Kristina Argustaite BSc Hons

CARE DELIVERY IN THE CURRENT NHS CONTEXT

Section A: Systematic literature review of the challenges in the current NHS organisational culture

Word Count:7,989 (71)

Section B: Mental health clinicians' language regarding care delivery in the current socio-political NHS context

Word Count: 7,976 (74)

Overall Word Count:15,965 (145)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2023

SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

I am finishing my research journey with a deep sense of gratitude for all who have been a part of this project. You all taught me more than a few words can express.

I sincerely thank my supervisors, Sue and [redacted], for sharing my passion and guiding me through the greatest academic challenge I have ever had to conquer. I am in awe of your skill and knowledge.

This journey would not have been the same without the support of my friends and family, who never stopped believing in me and motivating me. You know who you are. A heartfelt thank you.

Finally, I dedicate this research to the many ones who taught me that the most powerful form of resistance is to carry on and show love and care for other beings, even in the most adverse circumstances. You are the rebels who inspire me.

Summary

SECTION A: Since Francis report (2013) exposed systemic NHS culture issues that led to organisational failings, there has been an increased interest in researching NHS organisational culture. However, a shared understanding of NHS culture challenges is needed in order to address them. Therefore, this literature review systematically reviewed 11 qualitative studies exploring current organisational NHS culture challenges. The narrative review findings describe the negative impact of target-led priorities and managerialism in the NHS, neglected staff wellbeing, and these issues' effects on service user care. The review calls for a broadening understanding of the NHS culture across different professions and recommends exploring NHS organisational culture from a socio-political perspective using a discursive approach.

SECTION B: A turn towards a neoliberal mode of NHS governance in the 1980s gave rise to business-efficiency-led organisational NHS culture that can conflict with compassionate care priorities. However, research on how clinicians manage these competing NHS rhetorics remains scarce. Therefore, this study utilised Foucauldian Discourse Analysis to explore NHS clinicians' language regarding care delivery. Following an analysis of seven organisational meetings from a single Mental Health Directorate in the South East of England, four discourses were identified. In turn, they describe a dominant care-as-business rhetoric, a discourse of managerialism that ensured adherence to the NHS-as-business governance, a state of crisis in the current care delivery standards and a competing discourse based on compassion that aimed to rebalance power relations in the NHS. The research findings highlight how taken-for-granted business rhetoric shape clinical action and demonstrate the need to consider the broader socio-political context when evaluating care delivery standards and facilitating organisational culture transformation.

Contents

List of tables and figures

SECTION A

SECTION B

SECTION C

List of appendices

CARE DELIVERY IN THE CURRENT NHS CONTEXT

SECTION A: Systematic literature review of the challenges in the current NHS organisational culture

April, 2023

Word count: 7989 (71)

Abstract

There has been a recent surge in interest in researching organisational cultures to help improve organisational performance in the United Kingdom's (UK) healthcare sector, including the NHS. The Francis report (2013) drew attention to the need to address systemic NHS culture issues in order to prevent organisational failings and foster a compassionate organisational culture. To date, no previous research review has provided a shared understanding of NHS organisational culture. Therefore, this review synthesised research exploring the NHS organisational challenges since the publication of the Francis report. Arguably, achieving such understanding is necessary for the NHS systemic issues to be effectively addressed.

Following a systematic preferred reported items for systematic reviews and meta-analyses (PRISMA) process, this review synthesised current research using a narrative review method. Eleven qualitative studies were included in the final review. The review discussed five identified categories that described NHS challenges related to the target-led working environment and managerialism in the NHS, neglected staff wellbeing and the organisational culture's impact on service user care. Clinical implications were considered in the context of continuous NHS challenges that brought the efficacy of current systemic interventions in question and include a call for a research-evidence-informed systemic change. The author argues that future research would benefit from broadening an understanding of the NHS culture and its challenges across different disciplines and professions. The review suggested that important lessons related to facilitating staff's wellbeing may be found in the study of mental health clinicians' experiences navigating organisational NHS challenges from a socio-political perspective using a discursive approach.

Introduction

Epistemological position

In producing this literature review, the author adopted an epistemological stance that considers knowledge as socially constructed yet acknowledges it as reflective of reality insofar as it is possible to know and experience it. This stance, widely referred to as critical realism (Maxwell, 2015), allowed the author to consider current research as partly constructing and partly reflective of NHS realities and to comment on the potential of research to extend our understanding of important issues facing the NHS.

Defining organisational culture

The concept of 'culture' has its roots in anthropology and was traditionally used to study indigenous people (Malinowski, 1922). The application of 'culture' in understanding organisations is a relatively recent phenomenon, popularised in the 1980s as an essential aspect of managing organisational performance (Deal & Kennedy, 1982). The study of organisational culture in different industry settings has grown tremendously since, giving rise to extensive research aimed at understanding and optimising organisational environments (Davies et al., 2000).

Whilst the interest in researching organisational culture has grown, the definition of it has remained elusive and lacking consensus; one review reported 15 different available definitions (Brown, 1995). In considering the complexities of understanding organisational culture, Davies et al. (2000) theorised that it consisted of different layers that were both internal (e.g. organisational beliefs and values) and external (i.e. socio-cultural) influences. The authors summarised different perspectives and suggested two key distinguishable categories in understanding organisational culture. The modernist perspective of organisational culture describes it as something that an organisation *is*: a concrete socially constructed entity, the components of which can be analysed and explained, whereas a post-

modernist perspective postulates that organisational culture is something an organisation *has*: that can evolve and change over time and, therefore, can be 'manipulated' (Davies et al., 2000). The review by Parmelli et al. (2011) suggested that even competing definitions share a core understanding of organisational culture as a multifaceted phenomenon, characterised by people of the same organisation sharing a pattern of beliefs, values, behaviour norms and routines, that provides a symbolic context through which the organisation can be understood within its society.

Further, it is recognised that organisations may not be defined by a single uniform culture and may have sub-cultures with different levels of power and competing values and norms (Martin, 1992). That is, whilst different professional or occupational groups in a large organisation may share certain overarching principles and values, they may differ in their professional norms and ways of working and hold different degrees of influence, and may be understood as sub-cultures of the same organisation (Davies et al., 2000).

For the purpose of this review, the author adopts an integrative definition of organisational culture. That is, the author recognises different characteristics of organisational culture that can be assessed and explained while simultaneously viewing it as a dynamic and changeable phenomenon, sensitive to external socio-political climate, and therefore not inclusively controllable from within.

Organisational culture in the NHS

The interest in organisational culture has followed a trend in the healthcare sector globally and within the United Kingdom (UK). The public sector reforms in the 1980s, referred to as a shift towards a neoliberal mode of governance, describe a political ideology that frames all human activity in economic terms (Brown, 2015). Since then, the UK National Health Service (NHS) has undergone restructuring and reforms to align the sector

with business-model industries and enhance NHS performance and delivery (Moth, 2020). The dominance of clinician-led NHS culture was challenged by a rise in a management culture akin to the business industry model of efficiency monitoring (Cosgrove & Karter, 2018). Davies et al. (2000) described the NHS culture as characterised by two key constituent sub-cultures, clinicians and managers, competing over power and influence. Whilst shifting the balance of power from external government bodies to clinicians has long been promoted (see Department of Health, 2001), the UK government continues to take an active stance in managing the NHS, manifesting in numerous reorganisations and industry marketisation (Moth, 2020).

Francis report

Changes in the organisational NHS culture and the constant reconfiguration of the services were accompanied by increasing concerns regarding organisation-wide issues in the NHS raised by clinicians (Pope, 2019). Furthermore, investigations into failings in healthcare consistently pointed to systemic issues related to the organisational environment (Walshe & Shortell, 2004).

An alarming recognition of the negative impact of the organisational culture in the NHS followed from the Mid Staffordshire NHS Foundation Trust public inquiry led by Sir Robert Francis (2013), widely known as the Francis report. The report examined factors that led to serious Trust failings, causing unnecessary suffering and deaths of many service users. The report exposed organisational culture prioritising building a favourable organisational business image over genuine service user care, lack of consideration for service user experience, and failure to develop a positive culture for medical and nursing staff. The report called for a fundamental culture change and recommended fostering an organisational environment based on transparency, compassion and accountability. The Francis report has come to be viewed as an epitome of the perilous state of the NHS organisational culture and

gave rise to a growing interest in researching the organisational issues in the NHS (Johnson et al., 2016).

Whilst literature exploring aspects of organisational issues in the NHS grew, studies appear disjointed and focused on exploring the effects of eclectically identified organisational issues experienced by single professional groups and arguably lack an understanding of the NHS culture landscape as a whole. Further, perhaps due to a lack of a shared understanding of the organisational culture and its problems, there appears to be little change in the NHS organisational environment (see Brannan et al., 2021). It could be argued that an ongoing failure to develop a shared understanding of the NHS culture and its organisational problems made addressing the NHS systemic issues difficult. This may have contributed to a widely perceived deterioration in organisational morale and reputation marked by seemingly never-ending crises and operational failures (see Walshe, 2018; Church et al., 2018; Willis, 2020; Taylor & Goodwin, D, 2022).

Understanding NHS culture challenges through the psychological lens

Staff are at the heart of the NHS' primary task (Rice, 1963) of supporting the nation's health and wellbeing, and their experiences are central to the functioning of the NHS organisation (Department of Health and Social Care, 2021). Psychological theory can help us understand the challenges in the current NHS organisational culture by providing a theoretical framework to understand the NHS staff's experiences.

A construct of team psychological safety describes a shared tacit belief among the team members that their team environment is safe, which enables team learning (Edmondson, 1999). Edmondson (1999) characterised team psychological safety as a shared confidence that a team will not reject, embarrass or punish someone who speaks up that stems from mutual respect, trust and care for each other. The author theorised that psychological safety

facilitated team learning because it removed the excessive concern regarding others' reactions to learning behaviour, which by its nature, comes with a potential for getting things wrong. Extensive research evidence supports the notion of team psychological safety for team learning and performance (Edmondson & Lei, 2014; Newman et al., 2017).

The organisational social defence system theory (Menzies-Lyth, 1988) may shed more light on interpersonal processes contributing to and/or maintaining dysfunctional system behaviour in the NHS. Menzies-Lyth (1988) described how healthcare staff, who witness illness, trauma, and death as part of their role, in the absence of appropriate emotional containment, develop a defence system to manage working-relationships-related fears and anxieties. Menzies-Lyth (1988) argued that these defences manifest in staff's detachment from feeling and task-focused orientation, obscure distribution of responsibility and lead to avoidance of change. According to Menzies-Lyth (1988), not only do these defences fail to alleviate work-related stress, but they also cause secondary anxieties in the form of organisational crisis threats. The latter drives compensation by operational tasks, which can drain healthcare staff or job satisfaction, reduce staff engagement with service users, and lower care quality standards (Menzies-Lyth, 1988).

In light of the above, it could be theorised that the dysfunctional practices in NHS services could be understood as a product of the system's defence against anxiety. Wren (2014) argued that the current organisational anxiety and fear in NHS services are not appropriately contained, leading to insecurity and competition among teams and, in turn, a lack of psychological safety that disables organisational learning. The unaddressed system defences against anxiety and lack of safety likely maintain and reinforce current difficulties in the organisational NHS culture, highlighted in the Francis report (2013).

Literature review rationale and aims

NHS Values (Department of Health and Social Care, 2021) describe a commitment to quality care, compassion, respect and dignity for service users and staff, and putting community needs 'before organisational boundaries'. In light of the organisational difficulties discussed above, the study exploring how these priorities are maintained in the day-to-day running of the services is warranted.

Further, the literature highlights the importance of understanding organisational culture for its optimal functioning. In the NHS, research has highlighted how broader organisational issues affect the everyday performance of the NHS services and could lead to significant organisational issues (discussed above). Further, although the Francis report (2013) identified a need to address the NHS culture that gave rise to serious operational failures, there does not seem to be a shared understanding of what currently constitutes the challenges of NHS culture. Further, systematic reviews explicitly focusing on issues associated with the NHS culture post-Francis-report appear absent. Arguably, NHS organisational culture transformation may be difficult to achieve without a shared understanding of the current NHS organisational culture challenges. Therefore, this review aimed to produce a shared understanding of current challenges within the NHS organisational culture by reviewing the research literature addressing the following question: What organisational challenges are highlighted in the current research of the NHS culture?

Method

The aim of this review was to produce an up-to-date overview of the challenges within the organisational NHS culture. In order to increase the scientific rigour of the review procedure, reduce researcher bias, and enable replicability, the author followed the preferred

reported items for systematic reviews and meta-analyses (PRISMA) process described by Moher et al. (2009).

Eligibility criteria

Research characteristics for studies included in the review were decided prior to the study selection to reduce selection bias. The selection criteria are summarised in Table 1.

