Time to care?

Report of an action research project to examine the feasibility of introducing the Samaritans’ volunteer support system in acute NHS hospital wards.

Research team

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Research Partners

The Samaritans
Introduction

This project was undertaken as an outcome of a Nursing ‘Think Tank’ and the HSMC Policy Paper Time to Care? Responding to concerns about poor care (Sawbridge and Hewison 2011), which identified that nursing is hard, emotional work. However it was also noted that this is often overlooked in current hospital management practice, and rarely discussed in these terms. Consequently, there are few systems in place which provide continuing support to enable nurses to manage the emotional labour of caring (Smith 1992) as part of their daily routine. The work of Menzies (1960) Aitken et al., (2000), McKee, (2010), and West and Dawson, (2011), amongst others, has established clear links between the well-being of staff and improved patient care. In response to this situation a number of approaches to the provision of staff support are being investigated, ‘Schwartz Center Rounds’ for example which have been reported to be of benefit to staff (Goodrich 2011). They take the form of facilitated multidisciplinary discussions about the impact a case has had on healthcare professionals, and provide space for group reflection and acknowledgement of the emotional elements of care (Goodrich 2011). However this approach may not be suitable for all organisations because it requires ‘time out’ from normal duties on a regular basis and additional resources for implementation.

In view of this the ‘Time to Care’ project was founded on a partnership with three acute trusts in the West Midlands with the aim of developing a system of staff support for nurses that was sensitive to the local context, could be integrated into everyday practice, and was controlled and managed by the nursing staff. The Samaritans organisation has developed a system of support for its volunteers that has been in operation for many years (see partners section), and the principles of this approach were to be adapted for introduction to the wards. Over the duration of the project the plan was to implement a support mechanism that was both practical and effective, in partnership with the ward teams. Co-production of research has been identified as essential to the sustainability of long-term change in health care organisations (Hewison et al 2012), and the project was designed on this basis. The intention was that the project would provide insights on how best to develop such a system which could then be tested in further research, involving a larger number of Trusts (see aim and objectives below).

Research Aim

To evaluate the impact of the introduction of a self-managed system of staff support in three NHS Acute Trusts.
Research Objectives

- To work in partnership with the nursing staff on two wards in three NHS Acute trusts to introduce a self-managed model of staff support.
- To evaluate the impact of the introduction of the model of emotional support on the participants’ levels of stress.
- To ascertain participants’ views on the effectiveness of the model of emotional support.
- To identify the factors that facilitate the introduction of an emotional support system.

The Report

This report collates a range of evidence and experience to inform an assessment of the success of the project. It is organised into the following sections:

Methodology and methods

Project plan

Project partners/sites

Process

Findings

Discussion

Conclusion

Methodology

An Action Research approach was taken because of its focus on understanding social situations in order to improve practice (Hart and Bond 1995). It has been used successfully in a wide range of settings from hospitals and health clinics to clubs, factories and schools (Bowling 2002). It has a long history and centres on addressing a key concern identified by its founder: If we cannot judge whether an action has led forward or backward, if we have no criteria for evaluating the relation between effort and achievement, there is nothing to prevent us from making the wrong conclusions (Lewin 1946). Action Research can be characterised as a process that is:

Emergent and takes shape as understanding increases of the problems being faced in everyday health care.
Iterative and converges towards a better understanding of practice and change, where the stock of knowledge is added to and built on in attempts to do more with limited resources.

Pragmatic, in terms of action and of research, relying on rational, reasonable, local information.

Participative because change is easier to achieve when those affected by the change are involved in each cycle as partners and owners of it.

Reflective with careful thought being given to evidence from other studies, whatever methodologies they used, and to the evidence from what is happening in reality.

Evidence based, building on formal research, other studies, and the evidence collated from the real world (adapted from Earl Slater 2002).

Action Research involves a combination of mixed methods to collect quantitative and qualitative data and modified data triangulation (Sim and Wright 2000) to accommodate multiple perspectives. In the context of this study the approach taken was to focus on the extent to which the introduction of a team managed system of staff support, based on the Samaritans’ support model (see Appendices 1 and 2) had an impact on staff stress levels and their feelings of being able to care. The design also incorporated data collection to learn more about the change process itself. Action Research incorporates a degree of flexibility that is necessary when investigating complex phenomena through the application of the multiple exploratory methods.

