways in which staff engage with patient-centred care. Staff put the patient first, are sympathetic to patient needs, work to spend time with them and are respectful. Staff are generous, open and welcoming to patients. Caring for patients in this way was also a source of pride for staff. For example, at Felwater Hospital, Lily (the nurse in charge) once showed me a patient experience form with a positive review of their care on it [Felwater field notes, week -1]. This was an important acknowledgement for the nurse and one of the few times I witnessed real pride in a member of staff at Felwater Hospital.

By observing these patterns of behaviour on the wards at both hospitals I could see that staff values were underpinned by a solid work ethic that enabled the teams to contribute meaningfully and deliver what needed doing. But also the manner in which they did this was important, with patient-centred care at the heart of their work. However, elements of work spaces and work activities brought about by the transition, went against these values causing tensions between the ways in which staff wanted to work and the reality of their working lives. There were four key mechanisms relevant to work spaces and work activities: a) work activities: the effects of 'unsuitable' patients, b) work spaces: working in restrictive work spaces, c) work spaces: the disconnected ward and d) work activities: the fast-paced nature of work. Those mechanisms relevant to Felwater Hospital (section a) are discussed first followed by those relevant only at Arunwick (section b). The final two sections (c and d) discuss the mechanisms relevant to both trusts.

PART TWO: MECHANISMS REGARDING THE NATURE OF THE TRANSITION

a) Work activities: the effects of 'unsuitable' patients

The issue of 'unsuitable' patients is relevant in this exploration of the effects of transition on well-being as for some staff the relocation was viewed as a potential antidote to this problem: that the transition could initiate a fresh start that would somehow prevent the misuse from continuing to occur. In this way, the transition was viewed as a potential panacea.

Prior to the relocation the presence of 'unsuitable' patients was a significant cause of distress for staff. Patients' reason for admission can be in line with the specialty of the ward or, as was frequently the case at Felwater Hospital, considered to be 'unsuitable' or 'incorrect' for that particular unit. 'Incorrectly' housed patients were often present due to a high demand for beds from the wider hospital. The examples below show the type of upset associated with 'unsuitable' patients and as such what could be avoided if the practice was halted on the new ward:

> Alison (a staff nurse) was asked what [sort] ward this was. "Well," Alison replied making it sound up in the air as to what the ward was … Alison then went on to explain that it was a 47-hour short stay surgical ward. But that currently it is open at weekend and that the day case ward is open at night – which it should not be. This is a surgical ward with medical patients.
>
> [Felwater field notes, week -7]

A member of staff new to me came onto the ward wearing scrubs (Sharda – an auxiliary nurse). I advised her that I was conducting research into staff well-being during change. She advised me that bed management affected her well-being – that is the inpatients being housed on [Crawley ward]. She went on to say that the ward should open at 7am and close at 9pm but it does not.

[Felwater field notes, week -7]

Baldeep commented, "We have got the shittest ward." She laughs at this. {The laughter expresses not 'This is funny', more 'This is totally insane'.}

[Felwater field notes, week -4]

"That's just bloody mad, ain't it?" says Cecelia. She is referring to a patient who is in the ward who needs gynaecological care. {Patients are being housed in wards that are unsuitable for them.}

[Felwater field notes, week -4]

'Unsuitable' patients were so commonplace that the ward's identity had become uncertain. Interestingly, this misuse of space was not an enduring feature of ward life at Arunwick Hospital, occurring only on a small-scale fashion on the odd occasion. The presence of 'unsuitable' patients caused distress amongst staff in a number of different ways. The impact on demand and workload was a particular concern. Caring for 'unsuitable' patients placed pressure on staff to manage the official role of the ward as an DCSSU and the unofficial role as an overflow area. Distress could be

caused amongst staff because some 'unsuitable' patients were suffering from conditions that staff were unfamiliar with treating, or staff felt they did not have the right equipment on the ward to treat. Meeting the needs of these two different types of roles was additionally demanding because of the pressure staff were under to discharge patients in order to fit both planned and unplanned patients into the ward.

Furthermore, it was accepted practice that 'incorrect' patients were received by the DCSSU at Felwater Hospital without staff being able to challenge their admittance to the ward. In this way, the staff had little control over the case mix on the ward and, as a result, staff had little control over the spaces in which they worked and the activities they engaged with. Despite voicing their frustrations about this lack of control, staff persevered, suggesting a general surface acceptance in conflict with their voiced concerns.

However, staff were optimistic about the possibilities the transition presented. The relocation was considered by some staff as a means by which the problem of 'unsuitable' patients could be eradicated:

> Baldeep (a staff nurse) says, "Yesssss, only 5 weeks left." {I'm not completely sure if she is referring to when they move or whether she has a holiday. If it is the move it is the first bit of excitement I have heard about it from Carson Ward. [Looking forward through my field notes shows that Baldeep did not go on holiday.]}
>
> [Felwater field notes, week -4]

Here, the expectation that the transition may initiate a new beginning for staff acted as a source of hope. Although some staff were confident about the possibilities of the ward function changing to what it should be, others were cynical about the passing influence the transition would have.

> During a longer informal interview with Naveen (an auxiliary nurse) and Alison (a staff nurse), they tell me that last time they moved they got medical patients on the second week. They were left alone for the first week but Naveen said he came in on the Monday morning expecting to switch the lights on and put the kettle on but instead there were twelve inpatients on the ward. Alison added (in a fed up tone) that it is a matter of time before they fill us up.
>
> [Felwater field notes, week +1]

Despite these more pessimistic or cynical views, the way in which the ward operated on the new unit following the relocation did for a brief period follow the planned direction. That is, for a short time there were no 'unsuitable' patient transfers and the ward operated as an DCSSU. However, this reprieve was short-lived and before long the demands for beds resulted in the new DCSSU housing overflow patients. There was a considerable degree of upset among the staff group when they realised that the relocation had not provided a long-term solution:

> I went into the staffroom to have a drink and Kavita (an auxiliary nurse) was sitting in there taking a break. As I walked in I heard Kavita say, "It's ridiculous." I asked her 'What is?' and she said that they might put

beds in the trolley bay. I asked her what that meant for them as staff. Kavita said, "Mayhem … run us to the ground … sly if they are hiding beds … they are a sly bunch of arseholes … stabbed in the back … Hospitals are just a business … It's all mad." Kavita also mentions that it is not good for patients as they will not be getting the care they really need. {Kavita has a rant about this being a rumour. She is very worked up about the possibility of inpatients being added to their workload. She feels that the trust may be working in an underhand way. Kavita is commenting on the culture and thinks the hospital is working like a business [rather than an organisation that cares for patients].}

[Felwater field notes, week +4]

During a longer informal conversation with Baldeep (a staff nurse), I am standing around Zone L and Baldeep says to me, "Have you heard what they are doing?" I shake my head indicating that I have not. Baldeep adds they are "trying to put beds into the trolley area". {Baldeep is annoyed and seems frustrated and angry.}

[Felwater field notes, week +4]

Lily (the ward sister) tells me that a male bed is needed. She says they are going to put "beds in the trolley area if they can find some. Alison took the message so it must have been okay-ed...". {Lily seems unhappy with this news.} Just after this, Alison came over to Zone L. Alison says that they do not have the staff to cover it. Approximately an hour and a half later, Lily (the ward sister) walks past me and says,

"They've bought five beds up." {She sounds shocked, angry, let down.} Just after this, during an informal interview with Lily and Sharda, Lily says that they will move the beds into [one of the other rooms]. She says that they have ordered the beds and they are coming now.

[Felwater field notes, week +6]

These extracts (the final one of which was a combination of different extracts over that day) are examples of staff voicing their disappointment and fear over the projected arrival of 'unsuitable' patients. In this way, the relocation had not succeeded in protecting the unit from such patients. At this juncture staff were coming to terms with the fact that (possibly) the best opportunity to rid themselves of this problem had been thwarted by organisational factors beyond their control. By means of an interesting contrast, however, a work space that operates in the manner in which it is intended can maintain staff well-being. The pressures of conflicting demands then diminish and staff can work in spaces being used as they were intended:

Cecelia (a staff nurse) also mentioned whilst she was on her break (and I was writing up my notes) that the ward was going back to how it was originally intended to work. She explained [aloud] that inpatients were going to be in Zone M and N, and trolleys will be in the rest of the ward areas. She says she thinks this is a much easier way of running the ward as there is a lot of work on Zone N and L. {Cecelia seems pleased the ward is being changed to work in this way.}

[Felwater field notes, week +7]

The work space functioning as it should is more logical to Cecelia as it spreads the workload across the ward as well as enabling staff to accommodate patients in suitable single rooms rather than in bays intended for trolleys (this caused the initial outcry). The DCSSU operating as it should alleviates other pressures that come about as a result of misuse (such as increased demands on staff) and so can enable staff to work in a manner more closely aligned with their value set.

The presence of 'unsuitable' patients is a mechanism which drove effects on staff well-being during transition. The extracts explored above show how the transition can be seen as a cure-all for a key issue on the ward and the disappointment that ensues when this solution is not realised. The findings also show how the activities carried out within the workplace can cause tensions between how staff would like to work, in a patient-focused well-paced manner, and reality of their work. The chapter now moves on to consider how the nature of the transition affected staff well-being at Arunwick Hospital.

b) Work spaces: working in restrictive work spaces

A second example of the values held by staff being affected by the transition emerged within the context of work spaces. The change in work spaces was a salient feature of transition owing to the move from old hospital buildings to new purpose-built stock. The work space in the old unit at Arunwick Hospital (Darcy Ward) was large, roomy and there were fewer staff and patients than the space was designed for; this created a calm and quiet space. However, the new work space, although physically much larger, provided more confined spaces in which to work

(for a full description of the wards, both old and new, see Chapter Four). These confined areas created a tension among staff as they were required to work in a space that did not align with their patient-centred value set.

The comparatively cramped nature of one particular section of the new ward at Arunwick Hospital was considered incongruent with the work being conducted there. The tensions that staff experienced when working within this space were similar in origin to those experienced when staff at Felwater Hospital were dealing with 'unsuitable' patients. Such tensions centred on the additional demands that were placed on staff and the care provided not being considered optimal. The space, known as 'Zone C', was originally designed to accommodate patients in recliner chairs. Typical procedures cared for in such chairs, included infusion injections, which can treat disorders such as rheumatoid arthritis and osteoporosis. Zone C, although designed for recliner chairs, in fact housed patients on trolleys. Trolley units are intended for day-case patients (those not staying overnight) and are smaller than beds but much larger than recliners. Accommodating these larger models restricted the space in Zone C and as a result working in the area was unpopular with staff:

> During an informal interview with Annabelle (a staff nurse) she commented that she did not like Zone C because it was much too small. {Zone C is cramped.}
>
> > [Arunwick field notes, week +1]

> When Uma (a staff nurse) came past it reminded me that I had seen her earlier and she had said that she was on Zone C. Uma said this in

a tone that suggested working in Zone C was a bad thing, as if it was notorious. Staff do not like Zone C.

During a longer informal interview with Annabelle (a staff nurse) she said that "some people were flatly refusing to work there because they had to climb over chairs to get to patients". Annabelle said they (I do not know who they are) had taken some of the trolleys out now so it was better. Annabelle and I walk round to Zone C. {Annabelle did not like nursing in a small space. Refusal to work there must mean staff are very hostile to it. This is a strong reaction in a place that does not have many strong reactions. Fewer trolleys seems to have improved things.}

We walked round to Zone C. As we did so Katie (a staff nurse) said she is working on Zone C "cause I've been naughty". She mentioned that she had been told off but I was not sure whether she was joking or not. When we got to Zone C she said that it was a bit "tight on the ground", referring to how tightly packed-in the patients were. Her tone suggested that she did not think this was good. Katie said to me that she was working on Zone C about three times whilst we walked over there. This made it feel as if it were a problem.

I observed many occasions when staff voiced their unease regarding the capacity of Zone C to provide a reasonable standard of care for patients. Of particular concern to staff was whether dignity standards could be upheld in such a tight space. This situation provides a further example of the values held by staff being disrupted by the transition. The rejection of the space by some staff was a strong demonstration of the incompatibility of the area with what they felt were acceptable ways of carrying out their duties. Although it was said in jest, being rostered on to Zone C was viewed as a penalty by staff, a form of punishment for a perceived wrong that was corrected by a 'sentence' or shift there.

A further demonstration of the incompatible nature of the area came with the manipulation of the space to a more acceptable model of care:

> Katie (a staff nurse) is writing the patients' names on the whiteboard. There are seven patients expected to come in today. Katie has put the patients in alternate trolley spaces. {This is indicative of the lack of space on the ward.}
>
> [Arunwick field notes, week +6]

Alternating the trolley spaces as Katie did enables her to gain a greater sense of control over the space and to practice within it in a way that suited her. Organising the space in this manner also helped her to avoid the kind of clambering described by Annabelle above. This response is an example of staff adopting an active coping strategy to manage the tensions they experience in the workplace.

Working in the new restrictive space caused distress in staff owing to the challenging nature of carrying out their duties and due to the reduction in patient-centred care that could be offered in the area. As such, these restricted spaces acted as a mechanism that brought about negative effects on well-being. This finding was confined to Arunwick Hospital as there were no similar spaces at Felwater Hospital's DCSSU. The two sections that follow will explore those elements of work spaces and activities found to be relevant to staff well-being during the transition at both hospital trusts.

c) Work spaces: the disconnected ward

The disconnected nature of the new wards is a further mechanism that drove effects on staff well-being during the transition, this time at both case study trusts. As noted above, the relocation involved the move to new purpose-built facilities and as a result the staff at both Arunwick and Felwater Hospitals moved into new work spaces radically different from those they left behind. One of the central changes was a substantial increase in size. However, this increase served to disconnect the spaces in the ward, and hence the people inhabiting those spaces, from each other. As with the other mechanisms discussed so far these spaces caused distress because they separated staff from those they needed to support (patients and colleagues) and in addition the internal and external support systems staff relied on to work safely.

