

Resilience

A framework supporting hospice staff to flourish in stressful times



Acknowledgements

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About The Point of Care Foundation

Point of Care are an independent charity working to improve patients' experience of care and increase support for the staff who work with them. Their vision is radical improvement in the way we care and are cared for. They believe a truly patient-centred approach – focussed on listening, understanding and responding to the needs of the whole individual – is essential to the delivery of the best possible quality of care. Point of Care help to deliver this vision by providing evidence and resource to support health and care staff in the difficult work of caring for patients.

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Introduction

This piece of work was initiated by Hospice UK in response to the report issued by the Commission into the Future of Hospice Care in 2013. That report forecasted a future that would demand significant change on the part of hospices, which in turn would make further demands on their workforce – both staff and volunteers.

Hospice UK recognises that hospices need to support their workforce at a time of such profound change, and has sought the expertise of the Point of Care Foundation to help identify strategies that hospices may wish to adopt to support their workforce, so that they can continue to provide high quality care. The work we (The Point of Care Foundation) have undertaken comprises the following components which will be of interest to hospices:

- a review of the literature and other related evidence about work related stress and how it is best addressed by hospices
- a summary of the findings
- a framework describing interventions that hospice leaders may wish to implement
- a checklist for hospice boards and senior managers to assess the degree to which they recognise and respond to stress in their workforce.

We know from reported experience that healthcare staff experience high levels of stress and we wanted to find out whether hospice staff experience stress, what might cause it, and how to prevent it: are there effective things that can be done to support staff and mitigate stress?

This report is intended for hospice boards and chief executives but also anyone who has the responsibility of supervising, managing and leading groups of staff and volunteers, so that they can make informed and strategic decisions about how best to support their workforce.

We carried out literature reviews, which included academic and other studies, of the stress experienced by hospice staff and the measures that have been introduced to counter it, and we did a more selective review of the literature related to organisational change and ways of managing it.

Both these reviews (as well as our experience of running service improvement programmes with frontline healthcare staff, and talking to hospice chief executives) informed the framework and the checklist presented in this report.

Foreword – The Point of Care Foundation

Imagine you are a senior leader of a UK hospice, what keeps you awake at night? To all intents and purposes your organisation is in a great place. Your work commands tremendous public support. Your organisation, like other hospices, is most likely seen by outsiders as an exemplary place where ordinary people do extraordinary work. Extraordinary, because of the skill, goodness and virtue of the people who work for the hospice; and extraordinary in terms of achievements and reputation. In 2007, when we started the Point of Care programme (which was then an action and research programme at the King's Fund) we asked where we should look for examples of great patient experience and truly compassionate care. Almost always, people told us to look at palliative care and hospices.

If you are a leader it's probably a mix of current problems and future prospects that keeps you awake. Your income from voluntary and statutory sources is under pressure, and whilst NHS commissioners may be in awe of what you provide, they insist that 'gold standard' treatment for everyone is not affordable.

The demand for end of life care is high and rising, but it's also changing. As people live longer lives, the majority of people who need end of life care are old or very old. The majority suffer from more than one chronic condition. Many have adapted themselves to cope with a mix of chronic mental and physical ailments but have become increasingly frail, many are poor and socially isolated. The work of looking after them when they are dying is different from the care of patients with cancer and their families with which hospices are traditionally associated. It is more complex; it is more dispersed geographically because much of the care is needed in people's homes; it requires coordination with NHS services and with social care; and it demands new types of skill and skill mix.

Fundamentally, the quality of end of life care provided is dependent on the celebrated willingness of staff to go the extra mile for individual patients. Will you retain that quality if you increase the numbers of patients you look after? If the patients have more complex problems, and if they include patients with dementia? If you decide to change roles or dilute the skill mix? How willing are your staff to accept the need for change? Can you support them in their valuable work with patients and families when the organisation itself is under pressure?

In 2013, Hospice UK asked The Point of Care Foundation, widely known for its work on improving patient experience and support for staff, to examine the evidence on specific methods to support health professionals in their work with patients and report on it. Our definition of 'health professional' for these purposes was to be one that includes doctors, nurses and therapists, along with social workers, support staff, managers and volunteers. We already knew from other research that patient and staff experience are deeply connected, and that staff experience shapes patients' experience of care. What we did not know – and what the Commission into the Future of Hospice Care allowed us to explore – was the strength of the evidence for particular methods or tools for supporting staff, and whether some are more effective than others?

The report we have produced contains one surprising finding and one disappointment. The surprise is that contrary to the popular view that caring for dying patients is inherently stressful, we found that caring for dying patients in the environment of a hospice or palliative care team actually protects staff from some of the stress experienced by other health professionals. Healthcare staff in general suffer from high rates of stress and depression (as compared with the general population and other parts of the public sector) but hospice staff are on the whole less stressed than their NHS counterparts because the work itself has meaning and the environment is supportive.

The disappointment is that the published research evidence on methods and tools for staff support is not strong enough for us to be able to recommend to hospices that they adopt one practice or another. For hospice staff, as for their counterparts in the parts in the NHS, it is the quality of the management of everyday organisational life and the organisation's approach to managing change that are the causes of greatest stress, not the work with patients. It follows naturally that the greatest gains for hospices in relation to support for the workforce lie in strengthening the quality of personnel management in general, rather than relying on particular methods or tools to do the job.

The strength of the evidence in the review of the literature does not allow us to produce clear recommendations of the 'do this, don't do that' sort. There is not one true method we can recommend to hospices to support their workforce. What we have been able to do, however, is take the research findings and combine them with our experience at The Point of Care Foundation to produce a framework for senior managers and boards outlining the practical steps they can take to reduce the stress their staff experience, both as a result of organisational change and their work with patients. The test for the framework will be whether hospice leaders find it sufficiently useful to help them rest more peacefully at night.

There is increasing recognition today of the importance of supporting healthcare staff if we want patients and their families to experience kindness and empathy when they turn to formal services for help. Hospices have a record in patient care that is second to none, but the pressures on them to change are growing and demand is increasing. As they change and adapt to new conditions it will not be possible to protect the workforce from all types of stress, but the good news is that leaders can take action to create healthy, adaptable and flexible organisations in which staff can thrive.

We are grateful to Hospice UK for inviting us to work on this report and believe that it contains important messages for hospices and for the NHS.

Jocelyn Cornwell, Chief Executive, The Point of Care Foundation

Foreword – Hospice UK

This resource began its life at the, as it was then, Help the Hospices conference in 2013. Jocelyn Cornwell, from the Point of Care Foundation, led a masterclass on workforce resilience – at which participants from the hospice sector described a gap in their knowledge about how to most effectively support people working in hospice care, given the many challenges that they face.

They were keen to find ways of helping people in their organisations become more resilient – to be able ‘to respond to stress in a healthy adaptive way’ and not only [to be able to] ‘bounce back’ rapidly after challenges but also grow stronger in the process’.¹ This aspiration is not a new one in the world of hospice care. Dame Barbara Monroe and David Oliviere introduced the concept of ‘resilience’ in palliative care through the production of their edited volume in 2007², reframing aspects of palliative care by focusing on strengths and possibilities, rather than risks, problems and vulnerabilities.

With a similar lens, and together with Jocelyn and her team, we have been on a journey through the evidence and our experience to develop a framework which we hope that hospices will use to assess and build the resilience of their staff and volunteers.

This exploration has offered both of us new insights about how the hospice workforce can be supported in order that it can flourish, even in the face of the many challenges facing the sector.

This framework is designed to help hospices to improve the wellbeing of their staff and volunteers. It is evidence based – reflective of the literature and also the vast experience of the Point of Care Foundation – and makes some strong and clear recommendations to hospices about how to manage change, along with the inherent stresses of caring for dying people to get the best out of their workforce.

This is an important next step for hospices in taking forward the recommendations of the Commission and we encourage boards, senior managers and individuals to embrace and use the framework.

¹ Epstein and Krasner (2013)

² Monroe and Oliviere (2007)

Marie Cooper, Practice Development Lead, Hospice UK

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and formerly National Clinical Lead, Hospice UK**

Executive summary

Hospices are changing. They are under pressure to care for more people who are presenting with different, complex needs including chronic illness and dementia. They are also under pressure to be ever more efficient: inpatient lengths of stay are shorter with an increasing caseload in the community setting. As result, one of the most rewarding aspects of hospice life for staff – building relationships with individual patients – may be compromised. In many respects, the working life of hospice staff is becoming more like that of staff working in hospital.