**Methods**

The specific methods used, guided by the action research framework were:

**1. Survey**

The survey instrument employed was the ASSET tool, a validated stress and well-being assessment questionnaire. It has been used extensively for large organisational surveys, as well as for smaller team based assessments. Originally focussed solely on work related stress, it has been developed into a broader, more rounded assessment of employee well-being and engagement. It retains its stress risk assessment capability, but also encompasses aspects of well-being such as sense of purpose, positive emotional experience and, increasingly, resilience (Johnson and Cooper 2003; Faragher et al 2004; Johnson et al 2005; Donald et al 2005; Jacobs et al 2007). Participants were invited to complete this survey, pre and post implementation of the staff support system.
2. Qualitative Interviews

Interviews with a range of staff involved in the setting were planned to examine their experience of the support system and their views on its implementation. Qualitative interviewing is very effective in health services research (King 1994), and has an established provenance as a research method for accessing the views of individuals in organisations (Seale 1998, Fontana and Frey 1994). The intention was to conduct 6 interviews (two in each trust) with nursing staff who had been involved in the support system. Other key participants were also to be invited to be interviewed to access their perspective on the intervention (the manager(s) who led the introduction of the intervention locally).

Ethics

The project was reviewed and approved by the University of Birmingham Research Ethics Committee. Confirmation was received from the NRES service that the project was classed as a Service Evaluation and did not require NHS Ethics approval.

Project Plan

The project had several phases:

- Organisational sign up
- Assess nurse stress levels- pre intervention.
- Provide training in staff support
- Co-design and implement the intervention
- Evaluation- interviews and review of nurses’ experience/views
- Post intervention survey of participants
- Production and dissemination of report.

Two ward teams in each organisation were to be selected by the Nurse Director (six wards in total) and the staff teams invited to participate.

Project Partners

Established in 1953 by founder Chad Varah the Samaritans organisation aims to help anyone with nowhere else to turn and to stop the isolation and ignorance that leads people to suicide. It
provided the first 24-hour helpline in the world and currently 20,665 volunteers answer a call, email or text every six seconds.

Samaritans’ vision is that fewer people die by suicide and work to achieve this vision by alleviating emotional distress and reducing the incidence of suicidal feelings and behaviours. This is underpinned by a statement of values (see appendix 1) and involves outreach activity in local communities, workplaces, hospitals, schools and prisons to support people.

In order to provide emotional support for its volunteers the Samaritans organisation has developed a system that helps ensure those taking calls/responding to emails/text messages, do not leave after a shift feeling anxious or distressed (see appendix 2). The central aim of the project was to examine the feasibility of adapting this system for application in a health care setting. This involved working with the other partners-the ward teams in three NHS Acute Trusts.

There were two intervention wards identified at each site, and in view of the small number of staff involved, the names of the sites are not included in order to maintain the anonymity of the participants.

**Process**

Meetings were held with Senior Nurses who had responsibility for the ward areas identified for involvement on each site. The Senior Nurses concerned were nominated by their Nurse Directors, who had participated in the Nursing Think Tank (see page 1 and Sawbridge and Hewison 2011) or agreed to be part of the project. The understanding of the project team was that these individuals would act as on site project leads- maintaining the momentum of the work, and motivating the ward teams involved by problem-solving (organising staffing cover, funded from the project budget, so that the teams could attend the necessary training); providing support for the Ward managers, and providing a link between the trusts and the university team. At an early stage it became clear that the senior nurses were not fulfilling this role, as anticipated by the researchers. This occurred as a result of a number of factors. Some of the managers were not aware this was expected of them; in two sites the responsibility for the project facilitation was transferred to other managers part-way through the project who had not been involved in the early discussions/planning of the project so were again unclear about their role; and it is not apparent that a handover was provided which hampered continuity in managing the work. Further meetings were held with these project leads (the terminology used by the project team) in an attempt to clarify matters, however problems persisted with regard to them acting as local facilitators. Whilst they were generally helpful and willing, they served largely as a contact point rather than an active team member for the project. It may well be that this mismatch of expectations could be avoided in future if more discussion time had been possible, (the busy environment meant this was often a limiting factor) and the role was fully clarified, and agreed by both parties, via a written communication.