The disconnected ward can be created by a number of different design features within the physical ward space. Such separation can occur because of the distance between two areas or due to physical obstructions such as walls and doors. These

types of barriers were present at the new wards at both hospital trusts and created an uncomfortable detachment between staff, their patients and the wider hospital:

> During an informal interview with Uma (a staff nurse) I asked her how she was feeling about [working on the new ward]. Uma said that on the bedded zone (Zone A) she does not like it that you cannot see your patients. Uma takes me to the nurses' station to show me what she means. {Uma is not too bothered [about the new place of work] as she has worked here before. She does not like the fact that you cannot see your patients in the bedded zone.}
>
>> [Arunwick field notes, week +1]

> During an informal interview... Faith (an auxiliary nurse) was agreeing with a comment that expressed dislike for the fact that the nurses' station was positioned in such a way that you could not see any of the patients. Faith added that she thinks it is dangerous [I think referring to not being able to see patients].
>
>> [Arunwick field notes, week +6]

> The staff are talking about being concerned about patients having to walk to Patmore Theatres (a group of theatres within the hospital) from here. {There was genuine concern for the patients' feelings and safety.}
>
>> [Felwater field notes, week +2]

During an informal interview with Cecelia (a staff nurse) she speaks about the merger with the Hughes Ward and says there are "complicated operations … big ops for elderly people … this ward is furthest from anywhere … still haven't got an ECG machine (see glossary)… running about for equipment all the time, it seems to me." {The ward is considered to be badly positioned for big operations and does not have the equipment.}

[Felwater field notes, week +6]

Two central issues are highlighted by the examples above. First, that physical obstructions prevented staff from completing quick visual checks on patients, a common method of care when staff are occupied with other tasks or monitoring several patients at a time. The line of sight that Faith speaks about enables a professional to act quickly if a patient became particularly ill or needed assistance due to an incident. At Arunwick Hospital this problem was compounded as the area (Zone A) in which there were the most physical obstructions was also the inpatient area where the sickest patients were housed.

Secondly, the distance of the ward between some of the theatres was of particular concern for staff who felt that it was too far for patients in a pre-operation state (i.e. in their gown) to travel. The ward was considered to be badly positioned for the so-called 'big operations' coming to the ward after the merger with Hughes Ward (discussed in more detail in the previous chapter). The distance of the ward meant that if extra support was required it was further than staff would like it to be. It was also felt by staff that the ward did not have the right equipment to cover these big

operations, meaning being close to other parts of the hospital that were better equipped was important. Staff felt that a substandard level of care may be delivered in these disconnected ward spaces. Thus, the changes brought about by the relocation had caused distress amongst staff as it was necessary for staff to work in an area that was incongruent with their patient-centred values.

The separation from internal support structures brought about by the relocation was felt most heavily by the administrative members of the ward staff. In the newly designed wards administrative staff were in outlying areas rather than close to the main activity and the other members of the ward team:

> During an informal conversation with Fiona (a ward administrator) [about the new ward], she told me that she did not like being "so out of it out there". She says that she is used to seeing and chatting to the nurses. Fiona went on to say that she did not know what is going on in the ward when you are out there. {The administration/reception area is quite isolated from the ward. In the previous ward it was right in the middle so the administrators were in the thick of it. She misses the social interaction with the nurses and does not get to see what is happening; there is less communication.}
>
> [Arunwick field notes, week +2]

> Grace (a ward administrator) says that Daphne (another ward administrator) is not happy about where she is [located on the ward] but she adds that she (Grace) is not moving and that she likes it where

she is. Grace comes off the phone saying, "Daphne doesn't sound very happy at all." {I'm not sure what Daphne does not like about the front desk but she does not like it. The few times she has come on to the ward she had looked sad. Daphne has had to change the direction she sends the patients (i.e. not directly into the ward) so she is likely to be having little contact with the staff. For example, people like Cecelia, whom she is used to.}

[Felwater field notes, week +1]

During an informal interview with Daphne (a ward administrator) she says, "I don't feel part of the team at all." I ask her why (i.e. location or people). She says it is because she is so far out. She says that she does not even use their kitchen because it's too far, she uses a kitchen up this end. She adds to this that it "doesn't matter … you just get on with the job". {It does not sound like Daphne means this (i.e. the it 'doesn't matter' bit). She feels isolated in her current location.}

[Felwater field notes, week +4]

The physical separation of some administration staff from the unit created feelings of isolation among them at both hospital sites. Although a sense of isolation was felt with other areas of the new wards it appeared to be felt most severely amongst the administration staff. This distance affected various aspects of their work. Administrative staff no longer felt part of the team and saw themselves as cut off from the rest of the staff and activities on the ward. This meant that administration staff were often not as up to date regarding the 'goings-on', dramas, issues, gossip

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and concerns of the day as they might have been. Their positioning also placed them in much more of a process-based role as they dealt with ensuring the administrative tasks were completed on the ward but no longer dealt so closely with the more human side. Their location reduced some of the more prolonged contact with patients, ward staff and staff from other areas, such as consultants or theatre nurses. This demonstrates the interlinked nature of work spaces and activities as here the space affects the activity. Both work spaces and work activities can create conflicts between what staff feel comfortable with and the reality of their work.

Interestingly, however, the disconnection created by some of the spaces on the new ward acted as an avoidance coping mechanism at Arunwick Hospital when staff were reluctant to engage with new aspects of their work:

> During an informal interview with Laura (a staff nurse) I said that there are fresh changes coming in such as the new specialty patients. Laura said that she was happy that she is not down there and that the specialty is in that location (in one area at one end of the ward). Laura went on to say that they are just a day case here. She then makes a walking gesture to suggest that they trot/march along. She says that they do not deal with anything too serious. We do not do people who are the "brink" she says.
>
> [Arunwick field notes, week +7]

Laura felt happier that the more seriously ill patients (specialty patients) were far away from where she was working. The distance and separation afforded by the

organisation of the space on the ward enabled her to feel protected from the levels of responsibility these patients are associated with. In this way, the disconnection of the spaces acts as a shield against any difficulties that may occur at that end of the ward.

Disconnected ward spaces had a negative effect on staff well-being. To avoid these negative effects, ward spaces need to be organised to meet the requirements of patient dignity and the practicalities of care. Such spaces should allow staff to work in proximity to their patients, wider support structures and other staff.

d) Work activities: the fast-paced nature of work

A further mechanism that emerged at both hospital trusts centred on the fast-paced nature of work following the transition. The new facilities were purpose-built for day case and short stay patients; for example, the new wards were in close proximity to (most) theatres and had both trolley and bed bays to house day case and short stay patients respectively. The units were also built on the concept of 'patient flow' where the patient's time on the ward was spent moving on to different dedicated sections of the unit, much like a journey, as they progressed through their treatment.

These purpose-built facilities affected work activities as the new units could house many more patients than the old ones, and coupled with a focus on patient flow often produced busier, faster-paced working. This fast-paced working could place greater demand on staff and at times this was felt by staff to be linked to the quality of care they were providing. Demand on the ward was exacerbated by the co-ordination

between theatres and the ward and (particularly at Felwater Hospital) was owing to staffing levels:

>A little later Cecelia (a staff nurse) says, "Unless you get more staff it's gonna be dire down here, really." People all want to get up and go, Cecelia explains. {Staff are needed to get through the protocols that are in place before the patients can go and more can come on. This section [of the ward] has the potential to get very backed-up. Patients can go through Zone N faster than they can go through Zone L (where they are discharged from).}
>
>[Felwater field notes, week +1]

>During an informal conversation with Lily (the ward sister) and Baldeep (a staff nurse), Baldeep says it will "spread staff thinly … they will need more trained". {She thinks they will get busier without extra staff being brought in.}
>
>[Felwater field notes, week +4]

Levels of co-ordination between the units and the theatres were a further reason for the increase in demand. That is, as each DCSSU served several working theatres at any one time; if a number of patients came back from theatres simultaneously, demand on staff would greatly increase. Such pressures forced staff to work quickly rather than at the more steady pace staff preferred:

We go into a consultation room. Whilst we wait for a handover nurse to turn up I ask how yesterday was because I was not in. Isobel (a staff nurse) and Uma (a staff nurse) make noises as if to suggest it was busy. Isobel says, "All come back at once and all want discharge at once, just a nightmare."

[Arunwick field notes, week +5]

Annabelle (a staff nurse) is at the nurses' station talking about the patients coming back from theatre. Annabelle says that it is okay as long as they can get the obs (see glossary) in sync. If not, "by the time you write down two it's time to start again".

[Arunwick field notes, week +10]

Baldeep (a staff nurse) puts her head in her hands as another patient comes in from theatres. Naveen (an auxiliary nurse) says they have run out of space in Zone L. {The system is starting to get blocked up and the stress is showing in Baldeep, she is shaking her head and has her head in her hands. There is a different kind of pressure on this unit.}

[Felwater field notes, week +1]

Here, the fast-paced nature of work that resulted from the simultaneous arrival of many patients on the ward was a source of frustration and stress for staff. This fast-paced work had come about as a result of the transition. The demand created a tension between the fast-paced nature of work and the notion of what nurses

considered to be high quality patient care. This pace often requires nurses to, in their view, push patients through the system too quickly:

> Kate (a sister) says to Annabelle (a staff nurse): "I know that's really awful, Annabelle, sorry honey ... I'm just …" {Kate is having to push patients out and by her tone does not like doing it despite asking Annabelle to.}
>
> [Arunwick field notes, week +5]

> Kate (a senior sister) comes in, sits down and sighs. "Patient care eh, what patient care? I just think it's so wrong to be kicking patients out ... it's just, you know." {Kate is not happy about hurrying patients out }. [A little later she says] "I think I would feel really vulnerable to be honest." Kate is talking about being a patient on the ward.
>
> [Arunwick field notes, week +5]

> "I think they bring them round too quick … need to give 'em a chance to breathe". Lily (the ward sister) makes this comment when Layla says a patient is being sick in one of the receiving bays. {Lily was commenting on the levels of patient care.}
>
> [Felwater field notes, week +3]

> A few more patients come through and Baldeep (a staff nurse) comments that they (theatres) are in a rush to bring patients back, she has an [angry] tone when she says this. {Baldeep does not like the

practice of rushing patients back to the ward quickly after their operation.}

<div align="center">[Felwater field notes, week +9]</div>

During an informal interview Cecelia commented that minor procedures carried out on the ward can be diagnostic tests for more serious problems. This situation is something staff can forget. Staff send patients off advising them to come back in two weeks. These are likely to be the worst two weeks of the patient's life and for everyone around them. She does not like this.

<div align="center">[Felwater field notes, week +3]</div>

Staff need to perform their duties efficiently but at times they do not feel such haste results in the best level of care. Staff feel that insufficient time has been spent with their patients or that the patient's period of recuperation has been inadequate. As Cecelia explains in detail, some of the procedures carried out on the ward are not just simple straightforward procedures. In fact, some are diagnostic tests that may change a patient's life both dramatically and permanently. In this way, the pace of care does not always reflect the severity of the reason for the patient's admission.

CONCLUSION

The nature of the transition itself plays an important role in determining how staff well-being is affected. At Felwater Hospital it was hoped that the transition would prevent 'unsuitable' patients from being admitted to the ward. This expectation did not come to fruition and was a cause of distress among staff. This mechanism

appeared to be enabled by the fact that frontline staff seemed to have little control over the sorts of patients housed in the wards and the presence of a near-constant pressure for bed spaces. Staff at Arunwick Hospital relocated from a spacious facilitatory work space to one that was (in places) cramped and obstructive. At both hospitals the organisation of the new spaces created distance between the ward staff and many of their support structures. Both of these space-related mechanisms were enabled by the problematic physical layouts of the new wards. The new fast-paced working (that came about as part of the transition) was felt at times to be incompatible with high quality patient care. At both trusts this activity-based mechanism appeared to be facilitated by the 'patient flow', that is how the patients moved around the ward and theatres. In addition, there was the need to keep the flow and the management of patients functioning in an efficient manner to meet the needs of the busy DCSSUs.

Importantly, however, much of the distress experienced by staff appeared to be brought about by conflicts or tensions experienced on the ward. Such tensions arose because working with 'unsuitable' patients, in disconnected or restrictive spaces, or indeed in a fast-paced fashion was incongruent with the patient-centred values of staff. In order to reduce the impact on staff, the nature of a transition programme (i.e. what it involves) should work in a way that complements staff values. The chapter that follows will explore the impact of the transition on social structures.

CHAPTER SEVEN

THE IMPACT OF THE TRANSITION ON SOCIAL STRUCTURES

INTRODUCTION

The transition process affected social structures on the wards at both case study trusts. The social structures on the ward refer to the social customs and practices on the ward. Such structures can 'help to condition and structure the norms and values guiding behaviour' (Aveling et al., 2012a, Swedburg, 2003). The social structures were disrupted in two main ways during the relocation, by the reduction in support experienced and owing to changes in the team dynamics. It was these two elements that acted as mechanisms and drove effects on staff well-being during the transition.

Levels of support are particularly important during periods of change. This is because support from colleagues is often not only in greater demand (to push changes forward) but also, due to the pressures placed on resources during periods of change, less available. Team dynamics also play a key role in staff well-being outcomes during transition. At both hospitals the relocation of the ward caused the membership of teams to change as both groups moved to form larger teams of staff. As a result, the team dynamic with which staff were familiar was disrupted. However, as is explored below, staff then embark upon a journey of adaption to their new group.

In this chapter I will first explore the social practices at the case study sites to illustrate what was customary on the case study wards. This description serves as a backdrop for the mechanisms explored in Part Two. The conclusion will consider how the contextual details at each trust constrained and/or facilitated the presence of the mechanisms.

PART ONE: CONTEXTUAL DETAILS

SOCIAL PRACTICES AT THE CASE STUDY SITES

The social relationships between staff at both hospital trusts were interdependent in nature. The two groups relied heavily on the support structures provided as part of being a close-knit team. The ward teams worked together in some way to complete most tasks. As with work tasks, more social or personal activities such as lunch breaks were also frequently conducted together.

The social atmosphere was mostly characterised by respectful, friendly and caring relationships among the staff, demonstrated by the ways staff responded to and dealt with each other. To illustrate this atmosphere I will now explore two features of staff relationships, team bonds and support, starting with Felwater Hospital.

At Felwater Hospital many of the staff had worked with each other for several years, and had formed close bonds as a result. The close nature of relationships was shown by the way members of staff greeted each other on the ward. Greetings show those initial moments of an interaction between staff and hint at the sincerity of feelings of those involved. Indeed, staff were often greeted with hugs and warm welcomes. By contrast, when doctors came onto the ward the reaction was variable;

sometimes reactions were friendly and sometimes they were not. A further sign of the strong relationships among staff at Felwater Hospital came from the nicknames the group had for each other. These nicknames were jovial in nature and were both meant and taken well by staff:

> The staff are using nicknames for each other which are written up on the board. Layla (an auxiliary nurse) is referred to as "crazy lady" by Lily (the nurse in charge). Both Baldeep (a staff nurse) and Layla refer to Lily as "[Auntie]". {There is humour/banter on the ward.}
>
> [Felwater field notes, week -2]

This type of banter was considered an important part of ward life. The ward staff referring to the nurse in charge as "[Auntie]" was a mark of respect and gave the impression that she was viewed by the group as the head of the ward 'family'. This family characterisation made the group feel like a caring team of colleagues. The sense of family-style bonds was reflected in the way staff went about their evening meals:

> I am advised that most evenings the staff on shift in Carson Ward sit down and have dinner together. I commented that it was really nice that they did this. Lily (nurse in charge) said we do it because "otherwise we don't spend any time together".
>
> [Felwater field notes, week -5]

These dinners were something staff took a lot of care over, with either one person taking the responsibility for putting it together or each person bringing in some food, often resulting in an impressive meal. The sense of family was also highlighted in the loyalty staff displayed towards each other, such as making sure staff with long-standing relationships with the ward had access to bank shifts (see glossary) when they were required. In addition, the friendly nature of the ward made it feel as if the people were a major part of why everyone was there and why they came to work; for example, when staff were facing difficult, nervous or challenging circumstances their colleagues rallied to support them:

> Daphne (a ward administrator) says to Cecelia (the nurse in charge) that she is locking up and wishes her good luck. Cecelia replies that she is trying not to let her nerves get the better of her and that she just had another 30 minutes to get through, referring to the time left of her shift. Daphne leaves the ward and as she is leaving says good luck.
>
> [Felwater field notes, week -5]

Of course, at times relationships could become strained. However, this was very much the exception rather than the rule. In general, social interactions suggested warm, friendly, inclusive and supportive relationships among staff at Felwater Hospital.