In 2013, Hospice UK sought to respond to the findings of the Commission into the Future of Hospice Care by commissioning The Point of Care Foundation to examine research into the experience of hospice staff and volunteers and strategies to support them in their work. We know that caring for patients in hospices is difficult and emotionally challenging and that staff need support to cope with the associated stress. Staff wellbeing, ie the level of staff engagement with their organisation and the degree to which they experience themselves as stressed, matters. It affects the quality and safety of patient care and is key to ensuring patients receive good, compassionate care.

In all healthcare settings there are two different types of staff stress: the stress associated with caring for people who are ill, who are suffering and may be dying, and the stress associated with organisational life if staff feel disengaged or unsupported.

This report presents the evidence specifically related to hospices. The key findings are:

- Hospices do differ from other health organisations but have a number of things in common: staff can exhibit high levels of personal stress and low morale, and consequently staff engagement tends to be poor.
- Staff engagement is how staff feel about their job, their colleagues and the organisation in which they work. It is a two-way relationship between employer and employee but one in which the organisation should lead on developing and nurturing engagement.
- Hospice staff do experience work-based stress but its level is no greater than that of staff working in other care environments. Although the work of caring for patients in hospices is challenging, staff may be less stressed than other healthcare workers, partly because the intrinsic rewards of the work are greater.
- The majority of factors causing stress in the hospice workforce could be alleviated by good management practice. The quality of the work environment has a significant impact on stress levels, and most situations could be improved by effective leadership, a participatory culture and good line management of staff and volunteers.
- All hospice staff, professional support staff and volunteers need to be actively supported to reduce levels of stress, risk of burnout and compassion fatigue, and to improve job satisfaction.

Executive summary continued

- There is a wide range of possible interventions to support staff and relieve stress for which some supporting evidence exists. Each hospice must choose for itself from a range of approaches, and proceed by ‘testing as they go’ and by continuous monitoring and evaluation of the effectiveness of the measures they take.
- More research is needed into the risk factors for staff burnout, to guide organisations in its prevention. While there are many studies of risk factors for burnout, there are relatively few prevention programmes and even fewer evaluations of such programmes.

The report provides a checklist and framework to help hospice leaders and managers to assess strategies for supporting staff and to devise their own. The framework describes the range of interventions available for leaders to respond to the two different types of stress: that associated with organisational life, management and organisational change, some of which can be prevented or significantly reduced; and the stress that comes with caring for patients at the end of their lives and supporting those closest to them. The second type of stress is unavoidable but it is still possible to help staff to be more resilient and better able to cope.

We recommend that senior leaders use the checklist to inform strategies to ensure a healthy and resilient workforce and that boards receive annual reports on its use.

1. The framework

We have developed a framework drawing on the best evidence available and our work at the Point of Care Foundation (previously the Point of Care programme at The King's Fund), which includes running a number of interventions to support healthcare staff to provide high-quality, compassionate care.³ We spoke to hospice leaders to explore the key issues before writing our report *Staff Care* (Point of Care Foundation 2014).

We have organised the interventions in table form to reflect actions that can be taken by the organisation's senior leaders, team leaders and individuals (see Table 1 on page 8) and to show the three types of intervention described in the literature: primary, secondary and tertiary (see Table 2 on page 10).

It is clear that most investment by the organisation needs to be put into primary interventions. Organisations committed to the wellbeing of their workforce will:

- seek to recognise and reduce situations that cause stress
- equip managers and individuals (including volunteers) to deal with stress when it arises.

Generally these are interventions that would be in place in any sector, in well-led and well-managed organisations, and where there is a clear strategy for staff wellbeing. Much of the stress experienced by staff and volunteers is due to organisational and management issues. Good, well-managed teams mitigate against stress, so team leaders as well as organisational leaders need to put interventions in place that are tailored for local settings.

Training for good team management would be sourced and resourced at organisational level. Teams and the individuals in them will be equipped to deal better with stress caused by the organisation.

Interventions at the individual level (such as self-care, mindfulness etc) can address the factors related to the intrinsic nature of hospice work, ie dealing constantly with death and dying.

Hospice leaders need to give permission to access these interventions and to provide resources via teams for accessing training.

³ www.pointofcarefoundation.org.uk and www.kingsfund.org.uk/pfcc

Table 1: Strategies for reducing and coping with stress, in order to maintain high quality care

Senior
leaders/
organisation

Managing change⁴

- Engage staff and volunteers in strategic change: articulate strategies and plans and values in Plain English and advocate for them.
- Consult and involve everyone but don't delegate decisions to groups or put them in charge of decisions. Maintain momentum and focus – stagnation and uncertainty cause stress.
- Create opportunities for staff to interact with executives and managers and have honest conversations about present and future plans. Recognise that honest conversations don't happen spontaneously but can happen if they focus firmly on what the organisation faces and the implications for patients, staff and volunteers.
- Build a sense of shared purpose – share information with staff about the strategic imperatives for hospices and about patients' current and future needs and preferences.
- Intentionally manage the 'how' as well as the 'what' in strategic change. Plan the communications with staff and volunteers, and create time for conversations and attention to relationships.
- Develop and link incentives and rewards to changes. Not all incentives and rewards need be financial.

Collecting and using information to diagnose and monitor staff wellbeing and stress

- Use hard and soft intelligence about staff health and wellbeing – collect systematic information about staff health and wellbeing from regular staff and volunteer surveys, qualitative data and informal feedback.⁵
- Act on staff feedback – and let staff make the improvements they identify.

Engaging staff and developing resilience⁶

- Establish supervision arrangements.
- Seek out problems and target support for them.
- Assess training needs and plan education and training of staff and volunteers in relation to resilience.
- Create space for staff to reflect on patient care challenges, eg Schwartz Rounds.⁷
- Set coherent goals for quality and safety from board to ward.
- Articulate values and show how they translate into behaviour.

⁴ Landaeta (2008); NHS South of England 2012, Dixon-Woods *et al* (2013); PoCF (2014)

⁵ Department of Health (2009), NHS Grampian (2007)

⁶ McCann (2013); McAllister and McKinnon (2009); Edward and Hercelinskyj (2007); Jackson (2007)

⁷ Goodrich (2012); Lown and Manning (2010)

Managing stress

- Develop strategy for stress prevention and reduction.
- Assess and meet education and training needs.
- Prioritise good relationship skills and emotional resilience when recruiting staff.
- Develop relationship with suppliers of additional care for people who are stressed and burnt out.

Ensuring good team management

- Invest in team leaders and develop real teamworking.
- Train line managers in people-management skills.
- Have well-defined teams that regularly review how they are doing and get to know each other.
- Train team leaders in line management.
- Support team leaders to deal with problems within the team.
- Teach team leaders to identify and assess risks from work-related stressors.
- Give all staff well-structured appraisals and ongoing training and support for personal and career development.

Team
leaders

Ensuring good management⁸

- Create time for team meetings.
- Provide clear and shared team goals.
- Offer clarity about roles and responsibilities.
- Ensure team reflection is in place.
- Ensure support for physical and emotional self care is in place.⁹

Providing supervision

- Ensure clinical supervision is routinely in place.¹⁰
- Offer restorative supervision.¹¹
- Provide appropriate support for distressed and burnt-out individuals.
- Ensure appropriate rehabilitation for people returning to work after absence.¹²

⁸ West *et al* (2011); West *et al* (2006); Maben *et al* (2012); Dixon-Woods *et al* (2013); Boyle (2011); Beck (2014)

⁹ Merluzzi (2011); Alkema *et al* (2008); Aycok and Boyle (2009); Henry and Henry (2004)

¹⁰ CQC (2013); Butterworth *et al* (2007); Brunero and Stein-Parbury (2008) ; Hyrkas (2006); Papadou (2009); Hawkins and Shohet (2006); Buus *et al* (2011)

¹¹ Wallbank and Hatton (2011); Wallbank and Woods (2012)

¹² NHS Grampian (2007)

Table 2 below is organised to show: primary interventions to reduce the sources of stress; secondary interventions to improve people's

resources in responding to stress; tertiary interventions to help those who have become stressed.

Table 2: Examples of primary, secondary and tertiary interventions for different groups to use to reduce stress

	Senior leaders	Team leaders	Individuals
Source of stress	Challenging and changing external environment. Scarce resources. Increasing demand for care.	Lack of clear and shared goals, values and processes. Lack of time available for reflection and support by the team.	Distressing nature of the work – dealing daily with suffering, death and dying. Excessive workload. Lack of clear roles and responsibilities.
Risks if not addressed	Low staff morale, turnover and sickness. Reduced quality of patient care. Organisational reputation.	Team conflict, inefficiency, low morale and staff absence (sickness, turnover), poor patient care.	Unhappiness, stress, physical and mental ill health, (depression, anxiety) burnout.
Primary intervention	Good communication with staff: explain, consult and listen. Reward and thank. Monitor staff satisfaction and stress levels through surveys and sickness and absence data. Staff wellbeing strategy and policies in place.	Maintain consistent and strong leadership. Proactively meet with staff and demonstrate 'active listening'. Good management practice, eg team meetings, objective setting and appraisal. Clinical supervision. Allow time to attend, eg Schwartz Rounds.	Learn how to care for self, mentally and physically. Agree protected clinical supervision time. Plan work schedule and liaise with team members to help ensure clinical supervision time. Find someone with whom one feels safe to share concerns/debrief.