A number of briefing meetings were held with the ward teams from the trusts to ensure that they were fully informed about the project and the commitment required. To help the Nurse Directors secure organisational ‘sign up’, a short report was provided for consideration by the Trusts’ Quality Boards/Committees.
One full day of training was provided for each ward team member who agreed to participate. This was co-facilitated by members of local Samaritans branches located close to the trusts, and the two staff from the University of Birmingham. The training gave the ward teams in attendance the opportunity to practise listening, summarising and reflecting skills, and to consider their own emotional needs with regard to care. Much of the training was structured around the ‘listening wheel’ (Appendix 3) and involved a range of practical activities centred on listening and expressing feelings. This proved to be challenging for some of the participants as they reported much of their communication on a day-to-day basis was focussed on extracting information from patients and colleagues in order to address and solve a series of problems. Active listening and the discussion of feelings were less common in practice. The emotional support model used by the Samaritans is reliant on staff having these skills so this training was an essential part of the project plan. Those attending the training indicated in discussion, and their evaluations, that the time spent developing these skills was valuable. The final part of the day was devoted to agreeing action plans for next steps to develop ward based support systems.

The training days were evaluated positively by the participants (see Appendix 4 for examples of evaluations) and were both energetic and energising.

Originally two wards on each of the three sites agreed to participate, however both wards on one site withdrew shortly after the training sessions had been delivered. The explanation given for withdrawal is detailed in Appendix five, however in essence the ward staff did not feel there was a need for them to develop additional support systems for each other, as it was believed they were already providing support through the Sister’s open access policy, and their regular ward meetings. On one site, one ward did not commence the project despite the ward manager expressing a willingness to be involved during preparatory meetings.

The overall conduct of the project was managed by a Steering group (see Appendix 6 for membership) which met on three occasions during the course of the project.

**Findings**

Of the 58 team members from the three trusts who participated in the Time to Care project, 51 completed the pre-intervention stress questionnaire (see Appendix 7 for the report).

In comparison to the general working population the nurses who completed the ASSET well-being questionnaire pre-intervention (N=51) showed higher than typical levels of concern regarding their workload and job conditions, and also to some extent with relationships at work. Their expressed commitment to the organisation was substantially higher than the level of commitment they felt they received from the organisation – indicating they believed they were giving a lot more than they were getting back. On the other scales in the questionnaire the sample was typical of the general working population.

There was insufficient questionnaire data following the intervention (N=2) to evaluate impact. The project plan had been to interview three staff in each of the participating trusts, however whilst staff expressed a willingness, in the event only two staff were able to participate in a telephone interview,
and two provided some brief email comments in response to the interview questions. Of those interviewed one was a nurse director and the other was a ward manager. In view of this the information provided by these participants will be considered in the discussion section below rather than here in the findings section. The discussion draws together the lessons learned, suggestions for how work of this nature can be taken forward, and next steps with regard to the Time to Care project.

**Discussion**

The original intent for this project, of working in partnership with ward teams to adapt the Samaritans’ model of staff support to the needs of staff in the NHS, proved to be difficult to achieve. Although great efforts were made by the project team to ensure that only those ward staff groups who were willing to participate were approached, and the need for senior staff involvement and support was identified, it was not possible to conduct the study in accordance with the plan. Indeed the lack of data means no definitive conclusions concerning the feasibility of adapting the Samaritans’ model for use in the NHS can be presented. Whilst this is disappointing it demonstrates the challenges involved in addressing this area of practice, and by using an Action Research methodology, lessons learned from this can be built into the next iteration.

The key issues that emerged in the conduct of the work are summarised below. These have been drawn from a number of sources including: the two interviews and email correspondence mentioned earlier; the steering group meetings - where the experience of those involved in project was shared; discussion with staff teams at follow up ward meetings held to support the staff in the adaptation of the system; and informal discussions with a range of staff involved throughout the project.