At Arunwick Hospital (as at Felwater Hospital) the strength of social relationships were also reflected in the ways in which people greeted each other. Staff were friendly, hugging and kissing each other to say hello and goodbye:

Katie (a staff nurse) is leaving and kisses Isobel (a staff nurse) goodbye. {There are positive, friendly and caring relationships between staff.}

The manner in which staff dealt with and responded to each other was warm and made for a welcoming atmosphere on the ward. Staff seemed to care for each other; they were a small group and were mutually supportive. Indeed, staff were polite and fair when talking about or doing different work tasks, wanting to support each other to make sure that they had adequate breaks and assistance, and that the workload was being shared out fairly:

Faye (a ward administrator) is sitting at her desk and Katie (a staff nurse) and Elsa (a staff nurse) have come to her with different queries. Elsa has asked her to check if there is a patient on the system as a relative is on the phone. Faye seems to be dealing with Katie's query first as Katie says "Can I leave it with you? I don't want to leave you in it." Faye says that it is fine. Faye is just about to move away when Elsa asks Faye, in a very friendly tone, to check whether a patient is on the system again. Faye apologised saying she forgot Elsa had asked. Elsa explains that the person on the phone has dropped the patient off but they do not seem to be on the DCSSU system. Faye locates the patient as an ENT [Ear, Nose and Throat] patient. Elsa goes to tell the patient's relative on the phone. {Faye seems happy to help. They have

good working relationships. Faye often fields queries but is regretful if she forgets.}

Staff also demonstrated their support for their colleagues by behaving in a conscientious manner. Staff made sure they were helpful and respectful of each other's workloads, seemingly not wanting to burden other staff or appear lazy.

Other social aspects of ward life that were similar between the trusts were the presence of banter or humour. Although the humour on the Arunwick Hospital ward lacked the slightly naughtier edge of the jokes at Felwater Hospital, staff still shared humorous moments:

Rosa (a staff nurse) is delivering her part of the handover to the group. One of the patients she hands over is allergic to bee stings (there is a titter of laughter amongst the staff at this point). {I think they are laughing at the non-medical allergy that was provided by the patient i.e. bees.}

In sum, the ward at Arunwick Hospital seemed to be a ward that almost prided itself on the way its members treated each other. This atmosphere made it very hard to imagine that members of staff could or would ever be rude to each other, that being short with one another was considered totally unacceptable rather than something that would be overlooked. These were friendly, close, helpful, collegial and

supportive social relationships. Following this brief scene setting piece I will now move on to explore the different social mechanisms that brought about effects on staff well-being during the transition.

PART TWO: MECHANISMS REGARDING THE IMPACT OF THE TRANSITION ON SOCIAL STRUCTURES

In this second part of the chapter I will consider two key mechanisms (at each trust) that were relevant to social structures during the transition: a) Support structures at Felwater Hospital, b) Team dynamics at Felwater Hospital, c) Support structures at Arunwick Hospital and d) Team dynamics at Arunwick Hospital.

a) Support structures at Felwater Hospital

In the DCSSUs, I observed that patient care had to be based on teamwork to enable tasks to be completed within the tight timescales nurses were working to. In this respect support was a critical aspect of the way nursing work was accomplished. The transition, however, provided circumstances in which the support structures were disrupted. At Felwater Hospital this disruption occurred within both internal and external support structures.

External support comes from a more senior level or from the wider hospital and was required to release staff from their normal ward duties so that they may focus on the relocation:

> [Today is the day before the relocation.] I went into the report room on Crawley Ward and said hello to the staff who were in there waiting for

the morning handover/meeting to begin. Cecelia (the nurse in charge) came in a moment or so later and said that she was expecting not to have to do report today but because the ward was full [of patients] they were having to have it. Cecelia added that they should be packing up today [ready for the move]. As there was no surgical list today, the group spoke about the bed situation. It was commented on that as soon as the beds are cleared the beds will be filled with other patients. Daphne (a ward administrator) commented that they will be taking the patients with them; she added that there was no other option if the system is full. Cecelia said {what felt like the general plan for the day}, that we will "try our hardest … get reviewed early … and then see how it goes". {They expected to be packing up today but they have approximately fourteen inpatients. The group seem to have no faith in the beds remaining empty. There is a sense that other parts of the system are letting them down.}

[Felwater field notes, week -1]

This extract highlights two important elements of the expectations of staff regarding support structures. Firstly, for ward staff external support is an important part of the transition process. In this case they – particularly the nurse in charge – had anticipated that the ward would be relieved of normal patient care duties on the day before the move. The purpose of this day was to enable the staff to pack up the ward safely and to avoid the possibility of equipment being moved or stored that was required for any remaining patients. However, although the normal surgical list (see glossary) was not running, the ward had fourteen inpatients. Thus, there was a

sense the ward had been let down or had not been protected from these transfers by external support at more senior level. Secondly, the lack of faith evinced in this extract highlights the repeated disappointments that occur on the ward and that staff can become 'hardened', a form of coping mechanism when such disappointments regularly arise. Importantly however, the lack of faith shown by staff and the disappointment displayed contradict each other. This discrepancy suggests that previous experience of disappointment has produced scepticism among them yet, despite this, they retain the belief that they should be supported.

In addition to the role of external support, internal support structures – that is the support from within the team – were important for maintaining a state of congruence on the ward during the transition. However, in some cases, internal support was lacking and resulted in tensions on the ward. The extract below describes the development of such a situation throughout the course of a day:

> First thing on the first day of being on the new Grantham Ward there is a mixture of feelings. Staff are nervous about patients coming through, excited and also wishing them through the system so they can get on with the job in hand. Some time after 8.30am the information filtered through to the ward staff that Kavita (an auxiliary nurse) had called in sick. Grace (the ward administrator) says, "I can't believe that." {I observe in those staff who are around the nurses' station at this time a general sense of their being let down.} Later on that day the ward becomes much busier as patients have started to come back from theatres and the new ward is operational for the first time. In the middle

of this period Lily (now the sister on the new Grantham Ward) says that Charlotte (a second auxiliary nurse) needs to be told off for letting us down that Saturday (likely referring to the day of the relocation). {Again a member of staff has not been supportive.} Later in the day it became much quieter as the number of patients coming through the theatres and onto the ward had reduced. At this time the staff on the late shift were beginning to arrive when Lily came over to Zone L where I was doing my observations. Lily says she has had a missed call from Charlotte [the same auxiliary nurse that was absent on Saturday]. Lily says that means she is not coming. Lily telephones Charlotte back and speaks to her over the phone. When Lily finishes the conversation she says, "I don't believe that child … she's got a stomach ache." {The staff around the station cannot believe Charlotte has called in sick again on today of all days. They seem [angry]/disappointed with her. This means that two members of staff have not arrived for work today.}

[Felwater field notes, week +1]

Support was such an accepted feature of ward life that staff were shocked when two members of the group had called in sick on the first day. Both Lily and Grace's expression of disbelief demonstrates that the behaviour of the two auxiliaries was counter to the implicit set of rules that guide behaviour on the ward. These acts disappoint the group as no matter how ready the group was for the relocation, this first day was always going to be a challenge, one that they expected to meet in the customary manner as a team. The reaction from staff also suggested that feelings of mistrust were present; that the group thought the auxiliaries were not genuinely sick

but were instead avoiding this first difficult period. Other examples of sickness that I observed during my time with the ward were considered genuine and were not treated in this way.

In sum, staff at Felwater Hospital experienced a lack of both internal and external support during the critical 'just before' and 'just after' stages of the transition. These discrepancies went against the accepted practice on the ward and in doing so caused distress amongst staff. The focus of this chapter will now move on to consider the more social aspect of team dynamics during the transition at Felwater Hospital.

b) Team dynamics at Felwater Hospital

The importance of support structures as discussed above illustrates that teamwork was a common and strong feature of daily life on the ward at Felwater Hospital. The relocation brought about changes to the team dynamic, that is changes to the membership of the team. These shifts in team configurations include the Felwater staff groups being brought together, separated, reunited, partially integrated with a separate ward and then contemplating a predicted merger. These complex shifts in team dynamics (brought about by the transition) and how these different shifts affected staff well-being are explored below.

At Felwater Hospital the team arrangements had a confusing history. The DCSSU had originally worked as separate wards but (just prior to the start of my observations) they were joined and co-located to work together as one large team. The aim of shifting to work in this larger group was to familiarise staff with how they

would be operating, following the relocation, in the new DCSSU. However, due to pressures (that neither the staff group nor I were privy to) this period as a larger team was short-lived and the unit was quickly divided back into two wards (Carson Ward and Crawley Ward), approximately four months prior to the formal relocation.

The four-month period of separation enabled the smaller teams to settle into their groups. Indeed, prior to the relocation, both of the nurses in charge at the separated wards commented on what the transition (and new team configuration) might mean for their current ward teams. One was concerned about the sense of loss that joining the two groups together again might involve:

> During an informal interview with Lily (nurse in charge Carson Ward), she said that the team had really gelled as before you might do a shift with someone but not see them again for a while – here you work together more.
>
> [Felwater field notes, week -1]

> During an informal conversation with Layla (an auxiliary nurse) I asked her whether she felt there was anything that supported her at work. She said that on Carson Ward there was a "friendly undertone… that you feel welcome… and when you come on the ward it feels warm". However, "on other wards it feels cold." (not temperature but atmosphere). She also said that on Carson Ward you feel you can rely on the team. She mentioned Lily (the nurse in charge) and Baldeep (a staff nurse) as people she felt she could especially consult if she

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needed someone. I asked her why she got out of bed in the morning to do this job. Layla said it was the job satisfaction – "you feel like you have achieved something". She also said that the banter and joking on the ward was important. She added that it was not everything but that it was important. She went on to say that "on this ward you feel appreciated" – "it doesn't feel like you are just a number… you feel important". She added that this was not the case on all wards.

[Felwater field notes, week -2]

Lily anticipates that the new team configuration will result in those bonds that had developed within their small team going astray within a larger group. In this way, there is a sense of the potential loss of relationships between staff on the ward. As Lily hints, this upset could occur because of dilution, that is not seeing a colleague you are close to frequently enough to ensure the strong bonds remain or simply that staff would not see each other as frequently as they liked. Layla's extract shows the nature of these relationships and ultimately what the staff may be leaving behind after the relocation. However, different loyalties existed as the nurse in charge on Crawley Ward was looking forward to the larger DCSSU team coming back together:

During an informal conversation with Cecelia she spoke about the new hospital and said she was "looking forward to the new hospital as they are all getting back together". Being "back with Carson Ward – nice to be back together".

[Felwater field notes, week -2]

Cecelia (nurse in charge) is speaking to one of the Bank staff (see glossary). She talks about having a "good team here" and "be good when the team is all back together again".

Here both nurses are seeking to maintain their team dynamic; for Lily it is directed towards her current ward team and for Cecelia it is for a return to the larger unit. The mention of these changes to the team dynamic coming from the nurses in charge is interesting as they are likely to have more of a strategic view of what it will mean (i.e. a loss or gain of relationships) for their respective teams. Maintenance of the team and hence the team dynamic was an important means of preserving the ward life with which staff had become comfortable.

As the above has shown, long before the actual moving day the transition process had already brought the team together and then separated them again. This action brought about a strong sense of group identity particularly within Carson Ward as the separation caused rivalry to emerge. This consequence, although difficult to observe as the groups rarely came into contact, was enough of a problem for a remedy to be attempted with the alternated hosting of ward parties every few weeks:

At some point during the morning the nurses on Carson Ward talk about the party going on in Crawley Ward today. The party is designed to get the two wards to socialise whilst they are apart. I have heard that Carson Ward hosted the first one and now it is Crawley Ward's turn. Carson Ward staff discuss when it is and who is going to the party.

None of them is keen about going. Lily (nurse in change) is the most neutral but still you can tell she does not really want to. Baldeep (a staff nurse) is not keen on going either. As Baldeep and Lily feel obliged to they agree to go later in the shift; one will go at one o' clock and one at one thirty. {None of them is keen about coming together and spending time with their colleagues which is strange as they value this kind of togetherness and camaraderie with the staff on Carson Ward so much. There is definitely segregation between the two groups. I wonder if Crawley Ward feel the same way about Carson Ward as I have not got a sense of this yet.}

<div align="center">[Felwater field notes, week -5]</div>

Ultimately these ward parties were put in place to alleviate tension between the two groups ahead of the transition. On the surface, the rivalry that emerged was curious as although both wards worked for the DCSSU they had separate roles and functions within the unit and were not in competition with each other. Staff mirrored each other's thoughts on the party suggesting their influence over each other. Staff were also defensive about mixing with the other ward team and did not want to engage in activities with them. In this way, it seemed that the group were adopting a dismissive attitude to act as a protective force. This protection can be viewed as a form of coping mechanism, enabling staff to remain with what or whom they know leaving their particular group undisrupted.

This in-group/out-group mentality also emerged with an entirely different external group when Carson and Crawley Ward joined to form Grantham Ward in the new

premises. Part of this transition process required some staff to integrate somewhat with the O'Brien Ward team causing similar defensive reactions that this time the newly formed Grantham Ward felt the brunt of:

> Sharda (an auxiliary nurse) is crying because she does not want to go and work with O'Brien Ward. Sharda explains that on Monday it was fine but yesterday the O'Brien Ward staff were treating her like rubbish. Sharda said that Kavita (an auxiliary nurse) said she did not like it from the second she walked on the ward. She had said that she just got bad vibes. Sharda goes on to say that the O'Brien Ward staff are rude ... Alison (a staff nurse) adds that O'Brien Ward staff used not to let staff use the toilet in their area and that when Alison had asked to use it she had been told that she could use it just this once. Cecelia (a staff nurse) added that they had put the names of O'Brien Ward staff twice on some of their lockers so that they would not have to share. Cecelia said that they did not need to behave like that; they only had to say. Alison said that O'Brien Ward staff used to sit with them on breaks when they all used to be one department and then they separated into specialties. Alison mentions that she has often heard the O'Brien Ward team referring to staff as "band ones", adding that they do not use their names. {The unfriendly nature of staff had upset Sharda.}
>
> [Felwater field notes, week +1]

During an informal interview, Kavita (an auxiliary nurse) said that some
of the people who worked on O'Brien Ward were nice, but the rest of
the people are not and treat you badly.