	Senior leaders	Team leaders	Individuals
	↓	↓	↓
Secondary intervention	Provide access to and resources for management training, clinical supervision, organisational reflective time, resources for mindfulness, resilience etc, training.	Strong and supportive leadership. Team debrief. Group clinical supervision. Robust assessment of what is causing stress and inform executive of implications. Solution focused.	Find a safe place/ person for debrief and reflection. Seek support from line manager – be clear what support would help. Consider and offer possible solutions. Maintain own wellbeing, eg nutrition/hydration / rest. Meditation, relaxation, resilience techniques.
	↓	↓	↓
Tertiary intervention	Clear policies and support available for those suffering physical or mental ill health.	100% completed appraisals. All managers received management (and other) training.	Uptake of training and practice in the above.
	↓	↓	↓
Measures for success – are we improving?	Improvement in absence, sickness, stress levels using a recognised scale for measuring stress.	100% completed appraisals. All managers received management (and other) training.	Uptake of training and practice in the above.

2. Checklist

Checklist of actions for boards and hospice leaders

The problem	Action required	Check
The changing business of the hospice.	The strategy, plans and values of the hospice are clearly articulated in Plain English.	Yes/No
	You have explained fully why the changes are needed.	Yes/No
	You have planned enough time to have honest conversations with staff and volunteers.	Yes/No
	You have allowed time to consult and involve but made it clear that you are leading the change.	Yes/No
	You can maintain a sense of momentum and focus and avoid the stagnation and uncertainty that cause stress.	Yes/No
Staff lack clarity about goals, purposes and values. There is conflict in teams and/or between teams and the senior management.	You have trained your team leaders in people management.	Yes/No
	Your team leaders feel supported to deal with problems in the team.	Yes/No
	Your team leaders regularly meet their team to review how they are doing and to get to know each other.	Yes/No
	All your teams have clear, shared goals.	Yes/No
	You ensure team members have clear roles and responsibilities.	Yes/No
	You ensure everyone receives feedback and has well-structured appraisals.	Yes/No
Staff lack resilience in the face of external and internal pressures.	You assess needs for resilience training and have plans to meet them.	Yes/No
	You ensure all staff are adequately supervised.	Yes/No
	You have made arrangements for all teams to participate in some kind of reflective activity.	Yes/No
Members of staff, individually and/or in groups, exhibit signs of stress and/or burnout.	You regularly collect and review hard and soft intelligence about staff health and wellbeing and use it to plan your response.	Yes/No
	Employees with stress know they will be treated in the same way as employees with other health problems.	Yes/No
	Staff are aware how to access physical and emotional support and training in mindfulness and relaxation.	Yes/No
	Appropriate support is available for stressed and burnt out individuals.	Yes/No
	Appropriate support is in place to help individuals with stress following return to work after absence.	Yes/No

3. Review of the literature

The search strategy for our review of the research literature covered material published mainly over the last 10 years and aimed to include research into end of life, hospice and palliative care whether delivered in a hospice, in hospital or in the community.

The vast majority of the studies found for this review are of nursing staff. We did not find literature relating to other professional staff, apart from a small amount relating to doctors working in end of life care in the oncology literature. Literature was sparse on other groups of hospice staff – for example Allied Health Professionals, support staff, and non-clinical staff (with the exception of Richardson's *Life in a Hospice* (2007)). We have included a smaller literature review relating to volunteers.

Findings can be grouped into themes as follows:

1. Why address workforce stress at the current time?
2. What is its impact on care?
3. How relevant is it to the hospice workforce?
4. What are the causes of stress in the hospice workforce?
5. How will anticipated changes in the delivery of hospice care affect stress levels?
6. What can be done at organisational level?
7. What can be done for individuals?
8. Summary of evidence.

3.1. Why address workforce stress at the current time?

In recent years there has been a stream of government initiatives, enquiry reports and professional publications aimed at improving the quality of NHS care by 'putting the patient first'. At the same time it has been recognised (see, for example, Department of Health 2009) that healthcare professionals are unlikely to provide high-quality care if they are under persistent stress, dissatisfied with their working conditions and reduced to poor health as a result.

The economic and social environment in which hospices will operate in the future has been considered by the Commission into the Future of Hospice Care, in a number of papers produced on behalf of Hospice UK, and by other organisations including The King's Fund and RAND for the National Audit Office. These have identified a range of factors that will require hospices to change how and where they deliver care, how they relate to patients and families and how they plan and manage their services.

In particular, these papers suggest that:

- The need for hospice care is growing as the population ages. Life expectancy at 65 is now 21 years for women and 19 years for men, and the number of people over 85 has doubled in the past three decades. (Office for National Statistics 2013a).
- People's preference for dying outside hospitals (either at home or in a hospice) is increasingly recognised.

- More younger people are living longer with life-shortening conditions. If current trends continue, in just 15 years' time the number of people over 65 with a long-term illness could rise by 44%, and those suffering with arthritis, coronary heart disease and stroke will rise by 50% (Select Committee on Public Service and Demographic Change 2013). Most people over 75 live with two or more 'life-limiting' conditions (Oliver *et al* 2014).
- Hospice care will need to focus on service delivery wherever it is needed rather than on what happens in a particular building. Such a focus implies a change in the way that services are delivered, specifically a reduced focus on inpatient care and increased emphasis on care in the home and on an outpatient basis.
- Economic pressures are set to increase, mainly because of the pressure on public sources of funds, but also because of pressure on personal incomes. If the supply of hospice services is to be increased in line with projected need for care, ways must be found to reduce the cost of delivering care.
- Technical changes, in particular telehealth, will increasingly offer the opportunity for new forms of service delivery.
- Patients and families will be more assertive as to how they are treated.
- People with a wider range of conditions will be seeking hospice care and on average the complexity of their conditions will increase. Managing frailty in older people is a key issue for health and social care, and dementia often complicates frailty and multiple co-morbidities. Dementia affects 800,000 people in the UK already, and this figure is projected to double over the next 20 years (Select Committee on Public Service and Demographic Change 2013).
- Given the pressure on public funds in the next few years, volunteers and family members are likely to play a large role as caregivers.

These factors suggest that hospices and their staff face a period of sustained change in the working environment, in the mode of care delivery and in relationships with the wider health community.

Studies of change in the working environment are unanimous in pointing to the stresses that change gives rise to and the likelihood that staff will resist it. Lorenzi and Riley (2000), for example, state that 'Organisational change normally involves some threat, real or perceived, of personal loss for those involved. Not surprisingly therefore resistance to change is the norm and many change programmes fail as they fail to acknowledge these effects, and therefore do not allow for them, when attempting to implement planned change.'

Summary: This is a time of profound change for hospices which could be highly stressful for those working in this context. Staff and volunteers are unlikely to provide high quality care if they are under persistent stress.

3.2. What is its impact on care?

It is important to pay attention to its impact for two main reasons:

- a) Healthcare staff experience more than their fair share of stress. We look at the reasons for this.
- b) Patient care will suffer if staff are not cared for: the link between staff well being and patient well being is clear.

a) Healthcare professionals experience more than their fair share of stress

Healthcare professionals generally suffer higher rates of stress, depression and burnout than other members of the workforce. Self-reported stress of health service staff in general is considerably greater than that of the general working population: around 18% of the British

workforce suffer above threshold symptom levels on the General Health Questionnaire, compared to an average of 28% for health service staff (Wall *et al* 1997) with some groups of nurses, doctors and managers being particularly at risk. Reported stress of health service staff in general is greater than in the general working population and accounts for more than one-quarter of staff absence, which itself is higher than in other sectors.

Depression levels are high in healthcare staff (Caplan 1994). Depression and high stress affect the ability of staff to provide high-quality care in a variety of ways. With depression in particular, people withdraw, perhaps for their own emotional protection. Burnout is at the extreme end of stress, consisting of three key areas of a lowered sense of personal effectiveness, emotional exhaustion and depersonalisation (developing negative perceptions about patients) (Schaufeli 1999) – which is the area most likely to limit compassion or, worse, to produce cruelty in dealings with patients.