**Changes**

A number of changes occurred as a result of the project. It was noted by those involved that staff were thinking about staff support and talking to each other about it. In this way the Project raised the profile of staff support as an important aspect of ward organisation. In one of the sites it was included as a standing agenda item for ward meetings. On this same ward the team had introduced a ‘take five’ period during the afternoons so that staff in pairs or groups of three are encouraged to go off the ward for 5-10 minutes to have a conversation about the emotional impact of the day’s work and to offer each other support. This development was in its early stages at the end of the project and was the outcome of sustained discussion during follow up ward meetings. However as noted earlier it is not possible to determine the impact of this because not enough staff completed the follow up questionnaires, despite three reminders, for any meaningful data analysis to be conducted. Similarly the lack of interview data means that definitive conclusions about the impact of the project cannot be presented.
Benefits

It is not possible to make categorical statements about any benefits accruing from the project for the reasons noted earlier, however the evaluations indicate that the communication skills training was enjoyed by all those who participated and was felt to be valuable. This was reinforced in several unsolicited comments during later visits to the wards where staff made a point of mentioning how helpful the training days had been. Similarly the opportunity for ward staff to meet and focus on team needs during the training days was welcomed and reported to be helpful by the teams involved.

Challenges

The main challenge can be summarised up in a comment made by a team member at a ward meeting ‘we don’t have time to care’. Staff reported that the workload pressures they were experiencing and low staffing levels meant they were unable to put any system into practice, because they were too busy. They recognised the need for support but did not have time to put it in place. This was exacerbated in one of the wards by the introduction of 12 hour shifts during the course of the project. Adjusting to new working patterns delayed progress considerably. In other areas staff changes contributed to a lack of progress. Indeed, even without these difficulties simply organising one training session took 12 months at one site because the ward team was busy and senior staff had difficulties providing ‘backfill’ nursing staff to enable the team to attend (funding for this was part of the project budget). The absence of active facilitation by senior managers on site was problematic and this contributed to a lack of momentum once the initial training sessions had been conducted.

Reflections

The researchers and the Samaritans spent a considerable amount of time on the wards, observing the environment and talking to staff. There were a number of confounding factors which added to the complexity of adapting this model to a ward environment. These were discussed further by the project team and are summarised below:

Protected space – It was difficult to find a room on the ward for staff to have space to have even a quick conversation with each other or the Samaritans, as part of the project development. The staff room, where one existed, was usually busy, as was the sister’s office. When talking to staff, the sluice was often the only room in which to have brief, uninterrupted conversations. This is in direct contrast to the environment necessary for Samaritans to provide their service, in which volunteers are provided with protected and appropriate space in which to care for each other.

Protected time – it proved impossible to secure sufficient time for staff to consider fully the implications of being part of the project. When the planned first meetings took place on the ward, it was difficult to hold uninterrupted discussions. In one 10 minute meeting, the matron was called
away 3 times. On one occasion, all training in the Trust was cancelled at short notice, because of staff shortages, although the Director of Nursing intervened to allow the project training to continue as planned. The ward meetings were not consistently held or well attended, again indicative of the time pressures, and workloads in the practice setting. If they were to meet patient care needs, staff had little or no opportunity to address their own needs for support in the context of a normal working day. Even the Steering group meetings proved difficult for the Nurse Directors to attend—despite their enthusiasm for this project, and a willingness to be involved. At the final steering group meeting no representatives from any of the NHS Trusts involved were able to attend because of the pressures referred to earlier.

The importance of Emotional Support – caring for each other in order for patients to be better cared for was recognised, however it was not approached purposefully. Staff maintained that they ‘did look out for each other’, although a number of accounts of very stressful events, with no support being offered at the time or later on were shared by staff. For example one nurse watched a distressing death, cleared up the blood, dealt with the relatives and left the ward without anyone asking her if she was all right. She described sitting in a bath with a glass of wine as an (ineffective) attempt to replenish her emotional resilience ready for her shift the next day.

Ability to make the changes – in the training sessions staff identified changes that could be made. One was to structure the beginning and end of shifts for a handover based on the Samaritans’ debriefing model. Part of the normal nursing handover where relevant patient information is passed on to the group of staff coming on duty, was to be set aside for staff to trial the debriefing model—i.e enabling staff to discuss—what issues have you faced today which have upset or disturbed you, and how do you feel now? However in the event, implementing even this seemingly minor change proved to be too difficult.

Conclusion

The policy (and moral) context for delivering compassionate services to patients is clear. The links between this important requirement and the need to purposefully support staff in their difficult role as emotional labourers is beginning to be better understood.