[Felwater field notes, week +2]

Also on Zone N Lily (the ward sister) tells some of the staff that
[seemingly someone from O'Brien Ward] was asking a band one
member of staff (a low grade member of staff) to do swabs yesterday.
Cecelia (a staff nurse) agrees with Lily's tone and says they [the band
one staff] are not allowed to have any patient contact. {Staff seem to
think O'Brien Ward are taking advantage of them and that it is wrong to
ask staff to carry out work that is above their pay grade.}

[Felwater field notes, week +2]

Again, disruption of the team because of the relocation results in staff defaulting to
form an 'us and them' mentality. In this case it is the O'Brien Ward group who are
having their team disrupted by the inclusion of Grantham Ward staff. This disruption
is being dealt with by the O'Brien Ward group being dismissive to the new staff, and
suggests a rejection of the help and assistance of Grantham Ward staff. This time it
is the turn of the larger and newly formed Grantham Ward team to bear the brunt of
the rivalry that occurs between the different groups in the hospital. The lack of desire
to share lockers also hints at the lack of resources available to staff at Felwater
Hospital. This situation suggests that part of the reason why teams are defensive
may be because they want to retain resources when they are made available.

This 'in group/out group' behaviour upset staff in three ways: first, regarding the treatment of Grantham Ward by their colleagues in O'Brien Ward; secondly, because rules regarding the contact band ones can have with patients had been disregarded; and thirdly, regarding poor treatment of lower level staff, such as not using their names, making it seem as if they are identifying a class of people rather than an individual. These were considered by staff to be violations of acceptable behaviours and resulted in feelings of unease. Staff showed anxiety prior to starting their shift on O'Brien Ward, experienced poor treatment during the shift and felt that they had been treated in an unacceptable manner when they retrospectively considered their work.

A few weeks later the now more amalgamated Grantham Ward was threatened with the prospect of a completely new group coming into the fold. This merger (an unexpected part of the transition) has been discussed in the previous two data chapters:

> Layla (an auxiliary nurse) comes over to me and we begin an informal conversation. She asks me, whether I have heard about the Grantham/Hughes Ward merger? I say that it had been mentioned. I ask Layla what she thought about it and she says, that they all get on really well here together, and that she thinks the group who currently work up there have actively been chosen because they all get on so well. Then speaking about Hughes Ward staff, Layla says she used to work on Hughes and that some are really nice and some are not. {Layla seems concerned about unfriendly staff coming and upsetting

the group.} Layla then said there are numerous staff on the unit because they do three long days each. Layla then went on to say that "this will have more of an impact than the move". Baldeep (a staff nurse) adds at this point the "atmosphere on here is gonna change". {Baldeep is not happy about this. I assume she thinks the atmosphere will change for the worse.}

<div align="center">[Felwater field notes, week +6]</div>

This extract shows that the threat of yet more team changes has a negative impact on staff well-being. This example shows that retaining the atmosphere and social dynamic on the ward is important to staff, and suggests that the new ward's social group was something staff had grown to be comfortable with since arriving on the ward. At this stage in the transition process (six weeks after the move) the group, rather than being rivalrous as they were in their pre-relocation phase, had come together. This observation demonstrates that unlike other mechanisms presented in the thesis so far (such as the presence of 'incorrect' patients) staff can eventually adjust to changes in the team dynamic and as such this is not a persistent source of upset for staff during a transition process.

This section has focused on the role team dynamics play in staff well-being during transition. The extracts have shown that distress occurs when the relocation process causes the normal team dynamic to be disrupted. However the shifting nature of the staff loyalties to their new teams demonstrates the process by which the staff members become accustomed to their new group. As a result, although some staff may be trepidatious or rivalrous at first they will adapt to their new community. In this

way, although disruption of the team dynamic initially has a negative affect on staff well-being, it is not lasting. This chapter will now explore the impact of the transition on social structures at Arunwick Hospital.

c) Support structures at Arunwick Hospital

In a similar manner to Felwater Hospital, support structures at Arunwick Hospital were a fundamental part of ward life. Again, nurses worked together to get through the daily tasks and, this interdependence was critical for getting work done. At Arunwick as at Felwater Hospital the transition provided circumstances in which the levels of support on the ward could be disrupted. The discomfort that emerged as a result of the loss of support structures was particularly pronounced in the initial stages following the relocation, when some staff were experiencing the most acute phase of change during the transition: when they had lost many things that were comfortable and familiar to them and gained many things that were unfamiliar and uncomfortable:

> [In Zone B Isobel (a staff nurse) and Katie (a staff nurse) are talking. It is very early on in the shift, around 7.45am and patients are beginning to come on to the ward]. Isobel says, "I'm worried, don't know any of the consultants or anything ... I don't wanna be dangerous ... only done one shift in the bedded area ... don't know anyone, never worked with them before." {Isobel sounds very worried, with a wobbly voice, she sounds as if she might cry and is genuinely concerned. This is Isobel's first day back after a holiday; she has not had the time to settle in that other staff have had.} Later on that day Isobel said, "I was just really

scared, [a student] was showing me everything." She laughed at this.
{Isobel was not happy working round there but she did have support which improved things for her.}

Isobel describes not knowing anyone as one of the aspects of working on the new ward that is particularly concerning her. She is lacking the social connections she needs to feel supported placing her outside of her comfort zone. However, after the above extract (taken from across the day) she had received support which mollified her.

Isobel's reaction to a lack of support was arguably the most extreme with others asking questions, following other staff and taking onboard information to help them through this initial uncertain period. In contrast with Felwater, Arunwick did not feature a sense of being let down by support structures; instead it was the levels of unfamiliarity being experienced by Isobel that she required support for to enable her to get through.

At Felwater Hospital the two groups of staff that came together to form the new ward were well-known to each other. However, the Darcy Ward employees were joining a larger group of staff, who were relatively unknown to them. As a result, during the initial acute phase of change (just after the relocation) the now ex-Darcy Ward staff needed to overcome the potentially awkward social steps of asking for help from someone with whom they were unfamiliar. As a form of coping ex-Darcy Ward staff were inclined to go to those with whom they were familiar and comfortable, i.e. their

former colleagues, for support. This is a type of passive coping strategy, when staff seek to reduce the distress they are experiencing. Some staff however adopted more active-style coping strategies:

> Annabelle (a staff nurse) said to Laura (a staff nurse), "I can't get anyone to reply to a bleep from [a particular doctor's] team." Annabelle says this in a frustrated tone. Laura goes off the bay and a couple of minutes later she comes back. Annabelle says to her, "If I can't get hold of a team what should I do?" Laura says, "Talk to [a member of staff] - she's brilliant." Annabelle goes off. {Annabelle is frustrated, she does not know things like pager numbers which are essential to her job running smoothly and for enabling her to get tasks done. This must be especially frustrating when there is pressure to free up beds.}
>
> [Arunwick field notes, week +5]

To build support structures following the relocation staff seek to learn about those in the ward who are experts in particular aspects of their work. This response also shows that staff can adopt an active style of coping and seek out information that places them back in control.

In sum, staff at both Arunwick and Felwater Hospitals work in a manner that reflects the importance of support structures. When there is a sense that either internal or external support structures are lacking or that such structures have been lost, staff well-being suffers. Evidence from both hospitals demonstrated the importance of

support structures being in place for the acute phase of change. However, staff will adopt coping strategies to address the distressing circumstances they experience.

d) Team dynamics at Arunwick Hospital

Staff at Arunwick, as at Felwater Hospital were concerned with the potential disruption to their team the relocation would bring. The section that follows explores the journey that the team go through during the process of transition from fear regarding the loss of their team, to trepidation with the new group, to eventually forming a new team. Following the journey in this manner shows the different ways in which changes to the team dynamic can affect well-being during the transition process.

As with Felwater, the hospital teams at Arunwick Hospital played an important role in defining acceptable behaviours on the ward. In light of this social guidance role, changes to the ward team posed a threat to the comfort zone that staff inhabited:

> During an informal conversation with Laura (a staff nurse) she said that you get used to working with people, indicating that she was comfortable on this ward. They were a good team. She said she felt supported here. {The team and support are important to Laura.} Later on that day during an informal interview with Claudia (a staff nurse) I asked her if she is looking forward to moving and she said half and half. I asked her why. She said that there were going to be loads of staff on the unit, whereas here it is a very small team and you work with each other almost everyday. She said that you could work with

people one day and then not work with them again for a couple of weeks. {Claudia likes the small team and will lose this.} A little later during a further informal conversation, Annabelle (a staff nurse) said she was concerned about the number of staff who work on the new ward and that this may mean they lose the sense of being a team.

[Arunwick field notes, week -1]

This extract shows that, because of the transition, staff were apprehensive about losing the sense of team and comfort that they felt within that team. The concern centred on the issue of losing the recognition and the familiarity Darcy Ward staff had with their colleagues. The initial fear that staff voiced about losing the comfortable social dynamic within their team was not unfounded. Some staff shared information on the negative experiences they had been subjected to when first visiting and conducting so-called 'taster' shifts on the ward.

During an informal interview with Annabelle (a staff nurse) she said that on the first shift she had done [on the new Bennett Ward] she had to fill out forms that she had not used before. She asked someone how to fill it out and they had said to her, "How long have you been qualified?", in a cutting way. She said that this experience had put her off. But that the following two shifts she had actually enjoyed.

[Arunwick field notes, week -1]

During an informal conversation with Laura (a staff nurse) she said that people were not very friendly. She added, you know when you walk

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into somewhere and people do not look up when you say hello. {She seemed to feel that the staff were hostile on the new unit.}

Although these extracts show that Annabelle and Laura both had a poor first impression the issue seemed to have been remedied (in Annabelle's case) with subsequent positive experiences. The initial negative reaction from the staff Annabelle and Laura met appears to be a defensive mechanism suggesting that when established teams are feeling threatened by transitions they may act negatively towards newcomers. However, it is important to note that unfriendly or negative interactions between staff at Arunwick Hospital were rare.

Following the transition at Arunwick staff did seem to lose the sense of comfort and familiarity they drew from their old team. To this end, staff adopted coping mechanisms to retain a sense of their previous team; for example, they took time to see, talk to and catch up with each other:

Isobel (a staff nurse) walks out to the main reception/control centre area. She bumps into Kate (a ward sister) and another sister. Kate says, "Hello, sweetheart. How are you?" and then Isobel shows them the picture of her baby. {Isobel seems only to be sharing the picture with ex-Darcy Ward staff. She feels most comfortable with them as she started the pregnancy during her time with them. The ex-Darcy Ward staff are still very close.}

Claudia (a staff nurse) is running through the ward and playfully smacks Uma (a staff nurse) on the behind. {They have good humoured and familiar relationship.}

[Arunwick field notes, week +4]

Although (as noted above) there was an initial focus on maintaining relationships with the old team members, after some time staff became comfortable with the new staff group. A key way of observing this development was through their more jovial treatment of each other:

Isobel (a staff nurse) comes back to the nurses' station. She then walks down through the ward with a student as they are embarking on a ward tour. When she walked past one staff nurse from the new group, they shared an exchange and both Isobel and the staff nurse laughed. {A good rapport with staff from the new ward.}

[Arunwick field notes, week +9]

Uma (a staff nurse) and a staff nurse from the new group are at the nurses' station together laughing at something, I did not hear what. They are then talking about a patient being first on the list. {The staff laughing together is positive, it feels like a more relaxed working environment.}

[Arunwick field notes, week +9]

Laughter and joviality became more commonplace on the ward as the weeks progressed and ex-Darcy Ward staff became more comfortable in the social relationships they had formed in their new team. Yet in some of the more fundamental aspects of ward life the groups remained separate:

> Katie (a staff nurse) and Isobel (a staff nurse) walk through and off the ward together. {They are not working on the same bay but are ex-Darcy Ward staff and leave the shift together. It seems there are still separate groups.}
>
> [Arunwick field notes, week +10]

These more ingrained social habits appear harder to break. It seems that, although the staff were starting to build comfortable and relaxed social behaviours around each other, there were still relics of the previous teams in which they worked. This pattern suggests that at that time it may have been more comfortable for staff to retain partially these groups like a 'holding pattern' until the groups have had time to merge more fully.

CONCLUSION

The social structures of the ward played a key role in determining levels of well-being amongst staff during the transition. Exploration of the social practices revealed that staff relationships were based on interdependent working and strong family-like bonds. The relevance of support structures and the team dynamic to the staff experience at work meant that when these elements were disrupted the impact on staff was considerable. Thus, the style of work and the relationships staff have with

each other may determine (that is constrain or enable) the amount well-being is affected during change. Indeed, had tasks not been so heavily interdependent and the relationships not so strong, the disruption brought about by the transition might not have influenced well-being to such a degree. Importantly, however, when considering the process of the transition it becomes clear that disruption to the team dynamic is an element of the transition to which staff adjust; thus the effects of this mechanism do not appear to be long-lasting. The discussion chapter that follows will consolidate the overall contributions of this thesis as well as provide a set of evidence-based recommendations for practice.

CHAPTER EIGHT

DISCUSSION & CONCLUSIONS

INTRODUCTION

In Chapter Two I argued that staff well-being during change is a valid and important area of study. This topic was justified because of the robust associations between well-being and change, the low levels of well-being in NHS staff and because of the consequent effects staff well-being has on both the patient experience and the success of the organisation. My exploration of the literature identified the main themes or mechanisms that bring about effects on staff well-being during change and showed that the key gap in this area was a focus on the *in situ* experience of staff during transition. This led to the following three research questions: a) How do NHS staff experience well-being during periods of transition? b) Why do NHS staff experience well-being in this way? c) How does the context enable and/or constrain this experience?

The sections that follow are divided into five main parts. Part One focuses on the empirical contributions, particularly the different mechanisms that were found to bring about effects on staff well-being during change and how these were facilitated or restricted within the particular ward settings. I will also explain the ways in which my focus on the staff experience provides new insights to the field. Part Two explores the theoretical contributions of the work and will discuss how the work fits with existing models of transition. In Part Three I explain the methodological contributions

of my work. To answer the research questions I selected an ethnographic approach as it provided an excellent fit with the research aims. I will consider how successful this approach was in answering my research questions and the methodological issues that emerged. In Part Four I will further consider the implications my work has for local, regional and national policy. Finally in Part Five I will describe some of the limitations of the work and how these may lead to future areas of study. These five parts ultimately aim to demonstrate what my particular findings may mean, how helpful they are in developing an understanding of well-being during transition, and importantly why this is the case.