Consideration needs to be given to the two main sources of stress:

- i) The intrinsic nature of the work
- ii) The work context: organisational stress

i) The intrinsic nature of the work

Theoretical and qualitative research helps us to understand that the very nature of the work staff are doing in hospice care is incredibly difficult. Continuous contact with patients who are ill, in distress and dying means that staff, especially those who are with patients continuously, are constantly confronting their own mortality and vulnerability.

Psychologists and others have observed that death, disease and physical and mental degeneration generate a primitive fear in us, particularly in western cultures. The more serious or terminal the illness, the stronger the fears and taboos, and one immediate strategy that staff may adopt to deal with this

is to distance themselves. Menzies-Lyth (1988) has described how people withdraw, perhaps for their own emotional protection, and the uniforms, procedures and targets of modern healthcare provide organisational barriers to retreat behind. This natural avoidance, or self-protection strategy, means that compassion and good communication are unlikely to occur unless staff are supported to confront these difficult issues.

Compassion, from its Latin roots, means ‘with suffering’. Compassion is usually expressed towards others when we experience their suffering – being there with them in some way that makes their pain more bearable. On the other hand, an experience ‘with suffering’ may indicate that being compassionate is painful for the person expressing it.

Compassion – both giving and receiving it – entails an emotional response. It goes beyond acts of basic care and is likely to involve generosity – giving a little more than you have to – kindness and real dialogue (Frank 2004).

Stress and depression is evidenced by high self-criticism (Brewin and Firth-Cozens 1997); a lack of compassion towards oneself is likely to work its way through to a lack of compassion towards patients (Gilbert 2009).

The emotional labour of healthcare – ‘the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place’ (Hochschild 1983) – can be a source of stress in itself. Smiles and ‘little things’ are seen as necessary for good-quality care (Smith 1992, 2008) but if they become part of your job description, are expected of you and even assessed, you might do the smile and the greeting, but actually be feeling irritable and impatient. If your behaviour is at odds with your emotional state – if you are simply acting being kind – then you are more likely to become emotionally detached from those around you and from your own feelings (Brotheridge and Grandey 2002) and suffer burnout (Gross and Levenson 1997). The more you act in ways different to how you feel, the more burnt out you may become, which in turn can make you feel more negative towards your

patients. Psychoanalytic theory also captures the problems of kindness as an obligation rather than a desire: Phillips and Taylor (2009) tell us: 'Ordered to be kind, we are likely to be cruel; wanting to be kind we are likely to discover our generosity.'

Burnout in health service staff is more likely in: younger staff with less work experience; those with lower self-esteem; and those with less resilient personalities. They have more unrealistic job expectations, high dissatisfaction and increased intention to quit (Schaufeli 1999).

ii) The work context: organisational stress

We do know that job-related causes of stress and burnout at work – both in health service jobs and beyond – are manifold, but the known principal causes are: high workload, time pressures, low autonomy and participation in decision-making, role conflict, lack of social support and lack of feedback. In relation to health levels of stress and burnout experienced in healthcare in particular (Schaufeli, *op cit*) the factors identified most frequently are high patient contact and contact with patients with severe problems. Higher patient workload was found, with burnout, to link to compassion fatigue (Udipi *et al* 2008).

Although individuals differ in their capacity to withstand stressful jobs, healthcare organisations vary considerably in the levels of stress they induce.

With the emphasis on targets, financial efficiency and throughput, staff in NHS trusts are under stress personally, working in big, very busy, pressurised environments with little opportunity to establish good relationships with their patients and colleagues. We also know that stress is caused by a sense of lack of control. The current uncertain environment, with job insecurity and the threat of organisational mergers and redundancies, adds to the pressure already there for staff. Although not all these factors are present in

hospice care, as discussed, the context is changing and it is important to be able to guard against resulting stress by anticipating possible problems.

Teamwork and opportunities to reflect can mitigate some of the pressures and help individuals to cope. Studies have shown that members of good teams have lower levels of stress. Good teamwork does not occur spontaneously and has to be worked at.

In a busy day, reflective practice is hard to sustain. The consequence for individual members of staff if they are isolated is that they reflect on their own or away from work. They may experience guilt, anxiety and possibly burnout, which itself effects relationships with colleagues and patients.

b) Patient care will suffer if staff are not cared for

Research shows that the experience of healthcare staff and patients are closely linked. We have known for some time that healthcare staff report that their own wellbeing (or lack of it) affects the way they care for their patients (Boorman, in Department of Health 2009) – ie that the quality of care dips if staff do not feel well or happy at work. Clear links have also been established between results from the national patient and staff surveys in NHS trusts (Raleigh 2009).

Most importantly, a recent research study has shown that the experiences of healthcare staff are an antecedent for patients' experience of care – not the other way round (Maben *et al* 2012).

3.3. How relevant is it to the hospice workforce?

We found a substantial literature asserting that hospice staff are subject to pressures arising from the nature of their role, ie being in close contact with death and dying. The cost in emotional pain of caring for others has been constructed as 'secondary traumatic stress' (Figley 1995). A number of authors have concluded that the work of the hospice nurse is more stressful than that of other nurses (see, for example, studies of stress in hospice staff cited in Hackett *et al* (2009) and Hackett (2010) and Payne (2001).

Such pressure is described in a number of different albeit related ways (Benito 2014). The main ones are stress, burnout, compassion fatigue and depression/anxiety, but there are several others. These terms are not synonymous and each has its own set of measures or scales.

Box 1: Measures of stress and related concepts: some examples

Maslach Burnout Inventory
Nurses Stress Scale
Compassion Fatigue Scale
Secondary Traumatic Stress Scale
Depression Anxiety and Stress Scale
HSE Management Standards Indicator
Professional Quality of Life Scale
Cooper's Coping Skills Framework
Minnesota Job Satisfaction Scale

Because of the diversity of concepts and measures it is hard to compare the results of different studies. In what follows, except where quoting from these studies, we use the term 'stress' to include burnout and compassion fatigue.

On balance the evidence does not suggest that the pressures on hospice staff are any greater than those in other care environments. An early review (Vachon 1995) concluded that hospice staff 'experienced less job stress than coronary

care unit, ICU and oncology nurses and had less difficulty dealing with issues of death and dying than their colleagues in the hospital' (p 109). Nearly 20 years later, Pereira *et al* (2011) came to a similar conclusion: 'Burnout levels in palliative care ... do not seem to be higher than in other (health) contexts' (p 324).

Similarly Payne (2001) concluded that in general the level of burnout (characterised by high emotional exhaustion, high depersonalisation of patients and low personal accomplishment) was found to be low in a study of 89 nurses in UK hospices. Hackett (2010) reported similar results and Hackett *et al* (2009) found that hospice staff did not score significantly higher than the general population in respect of anxiety levels. A review of studies of stress levels in hospice nurses (Peters *et al* 2012) also found that hospice levels of stress were no higher than in other nursing fields.

Lobb *et al* (2010) found that most community-based palliative nurses were not affected adversely by multiple deaths. Whitebird *et al* (2013) surveyed 547 hospice workers in Minnesota and found that they reported high to moderate levels of stress in 60% of them but only a minority reported moderate to severe levels of depression, anxiety compassion fatigue or burnout. Bruneau and Ellison (2004) confirmed this finding in general but identified a small group of nurses who felt ill- equipped to cope with the pressures they faced and routinely found their work stressful.

There appears to be a number of explanations:

- The satisfaction arising from hospice care counters the pressure of dealing with death (Alkema *et al* 2008; Sinclair 2011). Penz and Duggleby (2012) report from a study of community-based nurses that 'participants felt that they got something back from the care they provided, which helped to offset some of the negative effects of aspects of their work they felt powerless to change' (p 369). A number of studies into job satisfaction in physicians show that burnout among palliative care physicians remains consistently low compared with other specialties (Lepnurm *et al* 2009; Asai *et al* 2007; Dunwoodie and Auret 2007).

- According to Hernandez-Marrero and Pereira (undated): 'It seems that professionals working in palliative care have a set of protective factors and strategies for preventing, coping and promoting, simultaneously, their own individual and team resilience' (p1).
- A review by Pereira et al (2011) identified factors that can protect palliative care nurses and physicians from burnout, particularly individual and/or team-based prevention strategies. Having time to spend with patients and families, as well as establishing communication with them, also provides protection against the development of burnout. Other studies showed that working in palliative care promotes personal enrichment because caring for those who are dying, and helping their relatives, is regarded by professionals as making a significant contribution to the patient and their family. They conclude that palliative care professionals can develop a sense of personal gratification, which leads to greater personal and professional satisfaction.
- Attribution of meaning to suffering, dying and death seems to help professionals build up meaning for the work they do in palliative care, and meaning is linked to a sense of personal and professional empowerment (Pereira et al 2011). Slocum-Gori et al (2011) use the concept of 'compassion satisfaction' (higher scores indicating a greater satisfaction related to the ability to be an effective caregiver), and found that this measure was negatively correlated with compassion fatigue and burnout.
- Hackett *et al* (2009) suggest that personal standards of perfectionism mask or overrule the occurrence of negative mood states. In other words, though stress may be experienced, it is not reported.
- Vachon (1995) hypothesised that from the early days of the hospice movement the need for staff support was recognised, ie earlier than in other parts of the health sector.