In order to review scientifically researched NHS challenges and minimise the selection of potentially biased papers, only full-text empirical studies were selected for the review, which meant that poster presentations, commentaries, reviews or purely theoretical pieces were excluded from this review. In order to review methodologically sound papers, only articles published in peer-reviewed journals were selected; unpublished material such as theses or unpublished articles were excluded. As the review focused on the organisational NHS culture in the UK, only UK publications concerning NHS services were included. Therefore studies published outside of the UK, not in English, and that did not specifically investigate NHS services (e.g. focused on the whole healthcare sector, private healthcare organisations, etc.) were excluded. In order to produce a review of the *current* organisational culture, issues of which were highlighted in the Francis report (2013), only articles that reported on data collected in 2013 or onwards were selected and screened. In order to maintain a focus on the challenges related to the organisational culture and prevent over-inclusivity, only articles directly addressing the organisational culture were included. Only studies using qualitative methodology were included to facilitate a more in-depth understanding of the issues of interest. Quantitative or mixed methodology studies were excluded on the basis of pre-existing assumptions of the NHS culture challenges that manifested in particular variables or study relationships researched as aspects of the organisational NHS culture when a shared understanding of the NHS organisational culture as a whole appears absent in the literature.

Table 1

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Articles from peer-reviewed journals	Unpublished theses/studies
Empirical study	Reviews/commentaries/posters
Qualitative methodology	Quantitative/mixed methodology
UK publications	Publications outside the UK
Published in English	Published in any other language
Data collected since 2013	Data collected before 2013
Research focused on the UK's NHS	Research not focused on the UK's NHS
Directly linked to the current organisational culture	Topic does not directly address current organisational culture

Information sources and search strategy

Five databases that covered different social and health sciences disciplines were selected for a broad data search. These were: the Applied Social Sciences Index and Abstracts (ASSIA), the Psychology research platform PsycINFO, the multiple scholarly field database Web of Science, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) platform, and the life sciences and medical information database MEDLINE. Search terms were selected following a preliminary literature search and reviewing keywords of potentially relevant studies.

In order to yield relevant search results, the search fields were selected to include the broadest search field available for that individual database but excluding all-text searches as the latter yielded predominantly irrelevant results. The search fields applied were: anywhere

except full text (noft) for ASSIA, all fields for Web of Science, and abstract field (ab. or AB) for PsycINFO, CINAHL and MEDLINE. Following the search in ASSIA, PsycINFO and Web of Science databases, the search terms were edited to include qualitative study keywords in order to narrow down the search and scan for potentially missed articles. The electronic search was completed in late October 2022. Table 2 shows the search terms and limits used for the individual platforms.

Table 2

Electronic search strategy

Database	Search fields and terms	Search limits
ASSIA	noft("national health service" OR "NHS") AND noft("workplace climate" OR "organi*ation* culture" OR "work culture" OR "workplace culture" OR "organi*ation climate" OR "work climate" OR "workplace climate" OR "ethic* culture" OR "ethic* climate" OR "work environment")	Peer reviewed journals, published in the UK, in English, studies published in the last 10 years.
PsycINFO	(("national health service" OR "NHS") AND ("workplace climate" OR "work climate" OR "organi*ation* climate" OR "organi*ation* culture" OR "work culture" OR "workplace culture" OR "ethic* culture" OR "ethic* climate" OR "ethic* environment" OR "work	Peer reviewed journals, journal article, in English, and published in the last 10 years.

	environment" OR "workplace environment")).ab.	
Web of Science	("national health service" OR "NHS") (all fields) AND ("workplace climate" OR "organi*ation* culture" OR "work culture" OR "workplace culture" OR "organi*ation* climate" OR "work climate" OR "workplace climate" OR "ethic* culture" OR "ethic* climate" OR "work environment") (all fields)	Published in the UK, in English, in the last 10 years.
CINAHL	AB ("national health service" OR "NHS") AND AB ("workplace climate" OR "work climate" OR "organi*ation* climate" OR "organi*ation* culture" OR "work culture" OR "workplace culture" OR "ethic* culture" OR "ethic* climate" OR "ethic* environment" OR "work environment" OR "workplace environment") AND AB (qualitative OR phenomenology OR narrative OR "grounded theory")	Scholarly (peer reviewed) journals; published in the last 10 years.
MEDLINE	AB ("national health service" OR "NHS") AND AB ("workplace climate" OR "work climate" OR "organi*ation* climate" OR "organi*ation* culture" OR	Peer reviewed journals; published in the last 10 years

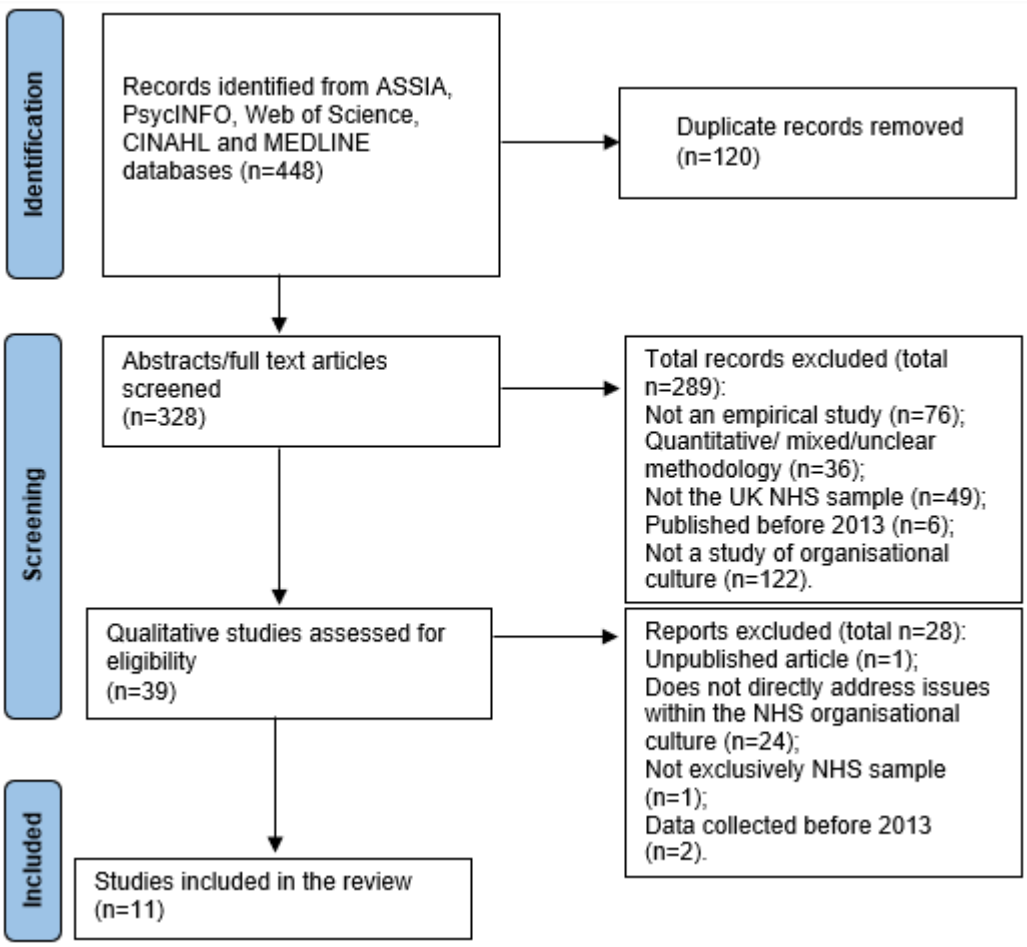
"work culture" OR "workplace culture" OR "ethic* culture" OR "ethic* climate" OR "ethic* environment" OR "work environment" OR "workplace environment") AND AB (qualitative OR phenomenolog* OR narrative OR "grounded theory" or interview* OR focus group* OR thematic)

Study selection

The search results were screened by applying the eligibility criteria outlined in Table 1 to study abstracts. If the article's eligibility remained unclear, the article's full text was screened using the same criteria. As the search and selection process was completed by a single researcher, to reduce selection bias, the rationale for excluding particular qualitative articles was discussed in supervision, and they were re-screened using the same criteria several days later. The PRISMA flow diagram (Figure 1) depicts a staged process used for study selection.

Figure 1

PRISMA flow diagram



Quality appraisal

In order to establish the trustworthiness of each study, the quality of the included articles was assessed using National Institute for Clinical Excellence (NICE) Quality appraisal checklist for qualitative studies (National Institute for Clinical Excellence, 2012; see Appendix A). This NICE tool is used to produce clinical and public health evidence-based guidance in the UK and was chosen for its widely accepted credibility. A second independent rater assessed a sample of articles to ensure rating accuracy. The articles were considered high quality if they met more than 10 of the 14 criteria outlined in the checklist (marked as ++ in Table 4 Criterion 15). The articles that met between 6 and 10 criteria were

considered satisfactory (marked as +). Those articles that met five or fewer criteria were considered low quality (marked as -). See Table 4 for the quality appraisal summary.

Review procedure

Since this review aimed to synthesise broad NHS organisational issues and outline a shared understanding of the matter in question instead of reviewing evidence of focused clinical problems, a narrative overview methodology was deemed most appropriate. In order to achieve this, the author adopted a narrative overview protocol outlined by Green et al. (2006). The first stage involved the author closely reading, familiarising herself with, and taking notes of key points of each article. Once initial note-taking was completed, the author organised common themes identified in these notes into distinct categories. These are discussed in the results section.

Results

The research strategy outlined above resulted in 11 articles being selected for the review. Table 3 summarises the articles, their findings and key limitations.

Overview of study characteristics

Altogether, selected articles included studies involving a range of NHS Trusts and services or, in the case of studies targeting a specific group of NHS professionals, people with experience working in specific NHS settings. The exact number of Trusts represented in these studies was unknown due to the names of Trusts and services being excluded from the papers to preserve the confidentiality of the people and services involved. However, studies reported sampling different regions in England (e.g. Midlands, North, West, London, West Essex) and some recruited representatives from multiple Trusts (e.g. one study reported a sample representing 17 NHS Trusts). Therefore, it is reasonable to suggest that the articles represented a wide range of NHS Trusts.

All studies have been published since 2016. However, most studies (i.e. 8/11) have been published since 2019. The reasons for the increased number of relevant publications since 2019 were unclear. It is likely that an increase in political, media and public attention due to recent increases in NHS services demand, issues with NHS staff shortages, and pressures associated with managing the Covid-19 pandemic led to more research interest. Another reason may be that studies that started collecting data prior to 2013 but published their findings in later years were excluded from the review due to no longer pertaining to the *current* NHS organisational culture post-Francis-report.

All studies, of which two were case studies, adopted an explorative qualitative design. Most studies (8/11) used interviews for data collection. Two used interview data with additional methods such as observation, document review or focus groups, and one adopted a psychoanalytic observational design. Thematic analysis was the most prevalent qualitative method (5/11).

Study samples varied significantly in size (range of seven participants to 81 participants plus additional documents and observation). They included participants from various professional groups (e.g. managers, clinicians, administrators, hospitality staff), different NHS bands, and various ages. Most studies (6/11) did not report any demographic information; five reported participants' gender (which was predominantly female: total of 106 females versus 25 men across studies). Whilst only three studies reported the participants' ethnicity, the majority of them were White British. Most studies explored staff's experiences and wellbeing concerning NHS organisational culture, some focused on the psychosocial impact of organisational culture challenges, and some explored the perceived impact of a challenging organisational environment on service user care.