PART ONE: EMPIRICAL CONTRIBUTIONS

My research offers two main contributions to current literature on staff well-being during organisational transition. First, the research has uncovered several different mechanisms (see Table 8.1). That is, elements that bring about effects in staff well-being (explored in Chapters Five - Seven). Second, whereas studies into staff well-being generally use a deductive approach, these mechanisms were established inductively drawn from the perspectives and experiences of participants in the study. This additional dimension offers a number of different insights that are explored below. The empirical contributions are explored in chapter order, thus: a) Information and communication during the transition (Chapter Five), b) The nature of the transition programme (Chapter Six) and c) The impact of the transition on social structures (Chapter Seven).

a) Information and communication during the transition

Communication plays a key role in ward functioning because passing information around the ward and wider hospital facilitates the tasks, activities and general working routine of the ward. Communication had an additional and fundamental role during the transition process, particularly regarding the extent to which change-related communications were systematic, that is structured and methodical, in nature. Chapter Five presented four components of such a systematic approach that were key mechanisms for staff well-being: i) Scheduling of communications, ii) Transparency of information, iii) Participation and involvement, iv) Job-related technical information. I will now locate these mechanisms within the current literature and discuss them in terms of how they inform that literature and extend our current knowledge.

i. Scheduling of communications

The scheduling of communications about the transition process is an important mechanism in the relationship between transition and well-being. Here, the scheduling of communications refers to the specific point in the change process at which staff received information about the transition. It was demonstrated at Felwater Hospital that inadequately scheduled communications had a negative effect on staff well-being. This feature often occurred because delayed information meant that tasks had to be completed in a shorter timeframe, placing staff under additional pressure to achieve them. This finding extends the existing literature as it highlights that a particular facet of communications (rather than communications as an umbrella concept) is important for staff well-being.

The workload or pressure added by late information could lead to unprofessional working behaviours, such as working in a rushed or confused fashion. Indeed, as discussed in Chapter Two, such demand has been shown to be a mediator in the relationship between staff well-being and change in the public sector (Noblet and Rodwell, 2009, Sutherland, 1995). At Arunwick Hospital, on the other hand, evidence showed that information came through to staff in a more gradual manner, which helped to maintain levels of staff well-being.

As well as the knock-on effects which late communication has on how demanding work is, study of the staff experience showed that there are other consequences for staff both in their working and personal lives. For example, as is explored in Chapter Two, when information is not forthcoming, rumours often emerge to fill this perceived gap (Bordia et al 2004). Rumours were something Felwater Hospital staff appeared to suffer from the most; it was also Felwater Hospital where the levels of communication were low. The home life of staff can also be affected, as was indicated here, as staff were required to adapt to meet sudden changes in the workplace.

The two wards had different communication practices, which enabled and/or constrained the scheduling of information. In Arunwick Hospital timely communication appeared to be a symbol of staff professionalism, and of how efficient and informed staff were in their practice. Yet at Felwater Hospital, the lack of timely communication suggested that this was not an organisational priority, and that perhaps the resources available to facilitate such timeliness were being used elsewhere. This finding fits with other reports on the wider cultural practices at

Felwater Hospital that characterise the trust as reactive, and one with a constant need to 'fire fight' emerging issues, rather than one that shows high-level or meticulous planning (Shapiro et al., 2010).

Importantly, the scheduling of communication is something which is realistically changeable. Specifically, once management is made aware of the need for timely communication, the deployment of information can be carefully considered in advance of transition periods, or regularly reviewed to fit the needs of staff. However, such continuous action requires an organisation to compile detailed plans that focus on proactively anticipating the information needs of staff. Exploring the means by which information could reach staff sufficiently in advance of events could enable organisations to influence the impact of transition on staff and prevent the emergence of some of the additional harmful effects discussed above.

Table 8.1: A table to summarise the different mechanism findings where the mechanisms are marked with o.

THEME/CHAPTER	MECHANISM

Information and communications during the transition	• Systematic approach to change-related information
	   o Providing timely scheduling of communications
	   o Providing transparent communications
	   o Providing of technical job-related information
	   o Enabling participation and involvement

The nature of the transition	• Work Spaces
	   o Working in restrictive spaces
	   o Working in a disconnected ward
	• Work activities
	   o Working with 'unsuitable' patients
	   o Working in a fast-paced manner

Impact of the transition on social structures	• Support structures
	   o Lacking internal support
	   o Lacking external support
	   o Losing support
	• Team dynamics
	   o Disturbing the team dynamic

ii. Transparency of information

The transparency of information refers to the extent to which information is clearly communicated, for example, through appropriate channels, or alternatively the extent that it is communicated in a manner in which the 'complete picture' is seen to be divulged to staff. When transparency was low (as it was at Felwater Hospital) this negatively impacted upon staff well-being. However, the presence of transparent information (as was shown at Arunwick Hospital) maintained pre-existing levels of well-being. Focus on the staff experience, as my research did, also extends current literature on the relationship between communications and well-being by showing a further component of effective organisational transition.

As discussed in Chapter Two, existing literature has focused on other elements of communication, such as the extent to which communication approaches are participatory, and has spent little time on the clarity of the information communicated.

The role of effective communication channels in change acceptance, however, has been noted (Leiter and Harvie, 1998).

As with the role of timeliness, much of the distress experienced with regards to levels of transparency occurred in the observed cases because a lack of transparency placed conflicting demands on staff. Conflicting demands existed between the way in which staff wanted to complete their tasks (in a well-informed manner) and the reality of their work. Indeed, during periods of change, uncertainty is one of the most commonly experienced psychological states (Begley, 1998, Bordia et al., 2004, Nelson et al., 1995, Sagie and Koslowsky, 1994). Information is considered as means of enabling employees to predict and understand change and as such helps staff to make sense of it (Sutton and Kahn, 1986). The staff experience of transparent communications (at Arunwick Hospital) enabled them to feel reassured that the information they had was as close to the knowledge of their managers as possible. Staff then experienced reduced levels of uncertainty, as they knew what to expect. Transparent approaches have been shown elsewhere to support feelings of trust and in turn improve levels of motivation (Jimmieson et al., 2004, Tan, 2005, Wanberg and Banas, 2000).

The staff experience provides a more nuanced picture of the role of transparency in communications. For example, the reassuring function of transparency means that transparency has an additional social or relational role in building the levels of confidence nursing staff have with their managers. Importantly, as with the role of scheduling information, the transparency of communications is a part of

organisational practices that can be improved to result in better levels of staff well-being during periods of transition.

iii. Participation and involvement

As is detailed in Chapter Five, communications that lack a consultative or participatory approach can have a negative effect on staff well-being, whereas incorporating such elements can maintain well-being in staff. The driving role of participation and involvement was particularly relevant to Felwater Hospital, as it was here that such involvement was lacking. As discussed in Chapter Two, several authors have found participation in changes to have a strong correlation with psychological well-being and change readiness (Gutierrrez and Dyson, 2009, Isaksson et al., 1999, Tan, 2005). When staff are involved and experience fair treatment they look more favourably upon changes (Sverke et al., 2008). Studying staff *in situ* highlighted other insights that I will explore below.

Much of the staff distress at Felwater Hospital appeared to stem from a conflict between the higher levels of consultation that staff were comfortable with and the low levels they were actually experiencing. More specifically, staff wanted to be consulted about the transition itself, which was evidently not the case at Felwater Hospital. It was suggested by a member of nursing staff that it would obviate the effects of change, as it was not the change itself that upset staff but the lack of meaningful consultation.

A non-consultative approach to communications implies that staff opinions or knowledge may not have been required, wanted, or more simply not actively sought.

This marginalised the perceived value of staff input and placed staff outside of the control of the transition, where changes are happening *to* staff rather than *with* them. Indeed, levels of control over change are often found to be a mediating factor in the relationship between staff well-being and change (Moyle and Parkes, 1999, Noblet et al., 2007, Noblet and Rodwell, 2009, Noblet et al., 2006).

As is demonstrated in Chapter Five, levels of consultation with staff were particularly low at Felwater Hospital. Furthermore, staff were familiar with this lack of consultation as it had been observed on the ward previously. One would assume that staff can be inured to such circumstances. However, although this desensitisation is a reasonable *a priori* expectation, it was clear that such circumstances were not observed at Felwater Hospital. In fact, despite continued exposure to low levels of consultation about change, staff still experienced feelings of distress. Conversely, factors such as team dynamics (explored later in this chapter) were something staff became familiar with and used to. This pattern suggests there are two different types of mechanisms, a persistent type that continually affects staff despite their levels of exposure, and an adaptive type to which staff will eventually acclimatise to.

The presence of two different types of mechanisms has implications for local policy in managing the transition processes (see Part Four of this chapter). Persistent mechanisms may be a more fruitful area to direct organisational resources. Yet adaptive mechanisms may be better managed by raising the awareness of their potential for distress. Messages such as these might prepare staff and could be

delivered alongside more comforting news that the effects of such mechanisms are unlikely to be long-lasting.

The role of participation links with other elements of communications discussed earlier such as the timeliness of communication. It is reasonable to infer that participation in change will engage staff in a transition process in the early stages and as a result they will be better informed. In this way, the same sorts of knock-on effects found with late communications are relevant to findings regarding a lack of participation. More specifically, there is likely to be a negative impact on the personal lives of staff, and further it is highly likely that such communications can enable negative hearsay and rumours to emerge. This pattern shows the interconnected nature of some of the components of communications and that by assuring the presence of one element (for example, consultation) this may facilitate another (for example, timeliness).

iv. Job-related technical information

Technical job-related information acts as a further mechanism in bringing about effects on well-being during transition. Whilst the findings discussed so far focus on the process elements of communication, the final relevant component relates to the content of communications provided. Specifically, when gaps were present in technical job-related knowledge, it had a negative effect on staff well-being. This gap was found at both hospital trusts and was caused because staff were working in a way which they found uncomfortable; that is without the normal certainty with which they approached their work.

Job-related technical information is an important component of communications, and can be explored in greater detail by considering the particular contexts at each trust. At Felwater Hospital the ward was opened when the staff I was observing relocated there. At Arunwick Hospital, on the other hand, the staff relocated to a new ward that had already been operational for a short period; so the staff were relocating to join the ward. In addition, at Arunwick Hospital a rotation of 'taster' shifts had been organised, along with a 'buddying' system as a means of support. No such system was observed at Felwater Hospital. However, despite this clear difference between the wards, both staff groups showed signs of distress in relation to the issue of job-related technical information. This similar reaction across both wards is particularly interesting because (as has been demonstrated so far) the different contexts at Arunwick and Felwater Hospitals typically resulted in the various mechanisms having different effects on staff well-being: usually more negative at Felwater Hospital and more positive at Arunwick Hospital.

This contextual information is important because it suggests a period of adjustment is unavoidable in becoming familiar with issues such as the new ways in which staff carry out their work. In the new hospital contexts, these issues included new patient procedures and new locations of equipment. Yet, even when measures are put in place to circumvent such gaps in knowledge and provide sufficient experience, distress still occurred. However, some staff did acknowledge that the taster shifts had been helpful in some ways. Thus it is reasonable to conclude that strategies to improve job-related technical knowledge (for example, taster shifts) only mitigate the effects of transition on job-related technical knowledge in some staff. This pattern follows many of the transition models discussed in detail both later in this chapter

and previously in Chapter Two, where a period of instability occurs during the acute phase of the transition.

To conclude, by focusing on the experience of staff, this study has been able to shown the different consequences an unsystematic approach to communication can have. The findings also suggest that there are two different types of mechanisms (adaptive and persistent) that bring about effects on staff. Communication appeared to be more effective when it was closely intertwined with a sense of professionalism. Indeed for the most part, Arunwick Hospital adopted a more systematic approach to communications during the transition process than Felwater Hospital. This systematic strategy meant staff well-being was better maintained as information appeared to better equip staff for transition, in that staff knew what to expect and as a result the levels of staff well-being remained on a more even keel. In addition, by breaking down the communication process to its constituent parts I have shown the role each of these parts (transparency, scheduling etc.) has to play in the process of communicating information effectively during the process of transition. This shows that good communication is multifaceted and should include information on both the content and process of a transition. Each component needs to be amalgamated into transition plans and efficiently delivered during transition to maintain levels of well-being amongst staff. In the present section I have explored findings presented in Chapter Five. I will now go on to consider those findings put forward in Chapter Six.

b) The nature of the transition programme

Change in the health services can be focused in nature or more system-wide, involving, for example, the overhaul of entire hospital trusts (see for example,

McNulty and Ferlie, 2002, Shapiro et al., 2010). The findings from this study suggest that the nature of the transition will, to a certain extent, determine the effects it has on staff. Indeed, it would be somewhat obvious to infer that, *ceteris paribus*, a small administrative transition project is likely to have less of an effect on staff than a more transformative one.

As is described in the 'setting the scene' chapter (Chapter Four), in the case of this study the transition involved the move to new purpose-built facilities where different types of work activities were carried out in different types of spaces. These changes to work activities and spaces impacted upon staff well-being during the transition process. The findings regarding: a) work spaces and b) work activities will now be located within existing literature and explored in terms of their contribution to that literature.

i. Work spaces: disconnected and restrictive work spaces

Two specific mechanisms within the area of work spaces were found to be relevant following the transition. First, it was shown that disconnected ward spaces can drive effects on staff well-being and secondly, that restricted space on the ward can also bring about effects on staff well-being. These types of spaces could violate the professional values and practices of staff and as a result negatively effect their well-being. This observation demonstrates that the outcomes of the transition are as important as the process of transition in determining levels of well-being amongst staff. Such outcomes need to align with the cultural norms of the staff group, in this case regarding the proximity of staff to the patient and the quantity of space needed to provide care in a dignified fashion. The role of values in determining staff well-

being echoes the eudaimonic approach (discussed in Chapter Two) where well-being is considered to be achieved by engaging in worthy and meaningful practices.

Interestingly, most research that considers the work environment focuses on the psychosocial work environment, including elements such as job strain (Begat et al., 2005), and less so on the effects of the physical environment on staff. Few studies that have looked at the physical environment have also considered its role in terms of well-being. For example, research has considered the environment in terms of the amount of sunlight that was available in the workplace (Leather et al., 1998). The physical environment is more frequently investigated as a possible source of healing for patients. As such, environments are judged on their ability to offer adequate therapeutic space for patients to recover within (Curtis et al., 2007, Gesler, 2005, Leather et al., 2003), rather than as environments that may influence staff well-being. The findings (presented in Chapter Six) therefore suggest that more attention should be paid to the spaces in which nurses carry out their work, and the compatibility of these spaces with nursing work. Because of the similarities between them, it is helpful to discuss the findings regarding disconnected and restrictive spaces together.