None of the above means that caring in a hospice setting is never stressful. Some studies quote high figures, eg Abendroth and Flannery (2006) suggest that 78% of their sample were at moderate to high risk of compassion fatigue. White *et al* (2004) describe how palliative care nurses find it difficult to deal with unrelieved suffering in their patients. In a very small study, Melvin (2012) identified the risk of compassion fatigue in the face of continual loss of patients. In a rare study of medical staff in palliative care and oncology, Berman *et al* (2007) reported that one in four experience stress.

Although it may be true that palliative care doctors may be less stressed and burnt out than their colleagues in other specialities, this is still relative. We do know that doctors, as an occupational group, have a higher SMR (standardised mortality ratio) in respect of cirrhosis, accident and suicide than the population as a whole and that suicide rates among female NHS doctors are twice that of the general female population (Dee Traue, personal communication 2014). Various studies on morbidity in the medical profession show this, eg Caplan (1994) – 47% stress, 29% anxiety, 27% depression. These problems are often long-standing and untreated (Firth-Cozens 1999). Traue (2014) has hypothesised that doctors often have an informal support role for other hospital/hospice staff, and they don't seek help for themselves because of the associated stigma and conflict with the perception they are able to 'deal with it'. There is also a lack of knowledge of support available and how to access it. Doctors frequently have no GP, and self-medicate.

Volunteers

There is some evidence about the pressures on informal carers – volunteers being included in this term. (NB: the literature reveals a lack of precision about the definition and scope of these roles.)

Volunteers have some need for support that is similar to staff's needs, but also some distinct needs. MacLeod *et al* (2012) identify a number of challenges faced by volunteers such as (poor) communication, unmet needs for emotional support and lack of education, while family caregivers suffer more from the mechanics of the healthcare system, fatigue and strain (but not lack of continuing education). Claxton-Oldfield and Claxton-Oldfield (2008), on the basis of experience in North America, conclude that volunteers experience four main problems: being under-used; being placed with a patient too late in their illness; feeling under-valued particularly by clinical staff; and feeling their role is too restricted.

Summary: Overall the evidence suggests that hospice care is no more stressful than other healthcare services. This does not mean that hospice workers do not experience stress; but analysis of the sources of stress suggest that the context in which they work, ie the characteristics of their employing organisation and the way it operates, account for a large part of this.

Non-professional caregivers would benefit from support programmes not only to relieve their perceptions of stress but also to help them be more effective in their roles. Volunteer issues cited here are amenable to management intervention.

3.4. What are the causes of stress in the hospice workforce?

There have been a number of studies into the sources of stress involved in hospice work. Riordan and Seltzer (1992) identified a mixture of factors related to organisation of care, workplace culture and the intrinsic nature of work caring for dying people:

- Inadequate communication between managers and staff as well as between staff members
- Unrealistic expectations from managers resulting in staff overload
- Conflicts and lack of support from co-workers
- An unrealistic perception and expectation of professional performance by other staff members
- Unrealistic expectations from patients
- Chronic anticipatory grief and loss
- A need to grieve and come to closure consistently
- Feelings of isolation
- Inappropriate motivations for choosing this special field.

Other studies have come up with different lists: for example DiTullio and MacDonald (1999) identify a wide range of factors, the majority of which reflect poor work organisation rather than the inherent nature of the work. Hospice staff view progressive constriction on available time, (which the authors call 'time cramping') lack of time for one's emotional self-care ('emotional cramping') and the volume and complexity of demands as the most stressful aspects of their work.

Table 3: Hospice staff's responses to the question: 'What is stressful about hospice work?'(n=38)

Thematic responses	Percentage
1. 'Time cramping'	71.0
2. 'Emotional cramping'	55.3
3. Volume/diversity/complexity of demands	55.3
4. Insufficient response up the line	55.3
5. Faulty communication, system malfunction	55.3
6. 'Policy cramping' ¹³	52.6
7. Unpredictability/distraction/discontinuity	47.4
8. Inadequate pay/job insecurity	34.2
9. Lack of appreciation, support at work	31.6
10. Paperwork	28.9
11. Interpersonal stress/tension/'politics'	28.9
12. Impingement of personal losses/stressors	28.9
13. Lack of input in agency policy	23.7
14. 'Controlling' co-workers	18.4

(Source: DiTullio and Macdonald 1999)

When considering the measures that could or should be introduced to combat stress, it is important to distinguish between the factors specific to hospice care and that cannot be removed, and those that can be addressed by appropriate management and organisational change. Most of the factors cited in Table 3 stem from the context in which the care is given rather than the nature of the care itself, and they are subject to influence by senior leaders of the organisation.

A number of other studies have also found organisational factors to be the main source of stress. Vachon (1995), for example, concluded that the main stressors were organisational level factors such as management regimes and funding levels, which vary between institutions. This conclusion is supported by Dougherty *et al* (2009) in their study of oncology staff, among whom almost two-thirds reported experiencing a great deal of stress. The main factors giving

rise to stress in this setting were workload, lack of time to grieve, lack of resources, lack of institutional support and lack of control over choice of workplace.

However, as Vachon acknowledges, certain personal characteristics may lead to some staff members being more likely to feel stressed in the hospice environment. Hawkins *et al* (2007) suggest, for example, that 'nurses with particular attachment styles may be more vulnerable to the effects of stress and less likely to seek emotional support' (p 569). Other studies bring out the variability among staff to the existence of stress. Payne (2001), for example, points out that not all hospice nurses respond to stress by becoming burnt out: 'This suggests that there are individual differences such as coping that mediate the potentially negative impact of nursing work' (p 397).

¹³ Restriction or demands imposed by federal healthcare policy

Obviously the importance of such personal factors is likely to vary between institutions as a result of different recruitment and training methods. This kind of variability suggests that at least some interventions should be designed for individuals rather than staff groups as a whole.

Summary: Hospice workers report a wide range of factors causing stress. An increasing lack of time to care for patients and for their own emotional needs appear to be important.

3.5. How will anticipated changes in the delivery of hospice care affect stress levels?

In this section we consider whether changes in the place of care (for example, caring for people at home) is more likely to create stress than care concentrated in a single building.

The evidence suggests that the main stress factors are similar in both settings, but some differences can be identified. Table 4 below shows responses to an open question about what staff perceived to be the main sources of stress in their work (with the higher the number representing higher stress). Hospice staff working with inpatients rate stresses more highly than staff working in the community.

Table 4: Perceived sources of stress in hospice care: a comparison of views of community and inpatient staff

Perceived stressor	Response Mean	
	Home Hospice	Inpatient Hospice
Making a mistake when treating a patient	4.84	4.96
Insufficient personnel to handle workload	4.53	4.93
Fellow workers not doing their job	4.12	4.91
Inadequate support from supervisor/manager	4.31	4.63
Personal insult from patients or their families	3.85	4.27
Disagreement with medical professional concerning the treatment of a patient	3.99	4.05
Performing procedures that patients experience as painful	3.79	4.13
Disagreement with colleague(s) concerning the treatment of a patient	3.59	3.82
Lack of an opportunity to talk openly with other staff members	3.61	3.58
Death of patient with whom you developed a close relationship	3.44	2.77
Assignment of new or unfamiliar duties	3.27	3.77
Operating specialised equipment	3.33	3.53
Lack of recognition for good work	3.09	3.59
Conflict when dealing with other departments (eg housekeeping, social security workers, pharmacists, dietary)	3.15	3.41
Caring for the emotional and spiritual needs of a patient or his/her family	2.24	2.66
Communicating with a patient and family about death	2.04	2.77
Total respondents	79	63

(Source: Martens 2009)

Staff were asked to rate, on a scale of 1 (low stress) to 6 (high stress) items that they perceived as sources of stress (stressors). There are a number of striking differences between the two workplaces relating in particular to the quality of the working relationships experienced by the community-based staff and their experience of the death of patients they cared for with whom they had developed close relationships. Problems arising from dealing with family members is given less emphasis by community staff. However, other studies suggest that dealing with family members appears to pose more stress when care is delivered in the home. For example, Wilson *et al* (2013), in a study of 40 district nurses in four parts of the UK, found that 'for some the home is characterised by conflict rather than consensus. Complexities surrounding family relationships pose a distinctive and challenging environment for DNs' (abstract).