Table 3

Review articles summary

Article (Author(s), year. Title)	Aims	Participants	Method	Results	Limitations
Ahmed, 2019. Staff wellbeing in high-risk operating room environment: Definition, facilitators, stressors, leadership, and teamworking—A	To identify, evaluate, and understand the factors contributing to poor staff wellbeing in the studied organisation and to explore and appraise measures that staff think would positively influence their wellbeing at work.	32 operating rooms (OR) staff from a single University Hospital NHS Trust in the UK.	Content analysis of semi-structured interviews.	Six themes were identified: 1) Wellbeing-at-work links to happiness and job satisfaction; 2) Poor organisational culture leads to poor wellbeing and low staff morale; 3) Need for investing in staff wellbeing; 4) Effective leadership as central to wellbeing-at-work; 5) Wellbeing drives team-	The study findings were limited due to its case study design, high chance of responder bias in data collection and poorly described analytic procedure that raised questions

case-study from a large teaching hospital.				effectiveness; 6) Staff wellbeing and good service user care go together.	about the findings' reliability.
Napier and Clinch, 2019. Job strain and retirement decisions in UK general practice.	To explore the impact of psychosocial factors concerning the UK general practice on GPs' morale and retirement decisions.	12 London GPs, five of whom retired early.	Biographical narrative interviewing method (BNIM).	Consistent theme: changes in the psychosocial work environment contributed to a decline in GPs' morale. Reductions in autonomy were the most commonly cited cause for reduced morale. Growing workload and a 'complaints culture' drained GPs of energy and work morale, whereas increasingly fragmented teams led to reduced social support.	Small and homogenous sample of a single professional group. Therefore, caution should be applied when extrapolating findings to other NHS contexts. Further, the authors commented on responder bias

				Nonetheless, retirement decisions provoked complex emotions and were not straightforward.	among GPs motivated to participate.
Sutton et al., 2016. The influence of organisational climate on care of patients with schizophrenia: a qualitative analysis of health care	To explore the impact of organisational climate on team working in clozapine clinics in one Mental Health Trust in the NHS.	10 healthcare professionals (three pharmacists, three doctors and four nurses).	Interpretative Phenomenological Analysis (IPA) of semi-structured interviews.	Three superordinate themes were identified: 1) 'Philosophy of care', characterised by a lack of awareness of the underlying principles of care; 2) 'Need for change', characterised by recognition of the need for change but no sense of how this could be achieved; 3) 'Role ambiguity', characterised by a lack of understanding and	The study's sample consisted of 10 out of 30 potential staff from seven clozapine clinics in one Trust. The researchers' relationship with the participants was not described. Further, participants' motivation to take

professionals' views.				agreement on the roles and responsibilities within the team for the efficient running of the clinics.	part was not considered. Therefore, there was a chance of biased reporting.
Black et al., 2022. Loss associated with subtractive health service change: The case of specialist cancer centralisation in England.	To understand experiences of loss associated with major system change and the impact of leadership and management on facilitating or hindering coping associated with that loss.	81 clinical and managerial staff from cancer services in London and West Essex. In addition, 134 hours of observational data from relevant meetings and analysis of over	Thematic analysis of semi-structured interviews, observational field notes and documents.	Three themes were identified: 1) 'Immediate subtractive change: Loss of activity, skill and continuity'; 2) 'Emotional repercussions of subtractive change: Loss of self-image, status and motivation'; 3) 'Support and coping strategies offered'. Support measures were undermined by	The lack of specific focus on the experiences of loss in the interviews may have resulted in an incomplete understanding of loss related to service centralisation. Further, the study

		100 documents were used to inform the analysis.		inconsistent implementation and negative consequences of accessing that support.	did not report the views/losses of those clinicians who may have benefitted from this system change.
McKenzie and Addis, 2018. Renal inpatient ward nurse experience and job satisfaction: A qualitative study.	To explore the experiences and job satisfaction of registered nurses working in renal inpatient wards.	12 renal nurses from four inpatient renal wards in an acute healthcare organisation in London.	Thematic analysis of semi-structured interviews.	Three themes were identified: 1): 'Safe care', characterised by key elements of nurse-to-service user ratio, workload and taking into account the complexity of renal service users; 2) 'Organisational culture', characterised by a need to support newly qualified nurses, challenging	Small sample. Further, the participant interviews were conducted during their working hours, which put time constraints on them and potentially limited the

				organisational culture, and need for effective leadership and work-life balance; 3) 'Work environment', characterised by a need for appropriate physical facilities and developing teamwork.	interviews' depth and breadth.
Sutton et al., 2021. A qualitative study of organisational response to national quality standards for 7-	To explore how organisations responded to the national quality standards and targets related to 7-day services from an organisational behaviour perspective.	43 senior management and frontline staff (numbers of each not reported) with knowledge of local implementation of targeted standards	Thematic analysis of semi-structured interviews.	Two types of organisational response were identified: 1) 'Compliance-oriented responses', characterised by hierarchical use of power, a lack of commitment and engagement among staff to make genuine improvements,	Used Trusts' self-reported data regarding their adherence to NHS standards, which may have been influenced by the low-performing

day services in English hospitals.		from eight different Trusts.		but better results on measured outcomes. 2) 'Commitment-oriented responses', characterised by a collaborative approach to implementation and efforts to engage staff but poorer results on measured outcomes.	Trusts' motivation to 'appear' compliant. The relationship between standard compliance and its effect on the quality of care was not examined.
Sheard et al., 2019. What's the problem with patient experience feedback? A macro and micro understanding,	To explore through macro and micro lenses what impedes the use of service user experience feedback.	50 ward and management staff from three NHS hospital Trusts in the North of England.	Unspecified qualitative analysis of seven ward staff focus groups and 23 interviews with	Results were explained in macro and micro-level categories. At the macro level, the industry of collecting data and a lack of focus on implementing feedback was observed. No resources and/or	The study reported on one single issue, and it is unclear how generalisable these findings would be to other contexts.

based on findings from a three-site UK qualitative study.			management staff.	training to analyse the collected data were noted on the micro level.	
Woodhead et al., 2022. "They created a team of almost entirely the people who work and are like them": A qualitative study of organisational culture and racialised	To explore the role of organisational context in workplace discrimination, bullying and harassment.	48 healthcare professionals, of which 5 identified as Asian, 13 as Black (African/Caribbean /other Black), 19 as White British, 7 as White Other, and 4 as any other ethnic group. The sample	Thematic analysis of semi-structured interviews.	Three key themes were identified that shaped the experience and perpetration of discrimination of ethnic minority staff: 'hierarchical organisation', 'pressurised work environment' and 'high diversity– low inclusion'.	The study specifically focused on racialised inequalities; therefore, it is unclear whether Trusts with less ethnically diverse teams would similarly experience

inequalities among healthcare staff.		represented different specialties, roles and bands from 17 NHS Trusts.			the hierarchical NHS structure.
Blacker et al., 2017. An in-depth observational study of an acute psychiatric ward: combining the psychodynamic observational method with thematic analysis	To explore the NHS acute adult inpatient ward's culture.	Acute psychiatric ward in the Midlands.	The psychoanalytic observational method with thematic analysis of observational field notes and supervisory discussions.	Three themes were identified. 1) 'How to connect? Difficulties relating', characterised by lack of purpose and connection among staff and service users' and staff's desire to be elsewhere; 2) 'A state of confusion', characterised by confusion regarding professional roles and	Lack of information and justification for design decisions and methodological procedures made the study's quality difficult to assess.

to develop understanding of ward culture.				responsibilities; 3) 'Alone and responsible: 'the responsibility is actually terrifying'', characterised by perceived criticism towards staff and staff's anxiety regarding their role.	
Riley et al., 2021. Sources of work-related psychological distress experienced by UK-wide foundation and	To explore junior doctors' experiences of work-related distress.	21 foundation or junior doctors working in the NHS with experience of stress, mental illness or suicidality.	Thematic analysis of semi-structured interviews.	Four main themes were identified relating to sources of work-related stress: 1) 'Workload and working conditions'; 2) 'Toxic work cultures', with sub-themes of 'abuse and bullying', sexism and racism', and 'blaming and	Whilst the authors expressed their potential biases, it was not clear how these were mitigated. Further, the study reflected the views of participants that

junior doctors: a qualitative study.				shaming'; 3) 'Lack of support'; 4) 'Stigma and culture of appearing invulnerable'.	were motivated to be interviewed for the study, which likely resulted in biased reporting.
Chesterton et al., 2021. A hermeneutical study of professional accountability in nursing.	To explore NHS nurses' everyday experiences of professional accountability from a cultural and environmental perspective.	Seven nurses with different specialisms and a range of experience.	Phenomenological analysis of semi-structured interviews using hermeneutic cycle.	Four key themes were identified: 1) 'Negative culture', characterised by fear of raising concerns; 2) 'Lack of managerial support'; 3) 'High workload and low staffing levels'; 4) 'Coping strategies', characterised by peer support.	A questionable generalisability due to a very small sample of a single professional group. Due to limited reporting, it was unclear how prevalent the

identified themes were.

Quality appraisal summary

Although most articles had clear research aims, five studies (Ahmed, 2019; Sutton et al., 2021; Sheard et al., 2019; Blacker et al., 2017; Chesterton et al., 2021) were assessed to have unclear or investigative (as opposed to explorative) research questions with implied relationships and predetermined assumptions about organisational challenges. Six studies (Black et al., 2022; Sheard et al., 2019; Woodhead et al., 2022; Blacker et al., 2017; Riley et al., 2021; Chesterton et al., 2021) lacked justification for study design decisions, which made it difficult to ascertain the defensibility of the methods employed.

Several studies (i.e. Ahmed, 2019; Napier & Clinch, 2019; Black et al., 2022; Sheard et al., 2019; Blacker et al., 2017; Riley et al., 2021) did not report their analytic procedure, making it difficult to assess the scientific rigour of analytic tool application. Most studies (6/11) did not include reflective considerations regarding the relationship between the researcher and the participants. Therefore, researcher bias and influence on collected data were not always clear. Similarly, 6/11 studies did not consider the possible influence of the context bias, leaving little room for understanding participants' motivation and representativeness of their views. Most studies reported rich data and produced original, clearly presented, coherent findings that were appropriately referenced with quotes. Further, all studies were assessed to report ethical issues appropriately and produced relevant and convincing findings and research implications.

Two studies stood out during the quality appraisal. Sutton et al. (2021) article was the only study that achieved 14/14 quality criteria due to its carefully selected and representative sample and detailed and justified design and analytic procedure. This enhanced the study's credibility and general validity. In contrast, Blacker et al. (2017) study was close to being rated as low quality due to limited reporting and lack of justification for its methodological decisions, making the overall appraisal of the study's quality difficult. Nevertheless, the

author considered that the absence of justification did not necessarily imply a lack of rigour, and two raters assessed this article as satisfactory due to its rich data and relevant and convincing findings.

Overall, although the articles could have been improved by a more transparent reporting of design and methodology, most of the studies were assessed to be of satisfactory quality (6/11), and the remaining were high quality. The trustworthiness of reviewed studies was considered as part of the critical data synthesis.

Table 4

Quality appraisal summary

Criteria	**Papers**										
	Ahmed, 2019	Napier & Clinch, 2019	Sutton et al., 2016	Black et al., 2022	McKen-zie & Addis, 2018	Sutton et al., 2021	Sheard et al., 2019	Wood-head et al., 2022	Blacker et al., 2017	Riley et al., 2021	Chester-ton et al., 2021
1. Is a qualitative approach appropriate?	Not sure	Appro-priate	Not sure	Appro-priate	Appro-priate	Appro-priate	Not sure	Appro-priate	Not sure	Appro-priate	Not sure
2. Is the study clear in what it seeks to do?	Clear	Clear	Clear	Clear	Mixed	Clear	Mixed	Clear	Mixed	Clear	Clear
3. How defensible/rigorous is the research design/methodology?	Defen-sible	Defen-sible	Defen-sible	Not sure	Defen-sible	Defen-sible	Indefen-sible	Not sure	Indefen-sible	Not sure	Not sure
4. How well was the data collection carried out?	Appro-priately	Appro-priately	Appro-priately	Not sure/ inade-quately reported	Appro-priately	Appro-priately	Not sure/ inade-quately reported	Appro-priately	Not sure/ inade-quately reported	Appro-priately	Appro-priately
5. Is the role of the researcher clearly described?	Clearly des-cribed	Clearly des-cribed	Not des-cribed	Not des-cribed	Not des-cribed	Clearly des-cribed	Not des-cribed	Not des-cribed	Not des-cribed	Clearly des-cribed	Clearly des-cribed
6. Is the context clearly described?	Clear	Clear	Unclear	Clear	Unclear	Clear	Unclear	Clear	Unclear	Not sure	Unclear
7. Were the methods reliable?	Not sure	Reliable	Reliable	Reliable	Reliable	Reliable	Not sure	Reliable	Reliable	Reliable	Not sure

8. Is the data analysis sufficiently rigorous?	Not sure/not reported	Not sure/not reported	Rigo-rous	Not sure/not reported	Rigo-rous	Rigo-rous	Not sure/not reported	Rigo-rous	Not sure/not reported	Not sure/not reported	Rigo-rous
9. Is the data 'rich'?	Rich	Rich	Rich	Rich	Rich	Rich	Rich	Rich	Rich	Rich	Not sure/not reported
10. Is the analysis reliable?	Not sure/not reported	Not sure/not reported	Reliable	Not sure/not reported	Reliable	Reliable	Reliable	Reliable	Not sure/not reported	Not sure/not reported	Not sure/not reported
11. Are the findings convincing?	Convin-cing	Convin-cing	Convin-cing	Convin-cing	Convin-cing	Convin-cing	Convin-cing	Convin-cing	Convin-cing	Convin-cing	Convin-cing
12. Are the findings relevant to the aims of the study?	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant
13. Conclusions	Not sure	Ade-quate	Ade-quate	Ade-quate	Ade-quate	Ade-quate	Ade-quate	Ade-quate	Not sure	Ade-quate	Not sure
14. How clear and coherent is the reporting of ethics?	Appro-priate	Appro-priate	Appro-priate	Appro-priate	Appro-priate	Appro-priate	Appro-priate	Appro-priate	Appro-priate	Appro-priate	Appro-priate
15. As far as can be ascertained from the paper, how well was the study conducted?*	+ (9/14)	++ (12/14)	++ (11/14)	+ (9/14)	++ (11/14)	++ (14/14)	+ (6/14)	++ (12/14)	+ (5/14)	+ (10/14)	+ (7/14)

++ All or most of the checklist criteria have been fulfilled; where they have not been fulfilled, the conclusions are very unlikely to alter (met more than 10/15 criteria).
+ Some of the checklist criteria have been fulfilled; where they have not been fulfilled or not adequately described, the conclusions are unlikely to alter (met more than 5/15 criteria).
– Few or no checklist criteria have been fulfilled, and the conclusions are likely or very likely to alter (met five or fewer criteria).