Disconnected ward spaces, that is ward spaces that were considered by staff to be separate or cut-off, were found at both case study trusts. These spaces changed the experience of caring for patients on the ward. The quality of care was felt to suffer in these spaces causing distress to staff. For example, patients were not always directly visible from the nurses' station, or were considered to be too far away from the central hub of the ward. This finding suggests an implicit cultural value that

equates the proximity of staff to the patient, with the level of patient care staff are able to provide. This cultural value, however, was constrained within the context of the new disconnected ward spaces.

The quantity of space in ward areas was found to be an issue at Arunwick Hospital only. Space on the ward could be restrictive, considered by staff to be limited or cramped. As with disconnected spaces, restrictive spaces were felt to provide a reduction in the quality of patient care. It appeared that standards such as dignity could not always be upheld when nursing in these confined areas. The distress that nursing patients in these areas caused staff suggested that maintaining patient dignity is a core professional value amongst the group. Indeed, upholding patient dignity is considered to be a core professional value by the Royal College of Nursing (RCN, 2008).

The impact of restricted space again suggests that a cultural norm exists regarding the amount of space required to deliver care in a respectful manner. These two findings taken together (regarding disconnected and restrictive spaces) also suggest that there is a balance to be struck with the arrangement of space on the ward. That space must allow for care to be nearby and thus immediate, if required, but also generous enough to allow for respectful care to be delivered. The congruence of ward space with staff values is an important point of consideration when planning new hospital facilities.

ii. Work activities: in correct patients and the fast-paced activity of work

Two mechanisms are pertinent in relation to work activities: first, the presence of 'incorrect' patients drives negative effects on staff well-being, a factor that staff hoped would be solved by the transition. Secondly, the fast-paced nature of work can also bring about negative effects on staff well-being. The pace of work was important because, in some cases, staff viewed the speed of work following the transition as incompatible with delivering high-quality patient care.

Through detailed examination of the staff experience, this study shows the effect 'incorrect' patients have on staff well-being, and in particular the conflicts caused by this experience. 'Incorrect' patients are those patients considered by staff to be unsuitable for a short stay surgical ward, for example, elderly patients with dementia. Conflicts were present because ward staff were required to undertake the work regardless of their objections, that is in a manner with which they were uncomfortable. Of course, the notion of conflict in nursing is not a new one, it is a persistent theme in this research and has been noted in other fields of nursing, from early work in psychiatric nursing (Lutzen, 1990) to more contemporary research in telecare (Holmstrom and Dall'Alba, 2002) and nursing managers (Udod and Care, 2011).

The presence of 'incorrect' patients on the ward is relevant to the transition process because new premises and new ways of working signalled the potential for a fresh start (without 'incorrect' patients) but also the potential for further disappointment (if the 'incorrect' patients were still present). For example, the view of some staff suggested that the new building could act as a panacea, which would prevent

misuse of the ward from occurring in the future. In this way, the newness of the building and the way that it had been planned to function was seen as a type of protective force that would prevent old habits 'creeping' into new facilities. However, as is presented in Chapter Six, the hope for the 'cure-all' was held alongside more cynical views that the presence of 'incorrect' patients would continue after the move, a judgement based on the previous experience staff had of transition where 'incorrect' patients had soon returned to the ward.

The role of such incidents is important as it highlights that previous experience of transition can adjust staff expectations about present transitions. This is particularly relevant in light of the continuously changing nature of the NHS. Indeed, staff may become disengaged by disappointing change outcomes. It also shows the limits to what organisational transition processes may achieve, and the importance that the aims of change be realistic, and transparent to staff.

The problem of 'incorrect' patients was enabled by contextual factors and was almost solely found at Felwater Hospital. The practice of the ward at Felwater hospital housing 'incorrect' patients did not appear to be deliberate, but rather that the ward was a victim of circumstances. The pressure for beds from other parts of the hospital was constant and given that many of the ward's patients were day case or short stay, beds regularly became available; possibly more frequently than other parts of the hospital. Ultimately, the ward and the staff within it were there to care for those who required it; as a result turning a patient away was against the values of the staff. Because of these factors the ward appeared to be somewhat of an easy

target for accommodating patients from elsewhere. It seemed there was little that the ward could do to protect themselves from such incursions.

The fast-paced nature of work was a further mechanism that brought about effects on staff well-being. This finding fits with two different sets of previous literature. The first, touched upon earlier, noted the negative influence that high levels of demand have on staff well-being during change (Noblet and Rodwell, 2009, Sutherland, 1995). Second, the finding aligns with literature, again detailed in Chapter Two, that demonstrates a relationship between staff well-being and patient-experience. Specifically, healthcare employees can enter a downward spiral where work demands, coupled with a sense of being at fault with the care they provide, which leads to higher levels of stress (Firth-Cozens, 2001). The link with the quality of patient care is important to highlight here. Staff felt, for example, that patients were being moved through the different stages of their care too quickly. This pressure again placed conflicting demands on staff, between the way in which staff wanted to provide care (in a steadily-paced manner) and the reality of their now very busy work.

This finding is relevant to the transition because, in both hospital case studies, the pace of work increased when they relocated to the new wards. This increase occurred because the day case patient flow was more formulated into particular stages, with specific parts of the ward devoted to each stage. For example, Felwater Hospital had an area solely for patients who had just returned from theatre, where an initial set of observations would be conducted before the patient was moved to

another part of the ward. Staff worked hard to ensure patients kept to this efficient movement and the timeframes this imposed.

In addition, both of the case study wards served several theatres that worked simultaneously. Thus, co-ordination was an issue. Serving a number of theatres could result in two or more patients coming back to the ward at the same time, causing spikes in demand amongst staff. Indeed, the standard tasks required of nurses such as completing sets of observations on patients could be required in quick succession. These particular circumstances caused the nature of work to become increasingly fast-paced and demanding, and therefore acted as a mechanism driving negative effects on staff well-being.

In sum, the findings discussed above show that the specific nature of the organisational change is an important part of determining the staff experience of transition. The nature of the organisational change refers to what elements of the workplace or the experience of work are being changed by the transition. A period of transition may be an opportunity to address areas of work that negatively affect staff well-being (particularly in relation to professional values and practices). Indeed, a new space can become a symbol for new ways of working. These areas are likely to be distinctive to a given organisational change and will depend on what is being changed by the period of transition. Planning work activities and spaces in consultation with staff to ensure such elements are congruent with staff values may be a powerful way of maintaining well-being during and after change. Such planning implies a specific type of engagement with staff, one that could be facilitated using the communication strategies suggested in the previous section. These details add

to existing literature by describing and analysing what the after-effects of transition mean for staff in practice and for their experience at work. The findings highlight change outcomes as an important area of consideration for both researchers and practitioners. In the final section of Part One I will turn to discuss the findings presented in Chapter Seven.

c) Impact of the transition on social structures

The findings relevant at the team or social level are considered in terms of support structures and team dynamics. The specific findings with regards to support structures will now be discussed. Findings regarding team dynamics are particularly applicable to the theoretical contribution of this thesis and are discussed Part Two of this chapter.

i. Support structures

Findings from this study show that the presence of internal and external support structures are important drivers of staff well-being. Specifically a lack of internal and/or external support during the transition had a negative impact on staff well-being. External support originates outside of the ward, such as support from senior management, and concerns the wider strategic or planning issues of the transition. Internal support originates from inside the ward team, and includes support with specific transition-based tasks. However, there was a subtle distinction between the experience of support during the transition across the two cases. At Felwater Hospital distress was caused by staff feeling that they had been let down by staff who were both internal and external to the ward, whereas at Arunwick Hospital it was the loss of support structures from their original ward team that created anxiety.

Support structures in the ward were fundamental to ensuring the ward tasks were completed in a timely manner. The ward staff would each contribute to different stages of nursing tasks; as a result supporting each other was essential to the functioning of both wards. The reliance members of staff had on each other meant that teamwork was very much part of the fabric of the wards. The significance of support structures being in place reflects and reinforces other research that has found lower levels of support to be correlated or associated with poor staff outcomes, such as change-related role stress (Swanson and Power, 2001). Indeed, it is considered that support is important at times of change because of the additional pressures staff are under, and the reduced level of resources that may be in place to implement the changes (Noblet et al., 2006). Other researchers have demonstrated a relationship between social support and staff well-being during change. Indeed, it is a common and robust finding (De Lange et al., 2004, Leong et al., 1996, Noblet et al., 2007, Noblet and Rodwell, 2009, Sutherland, 1995, Tan, 2005).

Although the connection between social support and well-being during change is an established one, the participatory methodology used to collect this data adds a dimension that captured the subjectivity of patients. It is possible to draw out how well-being was affected by the disregard of implicit group-specific norms. The disappointment that emerged from staff at Felwater Hospital suggested that the staff considered transition to be a team effort, as was the norm for the rest of their work. Conversely, at Arunwick Hospital it was the sense of a loss of support and the associated fear that distressed staff. This implies that keeping existing colleagues together at first may ease the upset felt from such initial deficits.

Capturing these local contextually-situated perspectives shows that the need for both internal and external support should not be neglected, and that each dimension is required to mitigate negative effects on well-being. From Arunwick Hospital, we can understand that a loss of nurses' support networks can be as distressing as being let down by that support network. This finding suggests that although the means by which loss occurs varies, the overarching problem is that sufficient levels of support were not present.

In the first part of this chapter I have explored the different empirical findings of this study. The findings show that communication during the transition, the nature of the transition and the effects transition has on the social group are key points of focus for staff well-being. Study of the staff experience of change has highlighted further messages: for example, that change should align with the values of staff, that some mechanisms have a persistent impact and that others staff adapt to, and that both the process and outcomes of change are important in determining levels of well-being. I will now move on to the second part of this chapter where I will explore the theoretical contributions of this research.

PART TWO: THEORETICAL CONTRIBUTIONS

In this part of the chapter I will turn to the process of transition itself; that is, the way in which transition develops over time. In Chapter Two I discussed theories of transition, explaining how these theories help to understand well-being during various change processes. This exploration showed that much of the work on organisational transition evolved from understandings of individual transitions

through major life events like bereavement. Indeed, it was shown that clear parallels existed between the stages of bereavement transitions and transitions within the workplace.

To recapitulate briefly, my exploration of transition theory led to four relevant conclusions. First, several psychological states can be passed through during the process of transition. For example, Kubler Ross's (1969) bereavement model describes five progressive states; denial, anger, bargaining, depression and acceptance. Second, the theories explored each followed a similar structure to that of Lewin's model of three overarching stages; breaking away from the current stable state, moving through a period of instability, before forming a new stable state. Third, these three stages of transition form a curve-like shape with a 'dip' during the acute or instable phase of the transition. Finally, the effects of transition are not usually permanent, as such periods are by their very nature transient. Below I will explore my findings in light of these four conclusions, particularly focusing on: a) the psychological states experienced and b) the process of transition.

a) The psychological states experienced

An exploration of the coping strategies used by staff during transition helps elucidate the different psychological states experienced by staff. Rather than focusing on the findings from one particular chapter or theme, examples of coping strategies occurred in all three of the different areas of well-being (covered in Chapters Five, Six and Seven respectively). These findings are particularly relevant because coping strategies have been noted as an important factor in staff adjustment to change (Jimmieson et al., 2004). Although no direct comparisons can be drawn between the

states observed in this study and the transition theories explored in Chapter Two, there are some interesting similarities.

Coping mechanisms enable staff to buffer any deleterious effects of the transition they may be experiencing. Indeed, coping strategies are considered as a means of circumventing or avoiding stressful events (Parkes, 1990). Literature that considers coping strategies often focuses on the different types of strategy that individuals in stressful situations use, such as cognitive, avoidance or active coping, and it was clear that a variety of strategies was indeed adopted at both Arunwick and Felwater Hospital Trusts.

One cognitive-based coping strategy that emerged was 'hardening', as shown in Chapter Six, which occurred mostly at Felwater Hospital. Staff are 'hardened' to situations when they become experienced in specific aspects of their work and as a result less reactive to its more unpleasant parts (Hunter, 2004, Rayment, 2011). Such strategies are similar to the early phases of the bereavement transition models such as denial (Kubler-Ross, 1969). By adopting this cognitive type of coping strategy staff are disengaging themselves from or rejecting those elements that may be causing harm in order to preserve their sense of well-being.

Cognitive coping strategies such as hardening can be likened to surface acting where we 'deceive others about how we are really feeling without deceiving ourselves' (Hochschild, 1983, p. 33), essentially faking a display of emotion. However, it is likely that more persistent requirements of staff to toughen up or

'harden' to aspects of their work would result in deep acting, where actual modification of inner emotions occurs (Hochschild, 1983).

Other members of staff used so-called 'avoidance' coping strategies, where the stressor is evaded to manage the effects of the transition (Holahan et al., 2005, Tan, 2005). Some staff used avoidance strategies to stay away from work with which they were unhappy, while others used such strategies to avoid particular social groups (see Chapter Seven). Avoidance coping strategies also link with the transition stages of denial (discussed above) and with defensive retreat (see for example, Adams et al., 1976, Fink, 1967, Kubler-Ross, 1969). These particular stages work in a protective manner to reduce the impact of the uncomfortable circumstances in which individuals may find themselves or by reducing the time that staff are exposed to the circumstances. However, the nature of hospital work itself means that avoidance-style coping strategies are uncommon. This is because a large portion of the work carried out is essential and so cannot be avoided. Thus, the degree of control that staff have over their choice of coping strategies may be limited.

Other coping strategies were more proactive, such as staff actively seeking out experts to help with their work (shown in Chapter Seven). Such active coping strategies are relevant to transition states such as Fink's adaption and Adams testing phase (Adams et al., 1976, Fink, 1967). These particular states come later on in the transition models when individuals, in this case staff, are adjusting to the new post-transition (stable) conditions. Proactive coping suggests a level of acceptance, that staff are adapting and that they therefore recognise this is the 'way things are now'. Staff then test the ways in which they can use the resources available to them to

become better accustomed to their new circumstances. Thus, some nurses adopted the kinds of active coping strategies that Tan (2005) found to be positively linked to well-being.

The above discussion demonstrates that some parallels can be drawn between psychological states set out in transition theories, and the behaviour I observed in staff responding to organisational transition. Links appeared stronger in the early and mid-stages of the different individual transition theories. Yet despite these similarities, the different stages observed do not directly link with those described in existing theories beyond the three broad stages set out in Lewin's (1951) model (see below). This observation highlights that any specific states passed through during a transition are likely to be unique in some way to that particular setting. This consideration further supports the need to consider transitions *in situ*, as this work did, to absorb the specific nuances of the setting.

b) Process of transition

It is also important to consider the process of transition as a whole, taking a step back away from the detail (for example, the individual psychological states) to consider in what ways the transition followed the 'change curve' characterised by transition theories. The findings on team dynamics explored in Chapter Seven are particularly informative in considering this pattern of change.