NHS England (http://www.england.nhs.uk/nursingvision/actions/area-6/) has identified supporting positive staff experience as its sixth action area to address in order to ensure the delivery of compassionate care. It is focused on nurses, midwives and care staff and ensuring they are supported in the emotional labour of caring. This means enabling staff involvement in decision making; promoting healthy and safe work environments; creating worthwhile and rewarding jobs; supporting each other; being accountable and being prepared to embrace innovative working and new technology. The Time to Care project has made a contribution to the debate about how to create a healthy and emotionally safe working environment, managed by ward teams. For the reasons noted above it has not been possible to collect the evidence needed to demonstrate the impact of this work, however the introduction of the 6Cs of care, compassion, competence, communication, courage and commitment (DH 2012), indicate that further action in this area is required. With this in mind some general recommendations are made based on the experience
accrued during the Time to Care project, which may be helpful for others seeking to work with ward teams to deliver more compassionate care. These lessons will be applied in future work undertaken by the researchers.

**Recommendations**

- Any initiatives to improve staff support and the provision of compassionate care need to be ‘owned’ by the organisation.
- There needs to be visible and sustained senior management support, commitment from and practical support for the ward leader, and willingness of the whole team.
- There is no single solution, approaches need to be developed for each team in context.
- Approaches such as this are only one element in bringing about cultural change and will not work in isolation.
- More research is needed in this area to develop an evidence base for effective interventions.

**Acknowledgements**

We would like to acknowledge the unstinting support of our colleagues from the Samaritans organisation. They are not identified in this report as the organisation maintains the anonymity of its volunteers, however the people we worked with from the Telford, Shrewsbury, Worcester and Hereford branches were helpful, enthusiastic and completely committed to the aims of the project.

**Funder**

We are grateful to the West Mercia Cluster Primary Care Trust for funding this project, particularly at a time of such upheaval during the transition from PCTs to CCGs.

**Staff**

It has been a pleasure to work with the ward teams who endeavoured to develop a more structured system of staff support. Their time and effort will not be wasted, and will be used to further this important area of research.
Appendix One

The Samaritans’ Statement of Values

The Values

We are committed to the following values:

**Listening**, because exploring feelings alleviates distress and helps people to reach a better understanding of their situation and the options open to them

**Confidentiality**, because if people feel safe, they are more likely to be open about their feelings

**People making their own decisions** wherever possible, because we believe that people have the right to find their own solution and telling people what to do takes responsibility away from them

**Being non-judgemental**, because we want people to be able to talk to us without fear of prejudice or rejection

**Human contact**, because giving people time, undivided attention and empathy meets a fundamental emotional need and reduces distress and despair.
Appendix Two

The Samaritans’ Support Model

Each volunteer undergoes a period of training prior to taking calls.

Each shift is between 3 – 5 hours, and the volunteers work in pairs.

The callers are often in highly distressed state, and the volunteers are actively encouraged to share the last call with their partner in the ‘down times’ in between calls.

If the volunteer needs longer to debrief, the telephones will be turned off to enable this to happen (it is rare that this action is required as most debriefs are possible in a few minutes). However it signifies the importance with which the organisation regards the emotional support of volunteers. It is recognised that if the volunteers are not cared for then they cannot care for the callers.

At the end of each shift, the volunteer “offloads” to the shift leader. This process involves the volunteer summarising the types of calls taken and their feelings about them.

The leader makes a judgement about the emotional health of the volunteer, and if they feel they were particularly affected, they will call them the next day to see how they are and offer support.
Appendix Three

Samaritans’ Listening Wheel

- Reacting
- Open questions
- Summarising
- Reflecting
- Clarifying
- Short words of encouragement
Appendix Four

**Time to Care Training Evaluation Forms**

We hope that you have found your course both helpful and enjoyable. Your feedback would be sincerely appreciated. Please circle the response which best represents your opinion. Below is a summary of the evaluations – July 13 – 7 participants

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<thead>
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<th>There was sufficient time set aside for each topic</th>
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**Comments / suggestions:**

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**Comments / suggestions:** Good scenarios

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<th>The Trainer explained topics clearly &amp; answered questions effectively</th>
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**Comments / suggestions:** both had very relevant experience and expertise

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**Comments / suggestions:** Just what our team needs to help us get better than we already are!