A narrative synthesis of study findings

The comprehensive synthesis of review articles resulted in five themes summarising studies' findings concerning the challenges of the NHS organisational culture. These were: 1) The challenges related to the target-led work environment; 2) The negative consequences of managerialism; 3) Neglected staff wellbeing; 4) The influence of the challenging organisational culture on service user care; 5) What keeps NHS staff going. Articles represented multiple themes.

Challenges related to the target-led working environment

Five studies described challenges associated with the target-led NHS environment. Napier and Clinch (2019) explored the career narratives of 12 British General Practitioners (GPs). They identified that one of the key aspects of the challenging organisational environment in general practice followed an introduction of 'performance indicators' in the 1990s, characterised by prioritising targets and focusing on budgets. This shift was perceived to have distorted clinical care. GPs reported increased focus on tasks to be achieved despite reduced resources and loss of meaningful relationships with service users. Further challenges associated with the target-led environment were described in terms of increased administrative burden and distorted professional values following the introduction of monetised targets. These processes were reported to create a bureaucratic culture that GPs resented, influencing their decision to retire early.

Sutton et al.'s (2021) study shed light on the target-led NHS environment across different settings. Their study of organisation responses to external targets explored factors influencing the implementation of national seven-day service (7DS) across eight NHS Trusts. The authors conducted 43 interviews with senior management and frontline staff with knowledge of the local implementation of 7DS. Respondents unanimously described an increased emphasis on hitting targets and achieving compliance. The authors identified two

fundamentally different strategies for achieving this in different organisations. They reported that most Trusts adopted a 'compliance-based approach' (p. 5) characterised by a hierarchical top-down implementation with little flexibility and support for frontline staff. However, whilst this approach seemed to be highly effective in obtaining the desired outcome (i.e. compliance with targets), there was little evidence of staff commitment to and appreciation of imposed systems, which raised questions about genuine improvements and their sustainability in the long term.

The few organisations that adopted a 'commitment-oriented' approach (p. 7) aligned external demands with organisational values regarding improved service user care and focused on a collaborative implementation of new standards. These organisations appeared to strive for genuine quality improvement and achieved more support among the frontline staff by working flexibly with them. However, these organisations reportedly performed significantly worse on the national audit of 7DS implementation than organisations that adopted a compliance-based response. Authors argued that organisations with pre-existing good reputations did not feel under scrutiny to demonstrate target compliance and, therefore, could adopt a commitment-based response. In contrast, organisations with a historical legacy of poor care quality ratings felt pressure to prioritise meeting imposed targets even though there was an acknowledgement that this may not have been a good use of resources in the face of more pressing care quality issues. The authors concluded that a unilateral approach to implementing changes in the NHS might result in tokenistic compliance. Further, well-resourced and functioning organisations may struggle to reflect good practices in the external audit data. Although this study was rated to be of high quality, one of the study limitations was the use of Trusts' self-reported data regarding standard compliance, making it likely that Trusts that adopted a compliance-based approach were over-reporting and that commitment-based Trusts were underreporting their adherence to NHS standards. Further, the authors

acknowledged that evidence regarding the effects of either of the two systems on the quality of care was not assessed. Therefore, it was unclear whether either of the two approaches significantly impacted the overall care standards.

Further, Woodhead et al. (2022), Riley et al. (2021), and Chesterton et al. (2021) (studies described in more detail below) identified highly demanding task-oriented work environment to be a significant source of work-related stress among NHS employees, which were argued to affect staff retention via staff sickness and resignation and in turn affected clinical outcomes.

The negative consequences of managerialism

Seven studies described organisational NHS culture challenges in the context of top-down-imposed organisational tasks that clinicians are expected (and monitored) to prioritise and implement. Dillow (2007) described managerialism as a top-down organisational control characterised by the organisation's central figures' belief that they alone have the skill and knowledge to devise policies to cope with competing quality and efficiency objectives. This review adopts Dillow's (2007) definition of managerialism to describe these organisational processes.

One of the challenges of managerialism in the NHS was described in terms of the hierarchical organisational structure. For instance, Woodhead et al. (2022) reported hierarchical structures in how staff and service users perceived their value in their organisation. That is, lower band workers perceived their organisation saw them to be of lesser value than higher band workers. Similarly, service user contact was perceived to be of a lesser value than managerial tasks that higher band workers performed. Further, the findings shed light on the racialised nature of the hierarchical NHS structures. That is, staff from minoritised racial and ethnic backgrounds were overrepresented in lower band positions

and reported hierarchy-based exploitation and unsympathetic treatment by more senior and white workers.

Similar findings related to the hierarchical managerial structure were reported by Chesterton et al. (2021) (the ethnicity of the participants not reported). The study described nurses experiencing adverse treatment from more senior staff and lacking managerial support in challenging situations. The hierarchical ward environment was described in terms of the 'blame culture' (p.193), where more senior staff blamed service shortcomings on individual clinicians. In turn, this made nurses fearful of making mistakes and raising concerns, affected their wellbeing at work and influenced their wish to leave the service. Although this study was rated to be of satisfactory quality, it lacked justification for its methodological decisions and had a very small sample (N=7) with no reported demographics, making it unclear how representative their findings were of their studied population. However, the blame culture within the hierarchical NHS structure was also noted in Napier and Clinch's (2019) study of GPs' experience, giving support to Chesterton et al.'s claims.

Further, Chesterton et al. (2021) identified an absence of effective leadership to implement service improvements where poor practice was known yet not addressed. The authors commented that the nurses felt powerless to change these issues and placed the responsibility for such changes with their management, which arguably reflects the hierarchical NHS organisational structure. Staff's perceived lack of capacity to challenge poor organisational culture was also noted in Woodhead et al. (2022) and Sutton et al. (2016) studies.

Black et al. (2022) explored the unintended effects of top-down-imposed subtractive changes from the wider service centralisation in national cancer services. To do so, the authors interviewed 81 clinical and managerial staff who experienced part of their services

being removed or ceasing to exist, completed observations of different organisational meetings and reviewed over 100 documents related to this subtractive system change. Their thematic analysis described the staff's experiences of these changes in terms of real and symbolic losses. The study reported that local unit clinicians whose specialist surgical activity was taken away to centralised hubs experienced professional losses of specialist skill, activity, and clinical autonomy. Further, there was a reported loss of a sense of community as clinicians lost meaningful and continuous service user-practitioner relationships. These relatively immediate losses were reported to lead to long-term local service losses of high-calibre staff and prospective trainees. These losses were associated with reduced clinicians' status and self-image, leading to decreased motivation and morale. The authors reported that the management's support for clinical staff was delivered in the form of persuasion to appreciate a new working model and offer practical solutions like staff rotation and further development opportunities. However, the latter was reported to be inconsistently delivered, adding to the workload and inaccessible to many clinicians. The management perceived emotional reactions to the system changes as 'resistance' and little emotional support was offered to the affected clinicians.

Similar themes of loss were reported by Napier and Clinch (2019). The authors described the loss of autonomy, service user relationships, and associated reduced work-related pleasure following top-down system changes as aspects of the challenging organisational NHS environment. Perhaps shedding more light on what were the effects of perceived loss of autonomy, Sutton et al. (2016) reported that clinicians lacked understanding of different professional roles and responsibilities in their teams, were concerned about the clinical competencies of professionals assigned to particular roles, and questioned the efficiency of imposed clinical resources-related decisions.

A lack of managerial support was noted in several studies. McKenzie and Addi's (2018) thematic analysis of inpatient nurses' job experience and satisfaction identified that the nurses felt their management did not understand the day-to-day issues of the frontline staff, did not provide moral support, and promoted further development opportunities when these were not practically accessible due to lack of time on shift and service budget reductions. A need for more effective leadership that would understand the difficulties that staff experience was also reported as one of the key themes in Ahmed's (2019) case study of staff's wellbeing at work in the NHS organisation that was 'under severe criticism by regulatory authorities' (p.5). Similarly, Riley et al. (2021) (discussed in more detail below) reported a lack of appropriate support for junior doctors and a perceived need to appear invulnerable following critical incidences, contributing to their mental distress.

Neglected staff wellbeing

Five studies described the challenges in the NHS organisational culture in terms of the unrecognised impact of the NHS culture on staff's wellbeing.

Ahmed's (2019) case study reported findings from the content analysis of 32 interviews with a diverse group of operating rooms (OR) staff in a single organisation that was criticised by regulatory authorities for poor organisational culture. The identified themes suggested that clinicians perceived emotional wellbeing at work as feeling valued and appreciated. Staff experienced emotional wellbeing at work as more important than physical wellbeing and associated it with job satisfaction and motivation to come to work. However, none of the participants could report a positive organisational experience concerning occupational health, sickness and grievance management and described the organisational response to clinicians' issues as controlling, intimidating and fear-inducing. Participants unanimously reported that issues such as lack of resources, managerial support, and clinician-blaming culture created a negative work environment that affected their wellbeing. The study

reported a clear message from staff that the support they needed was easily achievable and realistic.

The theme of unaddressed work-related stress was echoed in multiple studies. Woodhead et al.'s (2022) study of organisational culture and racial inequalities in NHS services analysed interviews with 48 healthcare professionals representing 33 London Trusts. The authors reported the culture that put organisational goals before the individual and described a pressurised work environment as one of the key factors that gave rise to racial discrimination and bullying. Further, such an environment, it was argued, perpetuated work inequalities that staff from minoritised ethnic backgrounds experience. Leaving their job was reported to be one of the staff's coping strategies.

Riley et al. (2021) studied junior doctors' sources of distress and conducted 21 interviews with a diverse group of junior doctors with experience of mental distress. Themes describing junior doctors' sources of distress reported unrealistic workloads in under-resourced services leading to emotional exhaustion and loss of morale. Further, working conditions were reported to fail to meet junior doctors' basic needs at work, contributing to those feelings. The most frequently cited sources of distress were reported to be experiences of being bullied by senior staff, sexism and racism, and a 'blame and shame culture' (p.5) that the services seemed to tolerate. Overall, these stresses had significantly affected junior doctors' wellbeing and, in some cases, triggered mental health issues and were associated with self-harm and/or suicide attempts.

Chesterton et al. (2021) explored seven nurses' stories of professional accountability from an organisational perspective. Authors reported a theme of high workload and low staffing levels leading to nurses compromising their people-caring ideals to meet the organisation's demands, negatively impacting their wellbeing and morale. This dilemma gave

rise to some nurses' desire to leave the profession. Similarly to the aforementioned two studies, this study reported experiences of bullying which many clinicians perceived as part of the job.

Whilst studies described unmet staff needs and reduced wellbeing giving rise to the wish to leave the organisation, this decision appeared to be not without a personal cost. For instance, Napier and Clinch (2019) reported clinicians experiencing existential anxiety and guilt regarding their decision to retire due to organisational challenges.

The influence of the challenging organisational culture on service user care

Five studies reported the challenges of the organisational NHS environment discussed above to negatively affect the quality of care that service users experienced. Several studies noted the disparity between NHS rhetoric and the issues that clinicians observe in practice.

Sheard et al. (2019) highlighted issues affecting service user care planning related to the target culture. The study explored difficulties putting service user feedback into practice across three NHS hospitals and reported macro and micro-level challenges that made service user feedback protocols not fit for purpose. That is, although all participants reported service user feedback to be of immense value and importance to their services, on the macro level, organisations maintained industry-like service user feedback collection practices, where achieving high rates of feedback collection became the sole targeted goal. This resulted in overwhelming volumes of data that no one appeared to be responsible for processing and actioning. On a micro level, collected data could not be meaningfully interpreted due to a lack of skill and allocated resources to do so in the individual teams. It was often received months after it was collected (which at times made it irrelevant as some system changes had happened in the meantime). However, this study lacked scientific rigour in its design, data

collection and analysis and only achieved 6/14 NICE quality checklist criteria, limiting the trustworthiness of the study's findings.

Blacker et al.'s (2017) observational case study sheds some light on how managerialism and suboptimal organisational culture affects clinicians' contact with service users. Their study of a psychiatric ward environment reported staff's confusion about role responsibilities on the ward and observed staff appearing unable to make simple decisions due to a perceived lack of required competence. There was a reported broader atmosphere of terror among staff related to a perceived threat of criticism by service users and managers. Such work atmosphere manifested in staff's anxiety about relating and connecting to service users, general passivity and service user avoidance, and a covertly expressed desire to be elsewhere. However, due to limited methodological rigour and lack of clarity of its analytic procedure, this study had the lowest quality rating in this review, and it was not clear how replicable and valid these study findings were.