The transition brought about changes to the team members themselves, and also to the team dynamic. This change was an area of concern for staff. The dynamics of the ward team are important because the team establishes the social norms on the

ward, and through this process those behaviours thought to be both comfortable and accepted by staff emerge (Aveling et al., 2012a, Swedburg, 2003). The centrality of the social norm-setting role of the group meant that changes to team membership were worrying for staff.

Prior to the transition the teams were in an established stable state; however, this stability was disturbed when the new ward teams joined. As a means of dealing with this change, staff could be seen to retreat towards those patterns with which they were more familiar. An example included asking colleagues from their previous teams for help, rather than engaging with new colleagues. This can be considered as the 'dip' in the change curve or the acute phase of transition. However, over the weeks that followed, the teams at both trusts gradually came together to form a new stable state. Signs of this new stable team at Felwater Hospital came when a merger with another ward was threatened and the staff group acted defensively to protect their newly formed team. At Arunwick Hospital the new team stability was symbolised by the joviality and humour the larger staff group eventually began to share (rather than remaining in factions). Through this use of humour it appeared that boundaries had been negotiated, that staff had established their own new set of social norms, and that what was acceptable and comfortable had now emerged. This pattern regarding the changes to team dynamics reflects the change curve, supporting both Lewin's (1951) model and the general shape of the other transition theories explored in Chapter Two.

However, taken together the different findings from this study extend our existing knowledge by suggesting that there are two possible ways in which a stable state is

achieved. First, it was observed that the lack of job-related technical information had an acute phase just after the wards had relocated. This dissipated once staff became used to their new working lives and what was involved. Here, by a process of adjustment, staff moved through a transition period to a stable state. However, other parts of the transition that had brought about distress in staff, such as the late arrival of information or a lack of consultation about change were spoken of as continually causing distress. In such situations the use of hardening (as discussed earlier) is a potential coping strategy for staff. Here staff form a stable state by internalising those effects of the transition over which they have less control. Ultimately, both methods follow Lewin's (1951) transition curve; however, the latter may have more negative consequences for the employees by, for example, forcing them to engage with the types of deep acting discussed earlier in this chapter (Hochschild, 1983).

To conclude, the above discussion has two wider implications for the longitudinal effects of transition. First, the changes brought about by transition are unlikely, on their own, to alter fundamentally the culture or ingrained practices of the wider organisation; indeed organisations are often impervious to change (Weick and Sutcliffe, 2012). This feature was demonstrated in the data regarding workplace activities (specifically the presence of 'incorrect' patients shown in Chapter Six, as well as in this chapter), in that although transitions can be an opportunity for reinvention they may not be the panacea that staff had hoped for. Second, although the effects of change do not appear to last forever, the means by which the stable state is formed may determine the well-being of staff in the future. If staff are able to adjust gradually and accept their new working conditions, this may be less harmful than staff needing to harden to the reality of their work.

PART THREE: METHODOLOGICAL REFLECTIONS

While ethnographic approaches have been used with fruitful results to study well-being in other settings (Adelson, 2000, Calestani, 2009, Camfield et al., 2009), and also to investigate change (Wilson, 2000), there are not any published studies, to my knowledge, that have considered the two together. Here, an ethnographic approach has been successfully used to gain an *in situ* understanding of a complex psycho-social state during a complex change process, and in doing so has produced knowledge that is practical and applicable in nature. While the methodology chapter (Chapter Three) focused on building a rationale for the methods I adopted, this section will explain how these were advantageous to the project. Indeed, adopting an ethnographic methodology had several benefits for this study.

My decision to choose ethnography for this project was motivated by the fit between the requirements of the research questions and the features of an ethnographic methodology. The focus of the research was on the staff; i.e. *how* staff experienced the transition, *why* staff experienced the transition in this way and what roles the *context* played in shaping this experience. The use of thick description enabled me first to describe and then analyse the staff experience. Thick descriptions made it possible for me to document a range of different emotional states considered by the literature to be reflections of well-being (see for example, Daniels, 2000). I also recorded those elements of the transition that had driven such responses and what it was about the context that was facilitating or limiting the presence of these mechanisms.

My time in the field also enabled me to observe a novel 'midstage' on the ward (discussed in Chapter Three), located somewhere, usually at the nurses' station, between the 'frontstage' patient bay and the 'backstage' staffroom (see for example, Goffman, 2010). The 'midstage' was important because it enabled me to observe how staff negotiated and used this space. It was also an effective space for recording immediate staff reactions to events. As I discuss in Chapter Three, the 'midstage' helped to triangulate the data by context, in other words, assess the content of the data to see if similarities existed between information collected from different parts of the ward.

My role within the field setting was a further privilege that the ethnographic technique afforded. Having this level of access to the different groups was essential for forming a picture of the transition from the perspective of staff. The role facilitated my engagement in informal conversations with staff. These were essential for an initial outsider to understand the idiosyncrasies of the ward. Such conversations helped me to build trusting relationships with the study participants. I also explored a range of other features of ward life through speaking with staff, such as the histories of the wards which enabled me to build a picture of why things were the way they were on the ward. I could also ask direct questions about what it was about events that distressed staff. All of these different elements were of central importance to me in forming an understanding of staff perspectives on what they felt influenced their well-being, and so were an essential part of this research.

There were a number of different methods I could have used to analyse the data beyond the basic thematic level of analysis. My selection of grounded theory centred

on its capacity to allow inductive consideration of the data. The open nature of inductive analysis enabled me to meet one of the central aims of the study, to privilege the subjectivity of staff. The balance of moving between description and analysis facilitated this project in two key ways. First, it enabled me to build a meaningful understanding of the wards and their practices, and through this develop a deep understanding of staff well-being. Secondly, I found that the description and analysis worked harmoniously together and helped to scaffold my experience in the field. The technique brought structure and sequence to the analysis process and avoided what could have developed into, as the volume of fieldnotes grew, a 'messy' or unmanageable data set.

Although there are many advantages of an ethnographic approach, as with any research methodology there are also limitations. The central limitation attributed to ethnographic work is the lack of generalisability of the study findings (see Chapters Two and Three). There are particular types of generalisation that this study cannot claim, such as statistical or analytic generalisation, yet there is one particular type, known as reader generalisability or transferability that does apply (see for example, Firestone, 1993, Polit and Beck, 2010). Transferability is the extent to which findings are transferable to a different setting (Horsburgh, 2003). In light of the current focus on evidence-based practice (particularly within the NHS), demonstrating generalisability for qualitative studies is becoming increasingly important (Polit and Beck, 2010). This is because studies need to be able to help inform decision makers (Groleau et al., 2009) and be considered as if they would be used in practice (Thorne and Darbyshire, 2005). Polit and Beck (2010) suggest a number of different

strategies for enhancing the transferability claims of a research project, two of which (thick description and to 'know thy data') were used in the current project (p. 1456).

The purpose of thick description (see also Chapter Two) is to provide readers with enough information so that they may understand both the participants and the context of the study (Polit and Beck, 2010). Care was taken to construct such a thick description from a number of different angles. For example, the demographic information of the participants was recorded (age, nationality, gender, job role, see Appendix 5, 6 and Chapter Four) alongside a detailed account of what life was like on the ward. The description also included details on the background to the transitions, the location of the hospital trusts, the populations they serve, the staff survey results at each trust, the physical layouts of the ward and the general ward routine. The time frame of the study was also noted to locate the study historically. In addition, a sense of the political backdrop for the transitions was described in Chapter Four to give a sense of the circumstances that led up to the transition. This type of thick description draws on a number of dimensions to provide a fuller picture of the circumstances of the study. This approach should enable the reader to engage with a more complete range of elements that may be relevant (i.e. transferable) into their own settings.

Conducting this sort of thick description, where a number of different sources are drawn upon, is important. Consideration should be given to the range of sources a researcher can draw upon (over and above the direct focus of the research) to develop this type of writing. Such contemplation is a helpful way to start forming a detailed picture of the circumstances in which the study was carried out. It may also

help to set a precedent since, as is pointed out by Polit and Beck (2010), many qualitative studies do not include even basic information on the demographics of participants. However, as the onus for determining levels of transferability can predominantly fall upon the reader (rather than the researcher) it will be difficult to ascertain how useful this detailed information has been in practice.

'Know thy data' is a further strategy for enhancing the transferability of data (Polit and Beck, 2010, p. 1456). What Polit and Beck (2010) mean by this is the extent to which the researcher is immersed in the data. The analysis conducted for this project was thorough and involved several different phases (described in detail in Chapter Three). In total I spent 18 months working with my data before the analysis was complete. Although this process can be arduous, by the end there was no doubt I was thoroughly conversant with the data, as its many features had become almost recitable. This is important because as Polit and Beck (2010) point out being immersed in ones data is required for the thick description transferability requires. This indicates the interconnected (essentially hermeneutic) nature of producing a generalisable study, in that many elements work together. This notion also hints at the planning that needs to be done in advance of entering the field, so that these enhancers of generalisability can be adopted, met, or used in the process of the research.

For the study I selected a definition of well-being that included both affective and contextual components (see Chapter Two). This definition was operationalised in the same way as affective well-being by using axes of affective experience, such as the depression–pleasure axis (van Horn et al., 2004). These were used as my guides to

identifying well-being in the field. This operationalisation was effective as it was open enough for me to include a wide range of affective states in my observations but also gave me something that could be accurately described as a reflection of affective well-being. It also enabled me easily to identify those states that were negative (i.e. those pertaining to anger, boredom, depression, anxiety and tiredness) and those that were more positive reflections of well-being (placidity, enthusiasm, pleasure, comfort and vigour).

The above discussion considers the methodological features of this study and how they assisted in facilitating the aims of the project. To do this I detailed the fit between the aims of this research and the ethnographic approach, my role in the field and my approach to data analysis. Through careful planning of the research process I was also able to explore how transferability can be demonstrated in qualitative research. I will now move on to consider one final area to which this thesis contributes.

PART FOUR: POLICY CONTRIBUTIONS

It is through the implications for policy that the findings and recommendations from this study link into practice. Policies that are relevant to this study include those national strategies laid out by the QIPP Agenda, the Health and Well-being Improvement Framework, the NHS Constitution, the NHS Operating Framework, and the Boorman Review (Boorman, 2009, Department of Health, 2009b, Department of Health, 2011b, Department of Health, 2011a). However, before dealing with larger national-level policy implications, the regional and local policy implications will be explored.

a) Regional and local policy

I will explore the regional and local policy implications of this study by working outwards from the inner workings of the hospital, namely the DCSSUs themselves, before moving on to the wider regional implications.

It is planned that the findings from this thesis will be directly fed back to the particular units in which the study was conducted, as well as at the strategic level of the trusts themselves. This intention was included in the protocol for this study and meets the aims of the CLAHRC to work collaboratively in answering research questions that are useful to our partner trusts (see Chapter One). The feedback phase will provide the trusts with concrete recommendations regarding how to go about future transition programmes of this nature (see Table 8.2).

Table 8.2: A table to summarise the key evidence-based recommendations.

Chapter/theme	Evidence based recommendations
Information and communications during the transition	- Adopt a systematic approach to change-related communications. - The systematic approach should be participatory/consultative in nature –it should involve staff. - Ensure that change-related communications are appropriately scheduled, providing enough time for staff to act or assimilate information where necessary. - Ensure communications are transparent: open with clear dissemination structures. - Ensure the communications content is comprehensive and includes the information staff will need during as well as after the transition, practical as well as processual.
The nature of the transition	- Ensure that space is ample enough for staff to provide dignified care. - Ensure that ward space is connected, for example, that clean lines of sight exist between nursing staff and patients - Ensure that opportunities for reinvention are not missed. That stressors such as 'incorrect' patients are addressed as part of the transition. - Ensure that changes to work activity such as the pace of work are in line with staff values.
Impact of the transition on social structures	- Ensure internal and external support structures are in place for staff, particularly during the acute phase of change. - Ensure that losses in support from pre-existing teams are mitigated.

These recommendations also contribute to trust-level policy agendas, particularly regarding the commitments that the individual trusts have made to their staff, such as creating a 'fit for purpose workforce for today and tomorrow' as well as improving the trust as a place of work (Arunwick NHS Foundation Trust, 2011, p. 3, Felwater NHS Trust, 2011). These statements exemplify intentions to continue looking to make improvements for the future. With the general acknowledgement that the NHS continues to go through a period of change, the recommendations above provide information that may help trusts to manage transition successfully in terms of meeting the needs of staff well-being.

The NHS agenda to modernise its building stock and the plan for hospitals to move some of their services to other sites, means that findings regarding the nature of transitions are especially relevant. Such findings are important because different ways of working, and working at different sites, may increasingly become a reality for employees in the NHS.

b) National policy

As staff well-being is so closely linked to both organisational and patient quality outcomes (Boorman, 2009) the findings from this research also link into the Quality, Innovation, Productivity and Prevention (QIPP) national agenda (Department of Health, 2011b). This agenda focuses on quality improvement and efficiency savings. The findings reported here fit within all dimensions of this strategy and have the potential for maintaining levels of quality through improved staff health, providing innovative ways of managing staff well-being, ensuring productivity by reducing

levels of absenteeism owing to sickness, and preventing errors by training staff adequately before they move to new roles.

The findings presented here also have implications for other service-wide policies, particularly those set out in the recent NHS Operating Framework (Department of Health, 2011b). These guidelines set out the targets and strategy relating to all areas of the service. The framework cites supporting the workforce throughout periods of transition as key, and recognises that the NHS workforce is its 'most vital resource' (Department of Health, 2011b, p. 32). In view of this, similarly to The Boorman Review (2009), the framework states that ensuring staff health and well-being during service reforms is key to delivering good patient quality outcomes. Findings from this study could inform the policy agenda laid out by the NHS Constitution to provide 'support and opportunities for staff to maintain their health, well-being and safety' (Department of Health, 2009b, p. 94). Staff could be made aware of issues (mechanisms) that may threaten their well-being during change and information could be provided on more positive ways of coping. Such action is particularly relevant because, as the NHS Health and Well-being framework recognises, 'in many organisations, staff still report poor experiences' (Department of Health, 2011a, p. 5).

PART FIVE: LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

In addition to the above discussion on generalisability, there are other potential limitations in this study that need to be explored. Many of these limitations drive important future research directions. The limitations I discuss below regard the following: a) the focus on the negative effects of transition on well-being, b) the

exclusive focus on the staff experience and c) the dangers of over-identifying with the group under study.