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<th>Most useful aspect of the training?</th>
<th>Communication wheel – reminder how to listen/question</th>
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<td>How important we are as staff/people</td>
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<td>Being able to discuss topics with each other and relate it to our everyday practice</td>
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<td>All aspects were useful</td>
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Revising what to say in different situations
To strengthen team and to improve communications
All of it was very useful and very interesting. I hope this will be something that becomes a permanent part of our shift
Fantastic information to help guide the group and aid us to make this challenge work

Please add any additional comments about the course you have attended.

Really hope enough time and effort is given to put ‘training’ and project into effect - to become a part of our way of working and not just an initiative
Excellent session. I’m looking forward to implementing it in the work place
Very useful - be able to take information away and put into practice
Thank you

Thank you for taking the time to complete this form.

**Time to Care Training Evaluation Forms**

We hope that you have found your course both helpful and enjoyable. Your feedback would be sincerely appreciated. Please circle the response which best represents your opinion.

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<td>Most useful aspect of the training?</td>
<td>Practical Scenarios.</td>
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<td>All training very informative and has given me the motivation to promote this on the ward from tomorrow!</td>
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<td>All of the ideas, topics and suggestions were very good; look forward to implementing them on the ward.</td>
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<td>The Listening Wheel (x7)</td>
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<td>Importance of open questions</td>
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<td>Awareness of support</td>
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<td>Self awareness</td>
<td>Many thanks for taking time out to be here with us.</td>
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<td>4WH and listening</td>
<td>A big thank you to you all.</td>
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<td>Improve my knowledge</td>
<td>I have enjoyed this training and have picked up good</td>
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<td>Being more aware of people’s problems</td>
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<td>An enjoyable day, lots of new skills to take away – thank</td>
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<td>Excellent / interesting project; very productive day – thank</td>
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<td>Very much enjoyed the day, very useful.</td>
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Please add any additional comments about the course you have attended.

Thank you for taking the time to complete this form.
**Appendix Five**

**Rationale for withdrawing from the project**

<table>
<thead>
<tr>
<th>Structural</th>
<th>The TTC methodology appeared to be difficult to apply on the Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Only three individuals agreed to be involved initially.</td>
</tr>
<tr>
<td></td>
<td>A further three joined after encouragement.</td>
</tr>
<tr>
<td></td>
<td>One has been absent through ill health</td>
</tr>
<tr>
<td></td>
<td>Applied at a time of intensive seasonal work pressures where staff were allocated to other areas within the hospital so difficult to apply.</td>
</tr>
<tr>
<td></td>
<td>Staff have reservations about the time needed to apply even brief interventions</td>
</tr>
<tr>
<td></td>
<td>Staff do not finish at same time or are on the same shift or stay on after shift has finished already. TTC was in these instances not a priority or feasible.</td>
</tr>
<tr>
<td></td>
<td>Alternative forms of support are used routinely</td>
</tr>
<tr>
<td></td>
<td>The ward sister however felt that there was generic peer support that staff found their own ways to reflect and de-escalate</td>
</tr>
<tr>
<td></td>
<td>A staff member who had agreed to be part of TTC detailed that the ward sister had an open door policy for staff and contact through a mobile and this was easier to use</td>
</tr>
<tr>
<td></td>
<td>The area supports regular ward meetings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theoretical</th>
<th>The burden of care/emotional labour of care identified as central to TTC was not the cause of frustration identified in the clinical area.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frustrations identified by staff in training related to non-patient care related concerns, (for example behaviours of non-nursing or managerial staff), that were consistently being applied at all times and for which resolution through TTC was inappropriate.</td>
</tr>
</tbody>
</table>
Appendix Six

Project Steering Group
(Samaritans and Nurse Directors are identified by role to maintain anonymity)

Members

Yvonne Sawbridge, HSMC, University of Birmingham
Alistair Hewison, School of health and Population Sciences, University of Birmingham
Director-Worcester Samaritans
Director and one volunteer, Shrewsbury Samaritans
Director and Trainer, Telford Samaritans
Director and one volunteer, Hereford Samaritans
Nurse Directors (3) of participating NHS Acute Trusts

(The group met on three occasions during the course of the project)
Time to Care Project

ASSET Survey Results Summary (N=51)

Gordon Tinline & Jack Evans

28th October 2013
Introduction

People perform most effectively in their roles when they have positive levels of psychological well-being and are managing their work pressures. Work pressures stem from different sources, including relationships with others, workload and perceived levels of control. Some degree of pressure at work is motivating and psychologically healthy. However, when pressure exceeds an individual’s ability to cope, it becomes stress and starts to affect work performance. The contents of this report will allow you to identify the key sources of pressure affecting your staff and focus your attention on the areas of highest risk.