Two studies explored organisational challenges related to service user contact in more detail. Sutton et al. (2016) explored the impact of organisational climate on team working across nine clozapine clinics in one Trust and reported a significant disparity between advertised NHS ambition and the realistic working environment in the studied clinics. Study findings described a lack of recovery values, institutionalisation of service users, devalued service user voice, and production-line-like work ethic. Although the authors located solutions and responsibility for the problem with the healthcare professionals, they hypothesised that the disparity between the broader NHS rhetoric and practice might be a manifestation of more deep-rooted organisational NHS challenges.

Further, McKenzie and Addis (2018) reported that nurses experienced organisational issues affecting safe service user care due to a lack of resources and workload demands,

which resulted in nurses working without breaks and high staff turnover. Ahmed's (2019) study presented OR staff's shared view that a high standard of service user care could not be achieved without the staff's wellbeing. The author reported the staff's perception that investment in their wellbeing would increase staff retention, reduce staff sickness and create a positive work culture that would improve service user care.

What keeps the NHS staff going

Two of the reviewed studies reported what keeps NHS staff going in a challenging organisational culture.

McKenzie and Addis (2018) reported that some newly qualified nurses perceived challenging ward environments to foster their professional development. However, whilst this is arguably a positive aspect of working in a challenging environment, it could be argued that nurses working in a challenging NHS environment may, over time, become less resilient and burn out, leading to fewer reported positive experiences. Nurses who reported a positive experience with their management, feeling supported and accommodated to maintain a healthy work-life balance, reported higher job satisfaction despite work-related challenges.

Chesterton et al.'s (2020) study reported that a central element of nurses' ability to deal with work-related issues was their perceived sense of collegiality, characterised by peer support in challenging situations and looking out for each other. Peer support was reported to prevent nurses from leaving their jobs. Another important aspect of nurses' resilience was reported to be the presence of role models in senior management who made newly qualified nurses feel listened to and understood. This significantly influenced their experience of the challenging ward environment.

Discussion

Theoretical appraisal of the review findings

Whilst targets have their value, the understanding of which fell beyond the scope of this review, it has been long recognised that target-driven organisational governance is linked to organisations neglecting non-targeted areas and reduced staff morale, giving rise to unethical organisational behaviour (Ordonez et al., 2009). Indiscriminate application of historical targets may not always be relevant in a fast-changing healthcare sector and ignore qualitative service user and staff experience (Rizq, 2014; Durham et al., 2016). These claims are supported by the review findings that suggested the targets-over-care culture continues to be at the centre of organisational NHS challenges that clinicians experience.

The studies described a lack of leaders and managers who would understand professionals' day-to-day concerns, support their wellbeing at work, and protect them in challenging situations. Whilst the concerns over clinicians' low morale are acknowledged among the NHS leaders, the clinicians' experiences are that they are expected to continue increasing their productivity and delivering 'more for less' (Appleby et al., 2014). It could be suggested that the problematic NHS culture is maintained or even exacerbated by the leaders who appear to listen to the concerns but are either blind to or unable to address those issues. The latter may reduce organisational trust in the leadership, associated with reduced psychological safety, inhibiting the team's ability to transform (Edmondson, 1999). This review expands the literature by suggesting that an organisational NHS culture where its problems remain unaddressed may give rise to racial, sexist, and hierarchical bullying and harassment that many professionals reported.

It was clear from the reviewed articles that the NHS staff had for some time been under increasing pressure and workloads to meet set goals and targets whilst working in shrinking teams and functioning at a less-than-optimal service capacity. Studies illustrated

that many clinicians experienced their workloads as unsustainable, leading to feelings of disillusionment, low morale or even significant mental distress, with many professionals choosing to leave the services; the issue alluded to in all reviewed studies. Further, in line with research that found that applying inflexible target systems to clinical tasks results in poorer outcomes for service users (McCann et al., 2015), this review illustrated the harmful effects of a challenging organisational environment on service user care.

There was evidence that business-efficiency-informed service reorganisation reduced physical and mental capacity for compassionate care due to top-down service demands and loss of meaningful working relationships that used to provide a sense of community for both service users and staff. In line with Menzies-Lyth's (1988) theory, this likely increased staff's anxiety related to their relationships with service users and drew clinicians away from meeting service users' needs as a defence against this anxiety. Further, it could be theorised that these unacknowledged feelings gave rise to secondary anxiety of service breakdown if the targets were not met, maintaining the targets-over-care issue. Whilst setting targets aims to improve the service provision in line with the NHS Constitution (Department of Health and Social Care, 2021), it could be argued that the lack of consideration for clinicians' wellbeing was a result of the system defences, manifesting in the denial of the significance of the individual (i.e. staff) at an organisational level. This expands the understanding of the effects of system defence against anxiety towards organisational treatment by senior clinicians towards frontline staff.

Further, the perception that staff's experiences were not considered important by their seniors and the anxiety-driven poor organisational climate left unacknowledged in the wider business-led culture likely reduced the psychological safety of NHS teams. This may have made implementing changes recommended in Francis report a decade ago impossible.

Implications for clinical practice

In line with claims that neoliberal reforms escalated performance management to the detriment of professionals' and service users' experience in the NHS (Moth, 2020), the studies portrayed the organisational NHS culture's challenges in relation to the business-like management of the services, where the focus on efficiency and production was often experienced as triumphing at the cost of reduced concern towards service users and staff. Further, a decade after the Francis report (2013) recommended tackling the NHS organisational culture, current methods to deliver organisational change remain in many areas ineffective. In light of the reviewed research, a more nuanced assessment and monitoring of local care quality standards that involve targets *and* consider qualitative service user and staff experiences are needed. Whilst it is acknowledged that local services may lack the power to change this, Trust senior leadership boards and directors may need to lobby the commissioning bodies to achieve it. This may facilitate psychological safety in the teams and enable organisational changes, recommended by the Francis report (2013).

Further, continuous service improvement, efficiency-led system reconfiguration, and service restructuring have arguably become defining features of the current NHS climate (Moth, 2020). This review suggested that these system changes can often have destabilising or even counterproductive effects, especially if they are imposed without meaningful consultation with clinicians left to implement and absorb the consequences of these changes. Therefore, balancing the scales between the top-down systemic interventions and bottom-up clinician and service user-voice-led local decisions may be a more fruitful endeavour. Further, examining the impact of targets on quality of care and considering how target achievement is measured may increase their utility and reduce the possibility of tokenistic reporting.

The NHS Constitution describes people's right to have a good working environment,

safe working conditions free from discrimination, and to raise concerns (Department of Health and Social Care, 2021). The reviewed articles highlighted that current organisational norms appear to condone clinician harassment and bullying by other professionals that give rise to organisational racism and sexism. This may perpetuate a myth of clinicians' invulnerability and mental health stigma (Mohammed et al., 2021; Gerada, 2022). The NHS People Plan claimed to put staff wellbeing at the heart of the NHS (NHS England, 2020) and pledged to 'improve the experience of working in the NHS for everyone' (p. 14). Whilst staff wellbeing is important in its own regard, it is clear from this review that failure to attend to issues affecting staff may inadvertently lower service user care standards. The review highlighted that organisational action to make its staff-focused rhetoric a reality is lacking. Further, current research suggests that NHS clinicians report unprecedented levels of work-related stress, likely exacerbated by the recent Covid-19 pandemic (Bhatnagar, 2020; Vizheh et al., 2020). Therefore active systemic efforts are needed to transform dysfunctional organisational norms and promote staff wellbeing.

Compassion is at the core of the NHS values (Department of Health and Social Care, 2021). Schneider et al. (2017) argued that organisational culture is primarily a result of the behaviour of its leaders. In order to nurture compassionate NHS culture, compassion must first be embodied in the organisation's leadership (West et al., 2017). Changes in managerial competencies to recognise and meet the needs of the largely overworked NHS workforce may support current staff and maintain their job satisfaction and presence in challenging working environments, reducing organisational system defences that decrease the quality of care.

Limitations

The NHS organisation is vast: it consists of over 200 acute, mental health, specialist, community, and ambulance Trusts and employs over a million members of staff (The King's

Fund, 2022). It would be erroneous to conclude that a handful of studies reflect universally applicable NHS challenges shared by all NHS teams. The broad scope of this review should be considered to highlight some, but not all, organisational challenges that appear to be shared across different specialisms and services. These should be interpreted in a context of relatively small-scale, qualitative papers that offer a far from a complete picture but may reflect real problems that NHS staff experience. Further, the review aimed to develop a shared narrative of important issues within the NHS instead of providing a comprehensive list of them.

The studies varied in sample sizes and targeted professional groups or specialisms; some were case studies. Although studies were of varied quality, many common themes were evident. The findings of smaller sample studies appeared to be supported by larger-scale studies, and could be seen as adding depth to more widely studied issues across different organisational settings in the NHS.

Further, whilst the studies appeared to have a strong message, they lacked exploration of the alternative reverse relationship between work-related stress and perceived organisational challenges. For instance, it could be hypothesised that staff distraught for reasons unrelated to their work tended to report higher levels of unrealistic work demands and organisational challenges.

Recommendations for future research

In light of this review's findings, future research would benefit from a clear understanding of what a good NHS organisational culture may look like and a review of studies exploring the facilitators and barriers of organisational culture transformation in the NHS. Further, a systematic review of quantitative studies exploring the link between staff's wellbeing and organisational NHS culture would help clarify this link's direction.

Whilst there are many commentaries published in peer-reviewed articles exposing the perils of current NHS organisational culture (e.g. Oliver, 2019; Brannan t al., 2021; Boddy, 2022), it is clear from a relatively small number of studies available for an NHS-wide review question, that more research is needed into the organisational challenges in the NHS. Considering the aforementioned effects of unaddressed NHS culture challenges, there is an urgent need for more research evidence on effective ways to overcome these. In order to yield more generalisable data representative of diverse professional groups within the NHS, future research would benefit from a clearer understanding of the potential differences in NHS culture challenges among medical and mental health teams and different specialist groups within them.

The empirical study of organisational culture challenges appears to adopt an individualistic perspective (Burge, 1986) that locates the problem in the person and not the socio-cultural context in which that problem exists. Fairclough (1989) argued that views and ideas hold socially, culturally and politically specific meanings and are part of broader discourses, i.e. historically located systems of meaning that construe a particular object (Parker, 1992). Further, wider ideologies are embedded and legitimised through discourses that, in turn, reflect and affect social action (Fairclough, 1993). Therefore, it is argued that the study of discourses is fundamental to understanding social practices and power relations that shape them (Fairclough, 1993). Discursive studies adopting a socio-political perspective may offer important insights into the power structures and mechanisms that maintain current ways of understanding and delivering care in the NHS organisation.

Conclusion

This narrative synthesis provided an overview of some current challenges of the NHS organisational culture described in the research post-Francis-report. Studies drew attention to

target culture that created a production-line mentality where the quantifiable evidence of auditable service targets was prioritised over the care delivery and staff's wellbeing, leading to reduced quality of care. The effects of current organisational NHS challenges were considered in light of psychological safety and system defence theories and raised concerns regarding the lack of implementation of the Francis report's (2013) recommendations. Clinical implications called for aligning the public NHS rhetoric with its systemic action to fulfil the constitutional NHS pledges towards service users and staff. Review limitations and future recommendations were discussed and called for more focused research into the NHS organisational culture and suggested an introduction of a socio-political perspective to the study of the NHS culture by adopting a discursive approach.

References

Ahmed, I. (2019). Staff wellbeing in high-risk operating room environment: Definition, facilitators, stressors, leadership, and teamworking—A case-study from a large teaching hospital. *International Journal of Healthcare Management, 12*(1), 1-17. https://doi.org/10.1080/20479700.2017.1298228

Appleby, J., Galea, A., & Murray, R. (2014). The NHS productivity challenge. *Experience from the front line. London: The King's Fund*. http://ignacioriesgo.es/wp-content/uploads/2014/09/NHS-productivity-Kings-Fund1.pdf

Bhatnagar, G. (2020). Physician burnout. *Lancet, 395*(10221), 333.

Black, G. B., Wood, V. J., Ramsay, A. I., Vindrola-Padros, C., Perry, C., Clarke, C. S., ... & Fulop, N. J. (2022). Loss associated with subtractive health service change: The case of specialist cancer centralisation in England. *Journal of health services research & policy*, 13558196221082585. https://doi.org/10.1177/13558196221082585

Blacker, R., Kurtz, A., & Goodwin, A. (2017). An in-depth observational study of an acute psychiatric ward: combining the psychodynamic observational method with thematic analysis to develop understanding of ward culture. *Psychoanalytic psychotherapy, 31*(1), 4-20. https://doi.org/10.1080/02668734.2016.1275037

Boddy, B. (2022). NHS Staff Survey 2021: Learning from the findings. *Practice Management, 32*(5), 21-24. https://doi.org/10.12968/prma.2022.32.5.21

Brannan, S., Davies, M., English, V., Harrison, C. A., Norcliffe-Brown, D., & Sheather, J. C. (2021). Ethics briefing. *Journal of Medical Ethics, 47*(8), 587-588. http://dx.doi.org/10.1136/medethics-2021-107676

Brown, A. (1995). *Organisational culture and leadership*. Pitman.