Penz and Duggleby (2012), in their study of community nurses, reported that some nurses working in close-knit communities, who knew their patients well, found that dealing with the deaths of those closest to them was particularly difficult (p 370). Another study, by Tunnah *et al* (2012), identified poor relationships with GPs as sources of stress.

However Penz and Duggleby also conclude that there were compensations:

'The participants' positive experiences of feeling valued and respected seemed to contribute to their resilience and helped them to deal with the negative impacts of their daily challenges. With much of the literature focusing on occupational stressors and the negative aspects of formal caregiving, it is possible that the positive influences of community palliative nursing practice may often be overlooked. Studies exploring palliative nursing in community settings have found that nurses are strengthened through the close relationships that are established in the homes of clients and family members and through having supportive working relationships with their colleagues.'

(Source: Penz and Duggleby 2012, p 371)

Summary: Given the conflicts within the evidence, it is hard to come to a firm conclusion as to whether a switch in the balance of care from hospice building to a community-based service will tend to result in greater levels of stress. However, the literature does point to potential areas of concern, particularly relationships with family members and professionals in other parts of the health system.

3.6. What can be done at organisational level?

We look at three types of organisational interventions highlighted in the literature that we believe can reduce stress for people working in hospice care:

- a) Management of change
- b) Staff engagement
- c) Teamworking

a) Management of change

As noted above, resistance to change is a universal phenomenon and there is an extensive literature on the factors underlying it: see, for example, Landaeta *et al* (2008).

The literature suggests a number of ways in which stress and change resistance can be reduced. In a review of a number of change programmes carried out in NHS South, the authors identified eight factors underlying successful change:

- Shared purpose – a shared purpose and vision lie at the heart of successful change.
- Leadership for change – change programmes need to be seen as legitimate and worthwhile at all levels.
- Spread of innovation is likely to be more effective if the organisation is prepared for change.
- Improvement methodology must fit the type of change desired.
- Programme delivery – planning and project management are critical.
- Meaningful measurement is needed to demonstrate benefits of change.
- System drivers need to be aligned so that they support change.
- Stakeholder engagement is crucial.

(Source: NHS South 2012)

These precepts are obvious enough. However, generalities of this kind do not provide detailed guidelines for how to bring about change in particular circumstances. Here the literature is less helpful.

Dixon-Woods *et al* (2013), drawing on the experience of the Health Foundation's evaluations of programmes it has supported, sets out 10 challenges facing those who aim to improve the quality (however defined, and whether large or small scale) of health service delivery. The main conclusion they draw is that 'there is no magic bullet in improving quality in healthcare'. Improvement requires multiple, often apparently contradictory, approaches: strong leadership alongside a participatory culture, direction and control and also flexibility in implementation according to local need and critical feedback on performance without the attachment of blame (p 882).

b) Staff engagement

Staff engagement is about the way that staff feel about their jobs, their colleagues and the organisations they work for. It is a two-way relationship between employer and employee – in other words the organisation needs to work to develop and nurture engagement. Staff engagement has been shown to have a demonstrable impact on efficiency and financial performance, and employers in the health services are increasingly concerned about recruitment and retention of staff, and about costs of staff sickness and absence. The Care Quality Commission (CQC) now includes as part of its inspections whether organisations are well led.

Many organisations have a strategy for providing support for staff wellbeing and to mitigate stress – a staff engagement or staff wellbeing strategy.

In our report *Staff Care: How to engage staff in the NHS and why it matters* (Point of Care Foundation 2014), we concluded that there is no simple prescription for staff engagement but there is evidence that some things do work (West *et al*, (2011) Maben *et al*, (2012) Robinson (2004) and Dixon-Woods *et al* (2014).

These include:

- giving all staff well-structured appraisals and ongoing training and support for personal and career development
- training line managers in people management skills
- having well-defined teams that regularly review how they are doing and get to know each other
- creating space for staff to reflect on patient care challenges
- articulating values and showing how they translate into behaviour
- acting on staff feedback – and letting staff make the improvements they identify
- using hard and soft intelligence about staff experience and morale to seek out problems and target support for solving them.

c) Teamworking

Studies have shown that members of good teams have lower stress levels (Carter and West 1999). The characteristics of a good team are well-established, as shown in Box 2 below:

Box 2: The characteristics of a good team

- Its task is defined and its objectives clear
- It has reasonably clear boundaries and is not too large (ideally fewer than 10 people)
- Its members know who leads it and the leadership is good
- There is participation in decision-making by all members, good communication, and frequent interaction between them
- It meets regularly to review its objectives, methods and effectiveness
- Its meetings are well conducted
- Its members trust each other and feel safe to speak their minds
- There is a shared commitment to excellence of patient care

Summary: Change can give rise to stress and is frequently resisted. To reduce both stress and resistance, strong leadership is critical. At the same time there is also a need to engage staff at all levels both in making the case for change, designing the proposed changes and subsequently implementing them. Organisations need to work to develop and nurture staff engagement, and to put a strategy in place for staff wellbeing or staff support. This should include action to ensure good team working in the organisation.

3.7. What can be done for individuals?

There is a wide range of possible forms of support for staff experiencing stress – and no agreement on terminology. Clinical supervision, for example, is used in the literature to describe a wide range of different activities, some of which are promoted as standalone interventions for individuals and some for groups. It is difficult therefore to set out a simple categorisation of the interventions promoted in the literature.

One approach used by a number of authors is to distinguish three types of intervention:

- **Primary** – aiming to reduce the sources of stress (sometimes described as ‘proactive’ or ‘preventative’)
- **Secondary** – improving people’s resources in responding to stress (sometimes called ameliorative)
- **Tertiary** – helping those who have become stressed (sometimes called remedial).

Table 5 below is one such example from the literature.

Table 5: Primary, secondary and tertiary interventions to address stress in the workplace

Intervention type	Intervention targets	Examples
1 – Primary Goal: reducing potential risk factors or altering the nature of the stressor before workers experience stress-related symptoms or illness	Stress at its source: organisation of work; working conditions	Job redesign, work-load reduction, improved communication, conflict management skills development
2 – Secondary Goal: to help equip workers with knowledge, skills and resources to cope with stressful conditions	Employee responses to stress (perceived stress or strain)	Cognitive behavioural therapy, coping classes, anger management
3 – Tertiary Goal: to treat, compensate, and rehabilitate workers with enduring stress-related symptoms or illness	Short-term and enduring adverse health effects of job	Return-to-work programmes, medical intervention

(Source: LaMontagne *et al* 2007)

The evidence cited earlier in this report relating to sources of stress suggests that the majority of factors giving rise to stress in the hospice nursing workforce are amenable to good management and effective working relationships between different skills and grades.

It is obviously the task of the organisation – its management and senior professional staff – to ensure that such primary measures are in place. If they are, then sources of stress such as time pressures, unclear role boundaries and the organisation of work should be eliminated or reduced to acceptable levels.

A crucial management task is to be alert to levels of stress in the organisation, and the factors underlying that stress. Although the literature includes reports of observed stress levels, there is no reason to believe they necessarily apply to all institutions or services; rather they illustrate potential levels of stress and it is an action for all organisations to monitor stress levels. This can be done through brief, regular questionnaires given to staff to complete anonymously, using a recognised survey tool (for example questions could be taken from the NHS annual staff survey: www.nhsstaffsurveys.com).

Armed with this knowledge, you can ensure that the necessary measures are in place to deal with the stress, and to anticipate and avoid situations – such as long-running staff shortages – that are known to give rise to it.

Another action is to have explicit policies for dealing with stress. Boorman (Department of Health 2009) and others have argued that all organisations should have these in place.

Examples are available from a number of trusts of what this involves, such as this example from NHS Grampian (www.nhsgrampian.org 2007):

- Identify and assess the risks from possible work-related stressors for individuals groups and teams.
- Reduce identified stressors, including environment, work organisation and people stressors.
- Provide training and development in areas of stress awareness as a risk control measure.
- Treat employees with stress in the same way as those with any other health problem.
- Provide appropriate support for stressed employees.
- Ensure appropriate rehabilitation of employees returning to work.
- Monitor potential stressors within the organisation.
- Train and develop staff to help identify and assess work-related stressors.
- Identify and assess work-related stressors.

NHS Grampian reports that since implementation of this strategy (which took considerable time) absences have been reduced and self-reported stress levels have come down.