The focus of this study is directed towards the negative aspects of staff well-being during transition. However, this focus emerged inductively, since it was the negative effects that dominated the study context. Few positive or well-being enhancing effects (to do with the transition) were either referred to by staff or observed by myself. However, it should not be assumed that change must, without exception, have negative effects, and in fact studies have shown that positive outcomes can emerge (Loretto et al., 2010). In the future, case studies should be sought that have the potential to show the well-being enhancing effects of transition. However, the lack of more positive perspectives may be a function of the data being collected as the transition unfolded. If data were to be collected in a follow-up phase longer-term gains may, by that point, have been realised.

Although the aim of this project was to focus on the staff experience of well-being, the exclusive focus on the nursing team has some limitations. Specifically, whilst producing rich and useful data, the tight focus limits the scope of the work in terms of building a broader understanding of organisational transition. Other perspectives such as senior management, doctors, divisional directors, chief executives and services users could be examined to provide a more holistic view of well-being during a transition process.

There is also a danger with research that focuses on the staff perspective, of 'going native' or over-identifying with the group under study (for a discussion on this issue

see for example, Taylor, 2011). Over-identification is problematic as it can result in a failure to offer a full challenge to or critique of group perspectives. The researcher becomes so immersed in reporting the perspective of the participants that his or her view as an analyst and interpreter of the data becomes submerged (Hammersley and Atkinson, 2007). I adopted two key strategies to prevent this lack of detachment in my own study, beginning first with keeping a research journal. My journal was a set of notes kept alongside my fieldnotes (as described in Chapter Three), and clearly demarcated with my initials "RY". By marking these notes with RY they became my space to explore ideas rather than the descriptive space of the fieldnotes. My journal enabled me to keep my analytic distance as I used this section to analyse and interpret the data as an informed outsider. Secondly, I am not a nurse and aside from the time spent collecting the data for this study my experience with hospitals is very limited. Ultimately this professional distance, with myself as the researcher and my participants as the researched, again enabled me to keep my analytic detachment. A study of multiple perspectives (as discussed above) may also help to avoid over-identifying with participants by preventing one group from becoming the sole focus of the work.

CONCLUDING REMARKS

Empirically, this study showed that the mechanisms which brought about effects on staff occurred in relation to communications during the transition, the nature of the transition and the ways in which the transition affected the social structures of the ward. Despite their apparent differences, similar mechanisms were found to be relevant in driving the effects of transition on staff well-being at both case study trusts. For example, social support structures, the fast-paced nature of work and

disconnected ward spaces were relevant to well-being at both trusts. In addition, it was also interesting to show that, for some mechanisms (for example, change-related information), the presence of information in Arunwick Hospital maintained well-being yet the absence in Felwater Hospital had a negative effect on well-being. As well as identifying some novel mechanisms, the empirical findings brought added nuance regarding, for example, the subsidiary effects of particular mechanisms and the ways in which staff adapted to such mechanisms.

Theoretically, the findings support Lewin's (1951) broad three-stage model of transition, moving from a stable state through a unstable state before a new stable state is formed. From observing these different stages of the transition this work has shown that there may be different ways in which a stable state is reached, for example, by adapting or by becoming hardened to the effects of change. Consideration of my findings also suggests that transitions can be experienced in different ways, that may be unique to a particular set of circumstances.

Methodologically, going through and observing the transition process with staff has provided substantive new insights regarding the overarching mechanisms at play when staff well-being was both interrupted and maintained. It is by watching these instances day-by-day and seeing and interpreting the experience of staff that I could make what was previously 'taken-for-granted' visible. Understanding from 'within' works to reduce the abstraction that can occur between practice and research when using other methodologies. In this way, claims can be more readily applied to practice because privilege has been given to what actually happens, and how things actually work in the organisations concerned. This factor makes the findings from

this research more applicable to practice settings, an essential component of conducting applied research in complex health care settings.

An additional major strength of this work is the relevance it has for policy at the local, regional and national levels. This is important as informing policy with fresh new evidence about staff well-being during transition may ensure its place remains in such agendas. If practitioners are provided with information about the areas to focus on during change, ward staff should be better able to maintain their levels of well-being. This approach could mean that staff face future transitions that are more systematically communicated, aligned more closely with staff values and with stronger support structures in place.

APPENDIX 1: LITERATURE REVIEW METHODOLOGY

DATABASE GROUPS	PAPERS GROUP A	PAPERS GROUP B	COMBINED	INITIAL SIFT
1. Business source premier	10,276	7,942	28	16
2. Psycharticles 3. Embase 4. HMIC 5. Medline 6. Psycinfo	36,455	54,941	126	21
7. Web of science	40,428	20,882	102	24
8. Soc abs, 9. Soc servs abs 10. Proquest dissertation and theses 11. IBSS 12. Brit nursing index 13. ASSIA 14. ABI/inform trade ind 15. ABI/inform global	62,651	18,496	130	42
TOTAL	149,810	102,261	386	103

Development and application of the search strategy

a. Search question/aim

This literature search sought to identify what is known about the relationship between well-being and organisational change. This search formed the basis of the literature review and enabled the inclusion of several other papers reached serendipitously through the reading/reviewing process.

b. Search specifics (below is an explanation of the above table)

- Literature searches were conducted using the search terms listed above. Boolean and wildcard symbols were used to pick up, for example, the UK/US spelling differences.
- The search terms were developed through pilot and synonym searches.
- Database groups: 15 databases were searched in total. Where possible groups of databases were searched together (the database groups are noted above). The common abbreviations for the databases are used above.
- Group A search terms: Well-being, wellbeing, well being
- Group B search terms: Organisational change, organisational transition, organisational relocation, organisational reform, quality improvement, health service redesign, service redesign, service improvement
- Combined: Group A and Group B search results were combined to include only those papers that included any group A and any group B terms together.

c. Inclusion/exclusion criteria

Papers were sifted on the following criteria
- Relevance to the above aim: papers were included that investigated the relationship between well-being (in what ever way the authors conceptualised/operationalised the term) and organisational change (in whatever form this took e.g. organisational reform or reorganisation, etc.).
- Papers were included that investigated mediating, moderating or driving factor(s) in the relationship between well-being and organisational change (such as the role of uncertainty).
- Papers were included that specifically considered well-being and explicitly operationalised this term in someway. Well-being was searched for specifically as it is a vast subject area. This strategy was used to: a) manage the number of returned studies and also to b) obtain information on how well-being specifically was being measured/assessed in the literature.
- Papers were excluded from the final selection if they did not meet the above inclusion criteria, because they were conceptual or where organisational change was being studied as an intervention.

APPENDIX 2: KEY TO FIELD NOTES

SIGN	CONVENTION	USE
"…"	Double quotation marks	Verbatim quotes
'…'	Single quotation marks	Paraphrases
(…)	Parenthesis (brackets)	Contextual information
{…}	Definite brackets	Researcher's interpretation
[…]	Squared brackets	Notes added for clarity
-1 / +1	Plus / minus symbols	Number of weeks before / after the redesign

ADDITIONAL NOTES

1. All field notes presented in the thesis have been copy edited to amend any grammatical, spelling errors or other errors from the original notes. The notes have additionally been edited to improve clarity. Meanings or otherwise have not been altered in any way as a result of this process.
2. For confidentiality reasons any potentially identifiable incidental participants have been removed. Where difficult to remove for sense-making purposes incidental participants have been anonymised to a generic title, for example, 'member of staff'.
3. All names used are anonymised synonyms within the text.
4. Where applicable short hand, especially brief or bullet pointed notes have been made into full sentences/paragraphs for ease of reading.
5. Some of the researcher's interpretation notes are with the data extracts marked with {…}, others are expanded upon in the explanation that follows or the preamble to the data extract. It is made clear where this is the case. Reminders for the researcher have been removed.
6. Detail such as ward names have also been anonymised along with any other material that may break the confidentiality of the sites and participants.

CONSENT FORM

Title of study: The effect of health service redesign on NHS staff well-being

Name of Researcher: Rowena Yeats

Please initial box

I confirm that I have read and understand the participant information sheet
dated 02/08/10 for the above study and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to
withdraw at any time, without giving any reason, without my legal rights being affected.

☐

I agree to take part in the above study.

☐

I confirm that I give permission to use direct quotations

☐

Name of participant	Signature	Date

Rowena Yeats

Researcher	Signature	Date

1 for participant; 1 for researcher

APPENDIX 4

School of Health and
Population Sciences
University of Birmingham
Birmingham
B15 2TT
Tel

Participant Information Sheet

Study title: The effect of health service redesign on NHS staff well-being

You are being invited to take part in a study on NHS staff well-being. This Information Sheet is provided to explain why this research is taking place and what it will involve, in order to help you decide if you want to participate. Please take time to read the following information carefully and to discuss it with others if you wish. Ask the researcher (Shapiro et al.) if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

What is the purpose of the study?
This study comes under the aegis of a larger service evaluation programme entitled '*Collaborations for Leadership in Applied Health Research and Care (CLAHRC) research Theme 1: From structure to function; health service redesign'*. This larger evaluation project funded by the National Institute for Health Research (NIHR), is comparing the drivers, processes and outcomes of service redesign in [LOCAL REGION NAME REMOVED]. The evaluation programme is looking at several dimensions of change including clinical, organisational and cultural factors. The purpose of this particular part of the evaluation is to capture and compare the effect of health service redesign on NHS employees. Specifically the study aims to:

• Identify the factors that affect staff well-being during health service redesign.
• Explore *how* these factors affect staff well-being during health service redesign.
• Compare the extent to which these factors emerge between three different hospital case studies.

What will happen to me if I take part?
We wish to observe the day-to-day working experience of staff on this unit/ward in order to document what factors affect staff well-being during the relocation of the ward/unit. The researcher may also chat informally to members of staff from time to time to discuss their well-being or ask for clarification regarding events the researcher has observed. The researcher may also undertake some short face-to-face interviews. These interviews will only take place with the interviewees' permission.

Do I have to take part?
It is entirely up to you to decide whether or not to take part. However, if you decide you would not like to be observed please let the researcher know and they will ensure that your contribution to events is not recorded. If you are invited to be interviewed your consent will be obtained before the interview. You will be given a copy of the consent form to keep. If you decide to take part in any aspect of this study you are still free to withdraw at any time and without giving a reason.

Will my taking part in this study be kept confidential?

The observation and, where applicable, interview data will be kept completely confidential and reported anonymously. Any direct quotation will be attributed to general job title only (e.g. "Clinician A"), however, it may not be possible to totally anonymise quotations as we cannot categorically rule out that readers of the report will be able to attribute quotations to the person(s) involved. If you prefer not to have your words quoted directly in any project reports, please confirm this on the consent form.

Observations will be recorded by the researcher taking notes. Any interviews will be recorded and transcribed. The digital recordings will be securely stored until the end of the study in August 2011, when they will be deleted. In line with the University of Birmingham's Code of Conduct for Research, the interview transcripts and written observation notes will be preserved and accessible for ten years after publication of the study's findings. The transcripts and observation notes will not identify the interviewees by name.

What will happen to the results of the staff well-being study?
Primarily the results of this study will contribute to a doctoral (PhD) thesis. Additionally the findings will be actively circulated amongst policy, managerial and academic communities.

Who is organising and funding this study?
The CLAHRC project is being organised and sponsored by the University of Birmingham in collaboration with the participating Trusts. It is funded by the NIHR, with nominal contribution from each of the Trusts too.

What indemnity arrangements are in place?
This study is covered by the University of Birmingham's insurance policy for negligent harm. The study is not covered for non-negligent harm, as this is not included in the University of Birmingham's standard insurance policy.

How can I get further information?
This doctoral project is being supervised by Dr Jonathan Shapiro
and Dr Nicola Gale
. Please contact them or the researcher Rowena Yeats
if you have any questions or would like more information.

Thank you for your help.

APPENDIX 5: ANONYMISED NAMED PARTICIPANTS – FELWATER HOSPITAL

	Alias	Unit before relocation	Age	Ethnicity
1	Eve	Crawley	30s	White
2	Molly	Crawley	20s	White
3	Kavita	Crawley	20s	Indian/Asian
4	Sharda	Crawley	20s	Indian/Asian
5	Lily	Carson	50s	Black
6	Charlotte	Carson	20s	White
7	Daphne	Crawley	50s	White
8	Grace	Carson	40s	White
9	Cecilia	Crawley	50s	White
10	Layla	Carson	40s	White
11	Naveen	Carson	40s	Asian/Indian
12	Alison	Carson	40s	White
13	Baldeep	Carson	20s	Asian/Indian

APPENDIX 6: ANONYMISED NAMED PARTICIPANTS – ARUNWICK HOSPITAL

	Alias	Unit before relocation	Age	Ethnicity
1	Kate	Darcy	40s	White
2	Annabelle	Darcy	40s	White
3	Uma	Darcy	40s	Asian/Indian
4	Rosa	Darcy	30s	Filipino
5	Claudia	Darcy	40s	Filipino
6	Fiona	Darcy	20s	White
7	Faye	Darcy	40s	White
8	Laura	Darcy	30s	White
9	Isobel	Darcy	20s	White
10	Faith	Darcy	50s	White
11	Ella	Darcy	40s	White
12	Katie	Darcy	40s	White
13	Elsa	Darcy	20s	Black

APPENDIX 7: NRES SERVICE EVALUATION CONFIRMATION

29 June 2010 17:41

Your query was reviewed by our Queries Line Advisers.
Our leaflet "Defining Research", which explains how we differentiate research from other activities, is published at:

http://www.nres.npsa.nhs.uk/rec-community/guidance/#researchoraudit

Based on the information you provided, our advice is that the project is not considered to be research according to this guidance. Therefore it does not require ethical review by a NHS Research Ethics Committee.
This is deemed to be a Service Evaluation.
If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may be available from the clinical governance office.
Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee.
This response should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.
However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.
Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.
If you have received advice on the same or a similar matter from a different source (for example directly from a Research Ethics Committee (REC) or from an NHS R&D department), it would be helpful if you could share the initial query and response received if then seeking additional advice through the NRES Queries service.

However, if you have been asked to follow a particular course of action by a REC as part of a provisional or conditional opinion, then the REC requirements are mandatory to the opinion, unless specifically revised by that

REC. Should you wish to query the REC requirements, this should either be through contacting the REC direct or, alternatively, the relevant local operational manager.

Regards

Queries Line
National Research Ethics Service
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

The NRES Queries Line is an email based service that provides advice from NRES senior management including operations managers based in our regional offices throughout England. Providing your query in an email helps us to quickly direct your enquiry to the most appropriate member of our team who can provide you with accurate written response. It also enables us to monitor the quality and timeliness of the advice given by NRES to ensure we can give you the best service possible, as well as use queries to continue to improve and to develop our processes.

Website: www.nres.npsa.nhs.uk
Email: queries@nres.npsa.nhs.uk

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