Brown,W. (2015). *Undoing the demos: Neoliberalism's stealth revolution.* New York: Zone Books.

Burge, T. (1986). Individualism and psychology. *The Philosophical Review, 95*(1), 3-45. https://doi.org/10.2307/2185131

Chesterton, L., Tetley, J., Cox, N., & Jack, K. (2021). A hermeneutical study of professional accountability in nursing. *Journal of Clinical Nursing, 30*(1-2), 188-199. https://doi.org/10.1111/jocn.15539

Church, J., Gerlock, A., & Smith, D. L. (2018). Neoliberalism and accountability failure in the delivery of services affecting the health of the public. *International Journal of Health Services, 48*(4), 641-662. https://doi.org/10.1177/0020731418793106

Cosgrove, L., & Karter, J. M. (2018). The poison in the cure: Neoliberalism and contemporary movements in mental health. *Theory & Psychology, 28*(5), 669-683. https://doi.org/10.1177/0959354318796307

Davies, H. T., Nutley, S. M., & Mannion, R. (2000). Organisational culture and quality of health care. *BMJ Quality & Safety, 9*(2), 111-119. http://dx.doi.org/10.1136/qhc.9.2.111

Deal, T. E., & Kennedy, A. A. (1988). *Corporate cultures: The rites and rituals of corporate life.* Penguin Books.

Department of Health and Social Care. (2020). *NHS recovery to put staff wellbeing at its heart.* https://www.gov.uk/government/news/nhs-recovery-to-put-staff-wellbeing-at-its-heart

Department of Health and Social Care. (2021). *The NHS Constitution for England.* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Department of Health. (2001). *Shifting the Balance of Power: securing delivery*. https://www.nuffieldtrust.org.uk/files/2019-11/shiftingthebalance.pdf

Dillow, C. (2007). *The end of politics: New labour and the folly of managerialism.* Harriman House.

Durham, M., Faulkner, M., & Deakin, C. (2016). Targeted response? An exploration of why ambulance services find government targets particularly challenging. *British Medical Bulletin*, *120*(1).

Edmondson, A. (1999). Psychological safety and learning behaviour in work teams. *Administrative science quarterly, 44*(2), 350-383. https://doi.org/10.2307/2666999

Edmondson, A. C., & Lei, Z. (2014). Psychological safety: The history, renaissance, and future of an interpersonal construct. Annual Review of Organisational Psychology and Organisational Behaviour, 1(1), 23-43. https://www.annualreviews.org/doi/pdf/10.1146/annurev-orgpsych-031413-091305

Fairclough, N. 1989. *Language and Power.* Longman.

Fairclough, N. 1993. *Discourse and Social Change.* Polity Press.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary* (Vol. 947). The Stationery Office.

Gerada, C. (2022). Doctors' identity and barriers to seeking care when unwell. *The British Journal of Psychiatry*, *220*(1), 7-9. doi: 10.1192/bjp.2021.52

Green, B.N., Johnson, C.D., & Adams, A. (2006). Writing narrative literature reviews for peer-reviewed journals: secrets of the trade. *Journal of Chiropractic Medication, 5(3),* 101-117. https:// 10.1016/S0899-3467(07)60142-6

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: a systematic review. *PloS one, 11*(7), e0159015. https://doi.org/10.1371/journal.pone.0159015

Johnson, A., Nguyen, H., Groth, M., Wang, K. and Ng, JL (2016), "Time to change: a review of organisational culture change in health care organisations", *Journal of Organizational Effectiveness: People and Performance, 3*(3), 265-288. https://doi.org/10.1108/JOEPP-06-2016-0040

Malinowski, B. (1922). *Argonauts of the Western Pacific.* Routledge & Kegan Paul.

Martin, J. (1992). *Cultures in organisations: Three perspectives*. Oxford University Press.

McCann, L., Granter, E., Hassard, J., & Hyde, P. (2015). "You can't do both - something will give": limitations of the targets culture in managing UK healthcare workforces. *Human resource management, 54* (5), 773-791. https://doi.org/10.1002/hrm.21701

McKenzie, A. T., & Addis, G. (2018). Renal inpatient ward nurse experience and job satisfaction: A qualitative study. *Journal of clinical nursing, 27*(23-24), 4353-4360. https://doi.org/10.1111/jocn.14552

Menzies-Lyth, I. (1988). *Containing anxiety in institutions: Selected essays, Vol. 1*. Free Association Books.

Mohammed, S., Peter, E., Killackey, T., & Maciver, J. (2021). The "nurse as hero" discourse in the COVID-19 pandemic: A poststructural discourse analysis. *International journal of nursing studies, 117,* 103887. https://doi.org/10.1016/j.ijnurstu.2021.103887

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group*. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine, 151*(4), 264-269. https://doi.org/10.7326/0003-4819-151-4-200908180-0013

Moth, R. (2020). 'The business end': Neoliberal policy reforms and biomedical residualism in frontline community mental health practice in England. *Competition & Change, 24*(2), 133-153. https://doi.org/10.1177/1024529418813833

Moth, R. (2020). 'The business end': Neoliberal policy reforms and biomedical residualism in frontline community mental health practice in England. *Competition & Change, 24*(2), 133-153. https://doi.org/10.1177/1024529418813833

Napier, J., & Clinch, M. (2019). Job strain and retirement decisions in UK general practice. *Occupational Medicine, 69*(5), 336-341. https://doi.org/10.1093/occmed/kqz075

National Institute for Health and Care Excellence (NICE). (2012). *Methods for the development of NICE public health guidance* (Appendix H). https://www.nice.org.uk/process/pmg4/chapter/introduction

Nelson, K., Boudrias, J. S., Brunet, L., Morin, D., De Civita, M., Savoie, A., & Alderson, M. (2014). Authentic leadership and psychological wellbeing at work of nurses: The mediating role of work climate at the individual level of analysis. *Burnout Research, 1*(2), 90-101. https://doi.org/10.1016/j.burn.2014.08.001

Newman, A., Donohue, R., & Eva, N. (2017). Psychological safety: *A systematic review of the literature. Human resource management review, 27*(3), 521-535. https://doi.org/10.1016/j.hrmr.2017.01.001

NHS England. (2020). *We are the NHS: People Plan 2020/21-action for us all.*

https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf

Oliver, D. (2019). David Oliver: Let's value and encourage problem raisers. *BMJ, 367*. https://doi.org/10.1136/bmj.l6871

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology.* Hove: Routledge.

Parmelli, E., Flodgren, G., Schaafsma, M. E., Baillie, N., Beyer, F. R., & Eccles, M. P. (2011). The effectiveness of strategies to change organisational culture to improve healthcare performance. *Cochrane Database of Systematic Reviews*, (1). DOI: 10.1002/14651858.CD008315.pub2.

Pope, R. (2019). Organisational Silence in the NHS: 'Hear no, See no, Speak no'. *Journal of Change Management, 19*(1), 45–66. https://doi.org/10.1080/14697017.2018.1513055

Rice, A. K. (1963). *The enterprise and its environment: A system theory of management organisation.* Tavistock Publications.

Riley, R., Buszewicz, M., Kokab, F., Teoh, K., Gopfert, A., Taylor, A. K., ... & Chew-Graham, C. (2021). Sources of work-related psychological distress experienced by UK-wide foundation and junior doctors: a qualitative study. *BMJ open, 11*(6), e043521. http://dx.doi.org/10.1136/bmjopen-2020-043521

Rizq, R. (2014). Perverting the course of therapy: the fetishisation of governance in public sector mental health services. *Psychoanalytic Psychotherapy, 28*(3), 249-266. https://doi.org/10.1080/02668734.2014.933034

Schein Edgar, H., & Bennis, W. (1965). *Personal and organisational change via group methods*. Wiley.

Schneider, B., González-Romá, V., Ostroff, C., & West, M. A. (2017). Organisational climate and culture: Reflections on the history of the constructs in the Journal of Applied Psychology. *Journal of applied psychology*, *102*(3), 468. https://doi.org/10.1037/apl0000090

Sheard, L., Peacock, R., Marsh, C., & Lawton, R. (2019). What's the problem with patient experience feedback? A macro and micro understanding, based on findings from a three-site UK qualitative study. Health Expectations, 22(1), 46-53. https://doi.org/10.1111/hex.12829

Sutton, E., Bion, J., Mannion, R., Willars, J., Shaw, E., & Tarrant, C. (2021). A qualitative study of organisational response to national quality standards for 7-day services in English hospitals. *BMC health services research*, *21*(1), 1-11. https://doi.org/10.1186/s12913-021-06213-w

Sutton, J., Family, H. E., Scott, J. A., Gage, H., & Taylor, D. A. (2016). The influence of organisational climate on care of patients with schizophrenia: a qualitative analysis of health care professionals' views. *International journal of clinical pharmacy*, *38*(2), 344-352. https://doi.org/10.1007/s11096-016-0247-z

Taylor, D. J., & Goodwin, D. (2022). Organisational failure: rethinking whistleblowing for tomorrow's doctors. *Journal of Medical Ethics, 48*(10), 672-677. https://jme.bmj.com/content/medethics/48/10/672.full.pdf

The King's Fund. (2022). *Key facts and figures about the NHS.* https://www.kingsfund.org.uk/audio-video/key-facts-figures-nhs

Vizheh, M., Qorbani, M., Arzaghi, S. M., Muhidin, S., Javanmard, Z., & Esmaeili, M. (2020). The mental health of healthcare workers in the COVID-19 pandemic: A systematic review. *Journal of Diabetes & Metabolic Disorders*, *19*(2), 1967-1978.

https://doi.org/10.1007/s40200-020-00643-9

Walshe, K. (2018). Gosport deaths: lethal failures in care will happen again. *BMJ*, 362. https://doi.org/10.1136/bmj.k2931

Walshe, K., & Shortell, S. M. (2004). When things go wrong: how health care organisations deal with major failures. *Health affairs*, *23*(3), 103-111. https://doi.org/10.1377/hlthaff.23.3.103

West, M., Eckert, R., Collins, B. & Chowla, R. (2017). *Caring to change: How compassionate leadership can stimulate innovation in health care.* The King's Fund. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

Willis, D. (2020). Whorlton Hall, Winterbourne View and Ely Hospital: learning from failures of care. *Learning Disability Practice*, *23*(6). doi: 10.7748/ldp.2020.e2049

Woodhead, C., Stoll, N., Harwood, H., TIDES Study Team, Alexis, O., Hatch, S. L., ... & Valmaggia, L. (2022). "They created a team of almost entirely the people who work and are like them": A qualitative study of organisational culture and racialised inequalities among healthcare staff. *Sociology of Health & Illness*, *44*(2), 267-289. https://doi.org/10.1111/1467-9566.13414

Wren, B. (2014). Managing staff experience to improve organisational culture. In L. Tate, E. Donaldson-Feilder, K. Teoh, B. Hug, & G. Everest (Eds.), *Implementing culture change in the NHS: contributions from occupational psychology* (pp.18-24). British Psychological Society.

CARE DELIVERY IN THE CURRENT NHS CONTEXT

SECTION B: Mental health clinicians' language regarding care delivery in the current socio-political NHS context

April, 2023

Word count: 7976 (74)

Abstract

Since the turn towards neoliberal governance in the 1980s, NHS services have shifted to a business-model mode of governance, characterised by efficiency and target-led culture. Whilst targets have value, neoliberal values-led NHS business priorities can conflict with delivering compassionate care.

However, research on how clinicians manage competing rhetorics of business and care remains scarce and tends to adopt an individualised perspective on systemic issues, which ignores the impact of neoliberal ideology on the quality of care. Therefore this study aimed to introduce a socio-political perspective in understanding care delivery in the NHS and explored mental health clinicians' language regarding care delivery in organisational meetings.

This study adopted a qualitative design and was co-produced with representatives of NHS clinicians and service users. The data consisted of seven organisational meetings' recordings from a single Adult Mental Health Directorate in the South of England, involving 63 different NHS professionals. Foucauldian Discourse Analysis was selected as the most appropriate method of analysis.

Four discourses relating to care delivery were identified in the data. The 'care as business' discourse constituted a dominant business-model-led narrative that prioritised business viability and positioned service users and staff as business commodities. The discourse of 'managerialism in care delivery' described a Panoptic process of surveillance and control to ensure adherence to the business model. The discourse of 'care delivery in crisis' described urgent rhetoric regarding the critical state of current care delivery standards that generated distress among clinicians. The 'contextualised compassion' discourse

highlighted an alternative to business discourse that competed with dominant neoliberal rhetoric and aimed to rebalance power relations in the NHS.