In spite of good management, other sources of stress inherent in the nature of hospice work will remain. In what follows, we set out some evidence relating to a number of possible forms of secondary and tertiary intervention. (However, it should be noted from the outset that within any one category the precise nature of the intervention may vary considerably. It is generally not possible from the literature to extract exact details about the way interventions are carried out. In addition, many studies are based on very small samples and, as noted above, are based in a single institution. The transferability of their findings therefore cannot be taken for granted.)

These are policies and interventions to benefit individuals:

- a) Self-care
- b) Clinical supervision
- c) Reflective practice
- d) Mindfulness and meditation
- e) Interventions to improve resilience
- f) Educational programmes
- g) Combining multiple interventions

a) Self-care

Self-care has a wide definition, meaning not simply physical care (exercise, diet etc) but also emotional wellbeing, which may include meditation, recreational activities, developing resilience and ensuring good personal relationships at work. Some activities can be done by an individual on their own or collectively, or with the support of their organisation, eg through training programmes or access to the required facilities.

A number of studies suggest that interventions in this broad spectrum can be effective. Mimura and Griffiths (2003) in an extensive review of the literature found that relaxation training, social support, cognitive techniques, exercise and music appeared to be effective in reducing stress. Merluzzi *et al* (2011) found that proficiency in self-care was associated with lower levels of stress and caregiver burden. A study by Alkema *et al* (2008) suggested that high levels of self-care were inversely related to compassion fatigue and burnout. Other studies have shown that self-care practices of a generalised nature are predictors of healthcare professionals' ability to cope with issues associated with palliative care (Henry and Henry 2004; Kearney *et al* 2009).

Holland and Niemeyer (2005) found in a small study that spiritual experience might mitigate physical, cognitive and emotional forms of burnout.

A number of small studies have found that arts activity reduced stress among health/hospice workers (Salzano *et al* 2013; Hilliard 2006; Potash *et al* (undated)).

A number of studies of chair massage reported in Mackereth *et al* (2005) have found reduction in blood pressure as well as anxiety depression and fatigue.

b) Clinical supervision

There is an immense literature on clinical supervision but its precise scope and manner of delivery vary.

A Care Quality Commission (CQC) definition runs as follows: 'An accountable process which supports, assures and develops the knowledge, skills and values of an individual or team'. The CQC paper states that the benefits of clinical supervision are as follows:

- It can help staff to manage the personal and professional demands created by the nature of their work. This is particularly important for those who work with people who have complex and challenging needs – clinical supervision provides an environment in which they can explore their own personal and emotional reactions to their work.
- It can allow the member of staff to reflect on and challenge their own practice in a safe and confidential environment. They can also receive feedback on their skills that is separate from managerial considerations.
- It can be one part of their professional development, and also help to identify developmental needs. It can contribute towards meeting requirements of professional bodies and regulatory requirements for continuing professional development (where applicable).

(Source: CQC 2013)

None of these statements is evidenced in the report itself, so it is not clear whether these characteristics are 'hoped for' or demonstrated. However, the list makes the important point that clinical supervision (however defined) is promoted as serving more than one objective.

Many studies support clinical supervision as a means of promoting knowledge transfer and professional development. We ignore this objective in what follows.

In a review of the current state of knowledge of the benefits of clinical supervision, Butterworth *et al* (2007) found that the literature (eg on stress levels cited above) typically asserts the value of peer support, frequently on the basis of interviews with staff who report it as beneficial. Such support may take a variety of forms including debriefing, formal group activities as well as supervisor feedback, mentoring, and some forms of clinical supervision. Some studies report on the value of informal support provided by colleagues. Adams *et al* (2013), for example, argue that informal support such as catch-up sessions can be effective.

A recent review of studies of clinical supervision (Brunero and Stein-Parbury 2008) aiming to evaluate the impact of clinical supervision (not specific to hospices) concluded that: 'There is research evidence to suggest that CS provides peer support and relief (restorative function) as well as a means of promoting professional accountability (normative function) and skill and knowledge development (formative function).'

However, they add that: 'Further study needs to explore the differences between similar forms of supervision, such as action learning sets and mentorship groups. Future studies should also focus on the relationship between patient outcomes and CS' (pp 93–4). No study has yet been found that links interventions, including clinical supervision, to patient outcomes (other than satisfaction) in hospice care.

However, Hyrkas *et al* (2006) evaluated clinical supervision within one hospital and found that it was cost-effective. Cost of implementation was low and there were benefits in terms of identification of training needs, higher levels of patient satisfaction and a reduction in sick days.

A review of a large body of work promoting the benefits of clinical supervision (Dilworth *et al* 2013) found that, despite the vast body of evidence, it is hard to derive firm conclusions as to what it should comprise and how effective it is. A review of group supervision (Francke and de Graaff 2012) concluded that: 'Although there are rather a lot of indications that group supervision of nurses is effective, evidence of its effects is still scarce. Further methodologically sound research is needed.'

Dilworth *et al* nevertheless conclude it has the potential to be effective, particularly if it is implemented in line with local circumstances. In other words, there are no general solutions. Each organisation must find for itself the best way of implementing some form of clinical supervision. This is confirmed by Fillion *et al* (2007) in a study of 209 hospice nurses using a formal statistical model of the causes of stress, distinguishing in particular job demands and job resources.

Restorative supervision

Wallbank and Hatton (2011) provide an example of an effective supervision programme. Their study involving 22 participants undergoing 128 restorative clinical supervision sessions led to a statistically significant reduction of 59% in stress levels to non-clinical levels in most participants.

Restorative supervision has an emphasis beyond the content of the work being done by the health professional, and aims to build their resilience and autonomy. The model is being rolled out across the West Midlands to 246 health visitors and results so far show that burnout has reduced by 43% and stress by 62%, with an increase in 'compassion satisfaction' (Wallbank and Woods 2012).

Although these two studies are not of hospice staff, they are cited because evidence of impact is so limited and could be of relevance to community practitioners in general.

A number of forms of intervention are aimed at strengthening the ability of the individual professional to cope with the stress they face.

c) Reflective practice

Reflection has been defined as a conscious dynamic process of thinking about, analysing and learning from experience and gives insights into self and practice. This may be carried out by the individual in their own time or collectively (and hence may overlap with some forms of clinical supervision). Butterworth *et al* (2007) state that:

‘Employees who are supported and are allowed time to reflect and develop will make a significant contribution to patient wellbeing and safety, and employers bear a considerable responsibility in sustaining and developing this activity in their organisations.’

(Source: Butterworth *et al* 2007, p 270)

However, they report no studies of its effectiveness. Mann *et al* (2009) review a large number of studies but identify none providing clear evidence of its impact.

Beck (2014) has reviewed the literature on reflective practice and concludes that the effectiveness of reflective practice has not been robustly demonstrated. The studies that have taken place have been limited to observational and qualitative approaches.

Importantly, the influence of the healthcare context on the effectiveness and outcomes of reflective practice groups is emphasised in the literature. Groups may develop skills for staff which then cannot be applied in practice due to lack of management support.

Schwartz Rounds, which offer an interdisciplinary forum where psychosocial and emotional aspects of patient care can be discussed, and thereby encourage reflective practice, have been introduced as a means of reducing compassion fatigue. Evaluations of this process have identified a number of benefits. Manning *et al* (2008) report that participants are extremely enthusiastic about them and found them relevant to their own needs. A large majority of those surveyed reported increased

insight into the non-clinical aspects of patient care, improved teamwork and more support as a result of participating in the Rounds. However, Lown and Manning (2010) note in some areas – perceived empathy, patient interactions, teamwork and stress – no change was identified in later surveys. When the Rounds were piloted in England in 2009 it was found that they had a beneficial impact on the individuals who attended, and on their relationship with their colleagues and patients, and there was a perceived impact on organisational culture (Goodrich 2012). A national evaluation of Schwartz Rounds (currently running in 80 organisations including 13 hospices) is underway.¹⁴

d) Mindfulness and meditation

Bazarko *et al* (2013) report a small study of the impact of Mindfulness Based Stress Reduction, finding that the intervention improved health and decreased stress and burnout. A literature review by Praissman (2008) concluded that ‘MBSR is ... therapeutic for healthcare providers, enhancing their interactions with patients ... MSBR is a safe, effective, integrative approach for reducing stress.’ Other studies have supported the use of mindfulness (Krasner *et al* 2009; Harrison and Westwood 2009).

Ferrer (2006) concluded on the basis of a small study that ‘meditation has the potential to shift home care nurses’ appraisal of a stressful situation from being a threat to being a challenge’.

e) Interventions to improve resilience

Developing psychological resilience and positive coping in healthcare staff can help protect against the impact of stress and adverse events. This reduces the likelihood of burnout and more serious mental health problems developing. Interventions to develop resilience are being piloted and developed in healthcare settings (Flaxman 2010). They often include mindfulness training.