Fig 1. ASSET model of Well-Being
Comparison (norm) group

In this summary report, the results from the survey have, where possible, been compared to the General Working Population (GWP) 2010.

Overall ASSET Results

Stem Score Format

The results are presented in two alternative forms; raw scores and sten scores. When comparing the data from the group to the norm group, a 1 to 10 (sten) score is produced for each ASSET measurement scale. For scores on the 6 Essentials, sten's 4,5 and 6 indicate that a response is typical of the comparison group. A more extreme score indicates that participants have responded in a way that is not typical of the comparison group: stens 1,2 and 3 are more positive (low risk) and stens 8,9, and 10 is less positive (high risk). Scores that correspond to sten 7 are approaching a level that would be considered high risk. The scores reported as stens are therefore not absolute scores, but an indication of how the results fair relative to the particular comparison group (see Fig. 2).

For the remaining scales, stens 5, 6 and 7 represent a score that is typical, however stens 1, 2 and 3 represent a less positive (high risk) score, sten 4 represents a score that is approaching a stress level that would be considered high risk, and stens 8, 9 and 10 represent a more positive score (see Fig. 3).

Fig 2. Sten reporting for the 6 Essentials (Higher scores more negative)

Fig 3. Sten reporting for the remaining ASSET scales (Higher scores more positive)
The table below shows the raw scores, standard deviation and sten scores for the 51 participants that we have data for from the Time to Care (T1) ASSET data collection.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Raw score</th>
<th>SD</th>
<th>Sten</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources and Communication</td>
<td>12.92</td>
<td>4.52</td>
<td>6</td>
</tr>
<tr>
<td>Control</td>
<td>13.51</td>
<td>4.64</td>
<td>6</td>
</tr>
<tr>
<td>Balanced Workload</td>
<td>26.82</td>
<td>5.66</td>
<td>8</td>
</tr>
<tr>
<td>Job Security and Change</td>
<td>14.63</td>
<td>4.36</td>
<td>5</td>
</tr>
<tr>
<td>Work Relationships</td>
<td>21.06</td>
<td>6.40</td>
<td>7</td>
</tr>
<tr>
<td>Job Conditions</td>
<td>27.45</td>
<td>5.15</td>
<td>10</td>
</tr>
<tr>
<td>Other Scales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of Purpose</td>
<td>18.37</td>
<td>3.50</td>
<td>7</td>
</tr>
<tr>
<td>Positive Psychological Well-Being</td>
<td>21.68</td>
<td>6.24</td>
<td>6</td>
</tr>
<tr>
<td>Engagement</td>
<td>22.02</td>
<td>4.45</td>
<td>5</td>
</tr>
<tr>
<td>Perceived Commitment of Employee to Organ</td>
<td>6.88</td>
<td>2.76</td>
<td>4</td>
</tr>
<tr>
<td>Commitment of Employee to Organization</td>
<td>9.16</td>
<td>2.16</td>
<td>7</td>
</tr>
</tbody>
</table>

In terms of the (6 Essentials) sources of pressure two areas appear more troubling to this group than is typical of the general working population: Job Conditions (sten 10); Balanced Workload (sten 8). Job Conditions is a fairly broad factor and includes physical working conditions and working climate, it correlates highly with established measures of job satisfaction. Balanced workload is fairly self-explanatory and this suggests that respondents were more troubled than most other people by their work demands and possibly work-life balance. It is also worth noting that there is a level of expressed strain in relationships at work that is slightly higher than is typical of the general working population (sten 7).

The other scales show that there was a generally positive sense of purpose in the respondent group (sten 7) as well as commitment to the organisation (sten 7). Note that the perceived level of commitment of the organisation to the employee was relatively weak (sten 4). This suggests that many in the group believed that they were giving a lot more than they were getting back and this can contribute to weaker engagement.

Other than the above the scores indicate responses that were typical of the general working population.
References