The study findings highlight the need to reformulate the aims of services in line with their primary task and might help to encourage NHS clinicians to exercise their professional powers to rebalance power relations in the NHS.

Introduction

Epistemological position

The principal researcher undertaking this project adopts a post-modernist/post-structuralist epistemological stance that recognises the multitude of realities contained and understood via language (Sandu, 2011). Post-structuralists reject the idea of 'true meaning' and explore how different subjects, including researchers, construct and make sense of 'reality' by detecting taken-for-granted discourses (Sandu, 2011). Discourses are defined as a historically located coherent system of meanings that construct a particular object and are realised by individuals taking up a subject position in relation to that discourse through language (Parker, 1992). In line with the post-structuralist stance, the author considers the theories discussed below as discourses that are shaped by and shape societal structures of knowledge and power.

Neoliberalism in the NHS

Rice (1963) coined the term ‘primary task’ to describe a core purpose for which organisations are set to exist and which gives authority to fulfil this purpose. At its creation in 1948, the United Kingdom’s (UK’s) National Health Service (NHS) primary task was ‘to provide everyone in the UK with healthcare based on their needs, and not on their ability to pay’ (Step into the NHS, n.d.). Justified by a lack of administrative systems at NHS inception, the NHS governance model at a time was dominated by a medico-central rhetoric that delegated the running of the services to local clinicians (Greener & Powell, 2008). In this context, the government’s critical narrative of the NHS early governance was formed, a rhetoric that characterised the NHS services as inefficient due to local professionals’ judgement-led service diversity and lacking economic considerations (Greener & Powell, 2008).

In the 1980s, the United Kingdom (UK) government's actions to improve public sector services legitimised a shift towards what is often regarded as a neoliberal mode of governance characterised by business-values-led ideology and 'Widespread economisation of heretofore noneconomic domains, activities, and subjects' (Brown, 2015, p31). The implementation of new government reforms within the public sector was achieved by introducing a business market discourse of performance management, which claimed to increase service efficiency by producing competitive markets for contracts to deliver services (Springer, 2012).

In the UK's NHS, neoliberal business-market governance generated a service audit, monitoring and evaluation culture based on performance targets (McCann et al., 2015). The progressive NHS business-centricity was propelled by successive governmental reforms that popularised a clinical efficiency rhetoric and promoted a 'faster-and-cheaper' approach to service delivery demands (Prabakaran, 2011). The constructive effects of these actions were particularly problematic in the NHS mental health services, where 'performance' and 'outcomes' may be difficult to measure (Greener & Moth, 2020), likely resulting in arbitrary targets. Further, the Conservative government's deployed austerity measures in 2010 legitimised a governmental expectation in the public sector organisations, including the NHS, for service provision for the lowest possible expense or risk restructuring, which led to service users in the NHS mental health services being positioned as commodities with economic costs and risks to the service viability (Cheetham et al., 2017).

Whilst it is recognised that targets have their value, criticisms have been made that the discourse of business-model NHS governance prioritised a rhetoric of giving the impression that targets were met and neglected other organisational issues, leading to organisational failures (de Bruijn, 2007; Ordonez et al., 2009). In line with these claims, the literature exploring systemic issues within the NHS draws attention to target-driven priorities working

against rather than in favour of optimal care, an organisational culture of fear, institutional 'deafness' to bottom-up concerns, and reduced staff morale (Rizq, 2014; Francis, 2013, Rawlinson, 2008, Steel et al., 2015; Holttum, 2018; Pope, 2019). It has been suggested that rather than addressing inefficiencies and saving money, the top-down organisational culture based on neoliberal ideology is part of the problem (McCann et al., 2015).

Institutional power: A Foucauldian perspective

Whilst dominant NHS governance discourses are often construed to have negative connotations, Foucault (2019) understood power as a necessary aspect of a functioning society that enables and constrains action. Foucault (1977) argued that those with power exerted pressure on the less powerful, who in turn resisted it and suggested that power was not simply the ruling of those lacking power but was 'transmitted by them and through them'(p.27). Foucault (1998) theorised that social enactments of power produce a multiplicity of subject positions with permitted and restricted social actions that different persons could identify with, depending on their relationship to a particular discourse.

Foucault (1998) proposed a relational conceptualisation of power and famously stated that 'where there is power, there is resistance' (p.95) and theorised that power and resistance are inseparable aspects of power relations that drive the production of knowledge. From his perspective, power relationships implied a struggle to extend one's influence by directing the conduct of others; the forces of resistance were not considered to be a mere reaction to power but were a part of dynamic power strategies aimed at governing the fields of matter (Foucault & Faubion, 2000). Therefore, resistance in the Foucauldian sense transformed power relations and had the potential to negate oppressive dominant forces that come with power imbalances (Foucault & Faubion, 2000).

According to Foucault (1977), an automatic functioning of power could be assured via operating a schema of Panopticism. He described Panopticism as an induced state of permanent visibility and surveillance, where a group of individuals, in the presence of a temporary observer of dominant power position, develop anxiety about being observed and become self-surveillant in effect, which renders the actual exercise of power largely unnecessary (Foucault, 1977). Foucault (1977) argued that Panopticism might be applied whenever there is a number of individuals with a shared task and specifically considered its governing presence in establishments such as healthcare institutions. Foucault (1977) theorised that applying the Panopticon principle increased individual discipline whilst reducing the economic cost of running the power apparatus, which he theorised to be especially palatable in a neoliberal era of marketisation of public fields.

Power and resistance in the NHS

Whilst the discourse based on neoliberal values appears to dominate within the NHS, another discourse based on ethics and values has also been identified (Fulford et al., 2002). The NHS values discourse is characterised by rhetorics of high-quality and compassionate care for all service users (Department of Health, 2021), the standards of which are monitored by the independent national regulatory body, the Care Quality Commission (CQC)(Care Quality Commission, 2022). Further, since the Francis Inquiry (2013), the NHS rhetoric emphasised a need to prioritise compassionate care, staff support, and transparent organisational culture within the NHS (Farr & Barker, 2017).

Nevertheless, research suggests that clinicians working in the NHS describe ongoing ethical conflicts between top-down service demands and personal values of care and compassion for their service users (Proctor & Hayes, 2017; Proctor et al., 2020). Thus, although neoliberal reforms in the NHS were intended to provide good services, which is

most likely in line with clinicians' values, clinicians nevertheless experience their personally held values as being contradicted by operational policy.

Moral distress among NHS clinicians

One way of understanding the constructive effect of competing business and care rhetorics that the NHS clinicians may draw on is through a theory of moral distress. Jameton (1984) drew attention to structural power issues in decision-making among healthcare professionals and theorised that when an individual's agency to do what feels to be the right course of action is constricted by their governing institution, which makes such action nearly impossible to take, moral distress occurs. Due to research evidence indicating its prevalence across diverse healthcare professions, moral distress is now commonly associated with the whole healthcare sector (e.g. Austin et al., 2005; Mitton et al., 2010; Allen et al., 2013). Despite the increased focus on job satisfaction and staff retention in the NHS rhetoric over recent years, the healthcare sector continues to be criticised for ignoring the 'human factor' in business-model-led service planning (Williams et al., 2020).

The growing discursive prevalence of moral distress in healthcare produced arguments for allocating resources to mitigate moral distress, justified to benefit the services in the long run (Williams et al., 2020) and generated constructions of evidence-based strategies to mitigate it. However, the study of healthcare clinicians' moral distress has been criticised for locating the problem at an individual level and ignoring the broader institutional context in which such distress occurs (Molinaro et al., 2023).

Study rationale and aims

Although the relevance of broader ideological issues of neoliberal targets and service marketisation in understanding the NHS clinical practices is hard to dispute, existing research problematises the impact of neoliberalism in the healthcare sector at an individual level. The

consequences of unaddressed socio-politically-embedded discourses that may not be consciously chosen likely generate an automatic functioning of power via dominant discourse. This may have direct consequences on constructions of permissible and restricted organisational action, which, in the context of the NHS and mental health services more specifically, affects service users and clinicians.

Taken-for-granted discourses that shape daily social action may be best detectable through their constant use in naturally occurring language (Willig 2013). Further, NHS values pledge a commitment to improving the quality of care and putting its community's needs above organisational boundaries (Department of Health and Social Care, 2021). This justifies an analysis of language in organisational meetings in order to understand how mental health clinicians in the NHS negotiate competing care and efficiency discourses of care provision in the everyday running of the services.

Therefore, this study aimed to introduce a socio-political angle on defining and legitimising NHS care delivery rhetoric via an exploration of mental health services clinicians' language regarding care delivery in different organisational meetings.

More specifically, this research had the aim of addressing the following questions:

1) What discourses and associated subject positions are drawn on in different clinicians' language regarding care delivery?
2) What are the subjective and social implications of different discourses that clinicians draw on? (i.e. what is being reinforced/reproduced and/or transformed/challenged?)

Methodology

Co-production

In order to synergise the worlds of academia and 'real-life' practice, this study adopted a co-production approach (O'Hare et al., 2010) and was designed in collaboration with the representatives from each group of individuals that the study analysis pertained to, i.e. NHS staff and service users. A paid service user consultant and NHS clinician/project supervisors were involved in all stages of this research study, from designing the project to research dissemination.

Design

The study aimed to explore different constructions of care delivery in different mental health clinicians' languages whilst considering the role of institution, power, and ideology. Discursive research aims to understand how different discursive constructions produce social realities and shape action (Cheetham et al., 2017). Further, Foucauldian Discourse Analysis (FDA) focuses on power relations and ways of seeing and being in the world that different discursive constructions enable and disable (Willig, 2013). Therefore, FDA was selected as the most appropriate research method. As the study aimed to examine naturally occurring language referring to care delivery, 'care delivery' was chosen as the 'discursive object' (Willig, 2013).

Participants

The data from a single directorate within one South of England Adult Mental Health Service locality was selected for feasibility and accessibility purposes. The potential sample of different adult services meetings was identified based on accessible pan-directorate meetings attended by the research supervisor as per their clinical role, considering a wide range of meeting types and remits. All meetings took place virtually via MS Teams.

Nine organisational meetings that took place between July and December 2022 were accessed for the purposes of the study (see Table 1). Two meetings were excluded from the study due to software-malfunction-related failure to record. A total of seven organisational meetings were recorded and analysed. A total of 63 professionals consented for their accounts to be used in this study. No participant demographic data was collected as the study's recruitment strategy focused on the organisational representation of diverse clinical roles, reflected in meeting selection, as opposed to individual clinicians' characteristics.

Table 1

List of recorded and analysed meetings

No	Title
M1	Research Planning Meeting
M2	Trust Acute Psychological Practitioners Meeting
M3	Locality Adult Services Psychology and Psychotherapy Leads Meeting
M4	Locality Psychosis Senior Leadership Team Meeting
M5	Two-day clinical training event for Trust's care-coordinators
M6	High-Intensity Service User Network Meeting
M7	Community Transformation Steering Group Meeting
Not used	Mental Health Service User and Carers Group Meeting
Not used	Monthly Ward Managers Meeting

Recruitment

Before data collection, the research supervisor attending the meetings checked with the potential attendees if they were interested in participating. Following an expression of interest, the study's information sheet (Appendix B) and a consent form (Appendix C) were

emailed to the meeting's attendees. At the beginning of each virtual meeting, the attendees were reminded of the study taking place and had an opportunity to ask questions. The information sheet and consent forms were shared with them again via the meeting's group chat. The meeting attendees who had not responded via email communicated their consent to participate in the study via MS Teams chat. If no meeting attendees dissented, then the research team member attending the meeting recorded the meeting using in-built MS Teams computer software. There were no changes to the standard content of the selected meetings. The meeting recruitment based on accessibility continued until the data saturation point was achieved.

Overall, the principal researcher processed 24 hours and 15 minutes of raw data. After removing discussions unrelated to the discursive object (i.e. psychological theory teaching in one meeting that was a training session) from the data sample, the final data analysis consisted of 12 hours and 48 minutes of meeting data.

Analytic procedure

The principal researcher accessed and transcribed each meeting's recording verbatim using NHS encrypted laptop and then deleted the recordings and any associated access links from her electronic devices.

Processed anonymised transcripts were securely shared with the service user consultant, who recorded their in-depth analytic observations for meetings 1-4 and shared these with the principal researcher, who incorporated them into the subsequent analytic steps.

The following analysis was guided by Willig's (2013) six-stage model of the FDA (see Appendix D). NVivo software was used to aid initial data processing and categorisation. Firstly, the principal researcher re-familiarised herself with transcripts and made notes in relation to the research questions (Appendix E). Then, going through each meeting's

transcript separately, the researcher identified different ways in which the discursive object, i.e. 'care delivery', was constructed by noting all implicit and explicit references to it and grouping these constructions within broader discursive themes (Appendix F for an example). Secondly, discursive constructions from all individual meetings were located within broader discourses. Next, the researcher examined all meetings' initial notes, data annotations, and service user consultant observations and identified associated gains and losses achieved by deploying a particular discourse (i.e. action orientation). Lastly, the researcher appraised how different clinicians were located in particular discourses (i.e. their subject positions), possibilities for action contained in them (i.e. practice), and considered broader consequences and relationships of different discourses (i.e. subjectivity). See Appendix G for a summary of these notes.