¹⁴ Led by Professor Jill Maben, Director of the National Nursing Research Unit, King's College London

This work is also being extended to consider how to develop compassion towards ourselves and towards others. This therapeutic application grew from a concern with how to counter the self-criticism, shame and guilt that often accompanies episodes of depression (Gilbert 2009). This led to the development of compassionate mind training which aims to help individuals to reorient themselves towards a more compassionate stance and relationship to negative and unwanted thoughts about themselves and others. Compassionate mind training is being incorporated and evaluated in psychological therapy interventions, and integrated into thinking about how to help healthcare staff stay compassionate to their patients while fielding high levels of emotional demands (Ballat and Campling 2011).

The Kings Fund Point of Care programme ran resilience workshops as part of the Hospital Pathways programme and subsequent Patient and Family Care Programme.

As McCann *et al* (2013) point out, definitions of these terms vary so it is hard to summarise the findings of the studies that have been carried out. They say:

‘The results of this review suggest that resilience involves the interactions of individual and contextual factors. These individual factors include demographic characteristics (age, gender, experience), personal characteristics (having a work-life balance, laughter, relaxation) and professional characteristics (continuing education, professional identity), and the contextual factors include partner or family support, clinical supervision and culture of the discipline. It is this interaction that enables the maintenance of personal and professional wellbeing in the face of on-going work stress and adversity.’

(Source: McCann *et al* 2013, p 74)

Similarly, McAllister and McKinnon (2009) conclude (p 374) that resilience can be learned, and propose that it should be built into both university and workplace learning. Edward and Hercelinskyj (2007) also argue that resilience can be learned ‘through related life and work experience’ and that this can be achieved through informal peer support, supervision and reflective practice.

Jackson *et al* (2007) view resilience as a quality necessary to succeed in nursing, because the conditions can be so adverse. They distilled five strategies to develop resilience in nurses:

1. Building positive professional relationships through networks and mentoring
2. Maintaining positivity through laughter, optimism and positive emotion
3. Developing emotional insight to understand one’s own risk and protective factors; for example, while caring is central to the work of nurses, many neglect self-care, an important aspect of resilience
4. Using life balance and spirituality to give one’s life meaning and coherence
5. Becoming more reflective to help in finding emotional strength and assist in meaning-making in order to transcend the present ordeal

f) Educational programmes

The measures set out above may be applied once stress has been experienced. Boyle (2011) argues that:

‘Continuing education programs that augment basic emotional support competencies in the practice setting, patient rounds, and interdisciplinary team meetings that integrate the humanistic perspective into healthcare are excellent modalities for developing these skills. Specialty education programs, such as those focusing on end of life training, also augment both knowledge and skill in an emotionally laden context of nursing care. It is important for the phenomenon of compassion fatigue to be integrated into every undergraduate and graduate nursing curriculum, as well as nursing-orientation programs.’

(Source: Boyle 2011, p 5)

g) Combining multiple interventions

What general lessons can be drawn? Hopkinson *et al* (2004) argue that no single intervention is likely to help either all nurses or any one nurse across all experiences of caring for dying people (p 131). They go on to say that: ‘The greatest impact on nurses coping is likely to be achieved through the implementation of multiple interventions from which they could adapt those most appropriate to their situation’ (p131).

Boyle (2011) also concludes that: ‘The management of compassion fatigue must be multifaceted and include prevention, assessment and consequent minimisation. Central to any discussion of interventions to manage compassion fatigue is the need to acknowledge its presence in a proactive manner.’

A review (Awa *et al* 2010) of interventions designed to reduce burnout among healthcare workers in general concluded that 80% were effective, although their impact fell over time. However, they also concluded that the best mix

of intervention – person, organisation and a combination – remained to be identified, in part because the research base was limited.

Ruotsalainen *et al* (2008) also identified limited evidence for the effectiveness of a range of interventions (personal and organisational) but concluded that ‘before large scale implementation can be advised larger and better quality trials are needed’. Another review (Marine *et al* 2006) concluded that person and work-related interventions could be effective in reducing burnout, anxiety, stress and general symptoms, but adds that ‘most of the studies are small and of poor quality’. van Wyk and Pilley van Wyk (2012) also identified some benefits but concluded that ‘rigorous trials are needed to assess the effects of longer-term stress management training and management interventions’.

Volunteers

As noted above, research has suggested that volunteers can suffer from stress.

Some suggested measures seem to be simply common sense. For example, Claxton-Oldfield and Claxton-Oldfield (2008) suggest that volunteer co-ordinators can help to maintain satisfaction in the volunteer roles by making sure volunteers feel that their time, skills and talents are being well-utilised (ie the volunteers have as much to do as they would like to do, the reasons for any lengthy gaps in their utilisation are explained to them, and regular volunteer meetings are held); and offering education sessions for other team members (eg doctors, nurses) regarding the role and responsibilities of the volunteers, the training that volunteers receive, and how volunteers can make their jobs easier etc. This may improve attitudes toward, and foster greater appreciation of, the volunteers (ie encourage others to regard the volunteers as equal and valued team members). In addition, if doctors and nurses become better informed about the volunteer role, they may be more likely to consider making hospice/palliative care referrals.

Drawing on the results of a community-based research project with hospice volunteers and family members they supported, McLeod *et al* (2012) set out a menu of strategies to support volunteers which included ideas such as providing emotional support through a 'buddying' system for volunteers whereby they would be paired up to support each other, or a mentoring system whereby the more experienced volunteers would support new volunteers. They suggest communication could be improved by follow up with volunteers by telephone, and they suggest that the volunteer role could be clarified with the different agencies involved in hospice care. They also recommend that volunteers should have access to continuing education by, for example, being given the chance to attend (free) courses and workshops, and to have an annual hospice volunteer convention.

Summary: a wide range of measures has been promoted as possible ways of reducing stress for individual staff and volunteers. Although currently there are limitations to the evidence in the literature, many of the suggestions are experience-based or common sense proposals made in response to the needs reported earlier in this paper, and as such could be made available by hospice leaders for their workforce.

4. Summary of the literature

Our review of the evidence suggests that:

- Hospice staff do suffer stress, but that on balance the evidence does not suggest that the pressures on hospice staff are any greater than other care environments. In fact, in spite of the intrinsic difficult nature of the work in hospices, staff may be less stressed than other healthcare workers, partly because the rewards of the work are greater.
- The majority of factors giving rise to stress in the hospice nursing workforce are amenable to good management practice. This is because it is clear that the work environment is very important in relation to staff stress, and most situations can be improved by good leadership and good management of staff and volunteers.
- The importance of strong leadership alongside a participatory culture for staff holds true in any time of organisational change, and also flexibility in implementation according to local need.
- There is a convincing argument for hospice staff to be 'supported' so as to reduce their levels of stress, risks of burnout and chances of compassion fatigue or their levels of job satisfaction. It also makes it clear that both professionals and non-professionals perceive a need for support.
- There is a case for intervention to reduce stress, but not clear guidance on the form of intervention likely to be most effective and the circumstances in which it is likely to be effective. Where evidence exists for interventions to mitigate stress it is not possible to say to what extent it is applicable to other institutions, particularly because many of the factors contributing to stress arise from the local context in which care is provided rather than the nature of the care itself.
- Even though many studies have examined risk factors for burnout, only relatively few prevention programmes have been conducted and even fewer have been evaluated. This may partly be due to the difficulties associated with implementing such programmes, especially organisation-directed interventions. Therefore, better designed and evaluated controlled trials (RCT or CTs), with comparable participants, appropriate baseline and at least two post-intervention measurements points (preferably up to one year) are needed in order that more reliable conclusions can be arrived at. Many of the studies analysed in this review had small sample sizes and high dropout rates as well as short intervention and follow-up durations. More research is called for and future interventions should work against such limiting factors in order to improve on the integrity of research results and conclusions.
- However, the literature provides a wide range of possible interventions for which some supporting evidence exists and each hospice must choose for itself from a range of approaches that mitigate the stressful nature of its work and its work environment. Organisations should proceed by 'testing as they go' and by continuous monitoring of the effectiveness and the measures they take.

Summary of the literature continued

We used this range of interventions to develop the framework set out in Section 1 of this publication, which is specifically for hospices.

We also designed a checklist (Section 2), which is intended as a practical tool to help hospice leaders devise and assess strategies for supporting staff, and to help them cope with the two major sources of stress at work. The checklist and framework are based on the best evidence available set out here, and our experience at the Point of Care Foundation.

We suggest that the checklist should be presented to the board at least annually, completed by senior managers and team leaders.

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