Methodological credibility

Levitt et al. (2017) proposed a unified approach for designing and evaluating qualitative research based on methodological integrity, achieved by establishing research fidelity and utility. They provided research recommendations that were followed to establish the study's trustworthiness and credibility (See Appendix H for more details).

In line with Levitt et al. (2017) recommendations for enhancing research fidelity, all research team members took part in a bracketing interview (Fischer, 2009) in order to identify personal and social influences to engage with the research topic and consider how these may shape the research process. Additionally, the principal researcher utilised a reflective research journal (see Appendix I for example extract) that helped to identify potential biases in research-related decisions and philosophical arguments, which were brought up in a group discussion with the research team.

Whilst in the context of the discourse analysis, eliminating personal biases is considered improbable (Parker, 1992), the research team's reflective actions enabled an ongoing discussion and reflection related to this research from a multitude of perspectives incorporated into the study's write-up.

Reflexivity statement

The bracketing interview highlighted the author's, her supervisors' and lived experience consultant's shared criticism towards medico-central discourses concerning mental distress that dominate the NHS. This stemmed from personal experience or witnessing a close family member experiencing mental distress and feeling not helped or sometimes worsened health by the high emphasis on mainstream medico-central understandings. The research team found alternative and less prevalent community-psychology-led approaches more helpful, which gave rise to interest in power structures in healthcare that shape service users' experience. The research team members wanted to engage in research that sheds light on and has the potential to transform invisible power structures in mental health services and in doing so, contribute to improving service user experience. These personal motivations are likely reflected in the research's focus.

The principal researcher feels passionately about stories of survival reflected in everyday forms of resistance, likely shaping a search for alternative discourses. The supervisor who co-participated in the meetings as part of his clinical role chose to distance himself from the analysis due to possible bias from his dual participant-researcher role. A more collaborative analysis would likely have influenced research findings differently.

Ethical considerations

Since this research focused on NHS clinicians' language in organisational meetings, the researcher sought ethical approval from the Health Research Authority (HRA) via NHS

Ethics application. Once HRA approved the study (Appendix J), the researcher agreed and actioned study conditions with the participating Trust.

The research team notified the participating Trust's service users by distributing a service user notification poster (Appendix K) in three Trust locations. The poster described actions to follow if they wished to discuss the study and/or express their right to object to their information being used.

No service user or professional exercised their right to dissent.

Any identifiable information related to the services, meeting attendees or individuals mentioned in the meetings was anonymised or removed. The accounts of meeting attendees who did not consent in writing (e.g. due to technical issues or lateness) were removed from the transcript. This did not significantly change overall data as many of the aforementioned speakers were largely silent in the meetings, and only around 5% of the data was excluded. The principal researcher stored the evidence of consent and kept anonymised transcripts on an encrypted USB.

Analysis and discussion

Four main constructs relating to care delivery in the NHS were identified in the analysis. In turn, they describe how constructions of care delivery were influenced by a broader neoliberal ideology, shaped available action, and had social implications for care delivery in the NHS. A competing discourse highlighted compassionate rhetoric in organisational settings. Discourses are illustrated with meeting extracts with multiple speakers, numbered in the order they appear in this text.

Discourse 1: Care as business

The overarching construct relating to care delivery was 'care as business'. Here, care delivery was constructed using corporate business rhetoric. This business-model narrative pervaded all organisational meetings and accounts.

Costing care

Within the care as business discourse, optimal care delivery was characterised in monetary terms. This narrative was implicitly prioritised over alternative ways of construing care delivery in service planning meetings:

Extract 1 (M4; 426-443; Speaker 2 follows on from Speaker 1)

Speaker 1	for some posts, there may well be additional cost that-that, that team leader needs to kind of you know man half a shift or whatever with agency. That was why [name] wanted it to be a pilot because we had concerns about the amount of money it might cost for maintaining safer staffing levels; it's a big issue. [230-236]
Speaker 2	the reason this is so important is at the moment from a board level there are different SROs [Senior Responsible Owners] that have been allocated to look at ward overspend. So [name] is the SRO for our inpatient ward overspend. This is literally the-the discussion. So the meetings haven't come through yet, but it's exactly this, which we need to keep all on, all on one page, to be able to talk about sort of where our spends are.

The above extract illustrates a seemingly emotionless, corporate way of discussing care delivery that characterised business needs as the highest priority. Here, corporate jargon prevailed and produced a construction of care delivery as a business to be maintained; clinicians and service users threatened business viability via acquired cost and risk of inefficiency. Further, constructions of clinical staff as a 'cost' or an 'overspend' characterised them as inanimate tools in a business apparatus. This adds to the literature by exemplifying

that where business-model care prevails, clinicians are also routinely constructed as business commodities.

The construction of care as a cost limited operational dialogues and prevented humane factors for staff shortages due to work pressures and staff burnout (Lamiani et al., 2017) from being considered in service planning discussions.

Achieving business criteria

Another way of employing business-model-led constructions of care delivery was through criteria-led talk that imposed controls over clinicians' autonomy:

Extract 2 (M1; 25-34)

Speaker 3 I was just talking… just made… tried to make a referral for someone to the specialist OCD service. And it got rejected. It was really interesting just hearing about that criteria because it's incredibly tight. And it's about medication. So being on the right SSRI, but not just about being on them for a long enough time, it's about the dosage as well. So there has to be maximum dosage and at least two attempts with SSRIs and at least two treatments of CBT not just a primary care level, so not just with IAPT. It's gotta be secondary care as well for more than 12 sessions each time.

Here, care delivery was considered in the context of criteria to be met where adherence to business protocols was prioritised over clinical needs-based decision-making.

The NHS business rhetoric is commonly justified as serving the needs of the services' imagined future of optimal and equal access to care for all (Moth, 2020). However, whilst actions for managing care as a business may make services appear more 'efficient', efficiency does not necessarily imply effectiveness. At times, construing care as business acted as a form of control over what care could or could not be delivered and restrained clinicians in their actions regarding what they perceived as effective care delivery. This dilemma was particularly evident in talks about discharges:

Extract 3 (M2; 946-950)

Speaker 4 there's been a lot of kind of feedback on patients being discharged and then bouncing back in, and 'what happened there?', 'were they discharged in the right way?'. So there's pressure, both sides, there's pressure to get people out. And then once you get them out and they bounce back in, 'why did you get them out?', 'what went wrong?'

Extract 4 (M1; 116-119)

Speaker 5 And she's really struggling, you know, and she's much more stable than she was. But she's about to be discharged. She's going to the CMHT [Community Mental Health Team], thankfully, which is really positive. And we had to really fight for her to go to the CMHT.

The above two extracts illustrate how, within the business-model of care, the system shifts responsibility regarding care outcomes towards client-facing clinicians. Failing to deliver appropriate care is then construed as a personal failure on the part of a clinician as opposed to systemic flaws resulting from care management as a business.

Dalal (2018) described how in neoliberally managed health services, the workforce might find themselves under immense pressure to meet system targets even when the resources to do so are insufficient, giving rise to workforce attempts of 'gamesmanship' (p.91), which produces a competitive organisational environment. Extract 4 illustrates how in order to adhere to their individual services' protocols regarding the length of care, clinicians seemingly 'gamed' the system by moving people over to other teams and, in doing so, transferred the responsibility and any potential blame regarding clinical outcomes to other clinicians. This strategy seemed only temporarily effective as people 'bounced back' into the services. Moreover, this gamesmanship appeared to position different service clinicians in conflict with one another, potentially creating division among the services and drawing attention away from delivering care and towards maintaining business efficiency. Further,

gaming the system within its current form implied the current system model's superiority over alternative ways of running the services and maintained its status quo.

Although an apparent implicit and explicit disapproval among the clinicians of care as a business and expressed concerns regarding it could be interpreted as a form of resistance against the business model NHS, the matter-of-fact way of talking about the system's drawbacks normalised the pervasive business-model-driven care delivery policy.

Discourse 2: Managerialism in care delivery

The discourse of managerialism constructed optimal care as a product, the delivery of which ought to be closely monitored to ensure its adherence to the business model. This had a consequential effect of reduced clinicians' autonomy. This discourse permeated meetings with senior clinicians and pan-directorate professionals that occupied managerial roles.

Panoptic surveillance

Organisational managerialism appeared to be justified by the implicit assumption that without active monitoring of clinicians' conduct, optimal care could not exist. The following extract illustrates these points:

Extract 5 (M7; 138-144)

Speaker 6 I know there's been lots of discussion in the [department] amongst the…I don't…Mental Health Heads, including myself, about-about this issue [defining key-worker's role], so I think, yeah, I think [Speaker X] kind of trying to kind of gather our thoughts and then she can present those in this meeting as well. And yeah, I-I would assume that we will need to liaise with our, with our-our partners outside [name of Trust] as well, including our-our commissioners around, you know, their expectations around who holds what roles and what the governance is in place around that.

What is apparent form this extract is that in a managerialist structure, senior clinicians are positioned as managers ('heads'), a role that generated discomfort for Speaker 6, who

attempted to negate their managerial status (‘I don’t’). The governing power structures, which included those that fund the services, positioned clinicians as subordinate, restricting clinicians-managers' power to effect change. Instead, clinicians-managers performed a function of information gathering and surveillance. The latter was most commonly operationalised in the form of professional meetings, where the primary function of a meeting appeared to be reporting and discussing the running of the services.

Further, managerialist surveillance was mirrored in clinicians’ interactions with service users:

Extract 6 (M7; 692-696)

Speaker 7 It was something about thinking about where patients are most safely monitored in that transfer between A&L [Assessment and Liaison Service] and the locality teams because, you know, by the very nature of them, it seems to have a better track record for managing that high turnover and lots of people, and they've got a really good system in place.

Extract 7 (M6; 661-663)

Speaker 8 the real issue with her is no compliance in-the-in-the community so that's something that has to be kind of taken by-by really kind of a…you know… worked through the admission but also then what we're gonna do as a plan in the community.

Here monitoring service users was constructed as an expression of care, whereas resisting surveillance was construed as ‘no compliance’ with treatment (of care). Whilst it could be argued that monitoring clients promotes continuity of care and managing risk, the effectiveness of a managerialist approach to client care is questionable if therapeutic intervention is not a part of the approach.

Foucault (1977) argued that establishments enacted the Panopticon schema and achieved surveillance and productivity via perpetual assessment and hierarchical monitoring of conduct. Over time, Foucault argued, these practises get integrated into the institutional

efficiency apparatus, the mechanisms of which would be passed on in training where instructors taught the mechanisms of maintaining the power that they themselves imposed. During this process, Foucault (1977) argued, the exertion of power gets normalised, and power relations are taken for granted and maintained. These processes appeared to be present in a managerialist approach to managing care delivery.

Loss of clinical autonomy

The Panoptic constructions of surveillance and reporting did not always have a clinically relevant and meaningful purpose:

Extract 8 (M3; 1238-1242)

Speaker 9 It's just it all just adds to how time-consuming the whole process is, that you literally have to check every single bit and then keep checking back and keep checking back that any of these things have happened, and the bits that you can, you know what's so frustrating, so the bits that you can control, they aren't the bits that you feel like you need to control.

The above extract illustrated how managerialism functioned as a vessel between the institution and the clinician, with the institution controlling terms of clinical engagement. It seemed that managerialism had the power to take away clinical autonomy and, in doing so, slowed down clinically significant processes related to care delivery. Whilst it could be argued that there may be valid practical reasons for system checks, Extract 8 illustrated that constructions of 'checking' went beyond what was considered meaningful.

Extract 8 illustrates how a Panoptic regime subjected clinicians to a powerless position, generating their acceptance and compliance with the system instead of its transformation. The perceived powerlessness produced a shared sense of confusion regarding roles and responsibilities, with available action being restricted to *talking* about change instead of *enabling* change, a publicly recognised constructive effect of many managerial

meetings (see Extract 11). Hirschhorn (1990) argued that systemic change could not happen without a person's taking personal responsibility and making decisions. These findings challenge the localisation of the problem within individual clinicians and suggest that the managerialist structure reminiscent of the Panoptic scheme of service governance may prevent clinical decision-making and autonomy.

Discourse 3: **Care delivery in crisis**

There was a strong narrative of a failing care system characterised by constructions of clinicians' concerns and perceived implications related to current working conditions in services with destabilised teams that served as an urgent call to address challenges in delivering optimal care. A construct of a care system in crisis appeared to be shared and recognised by clinicians from all hierarchical bands.

Clinician-blaming system

'Care delivery in crisis' discourse was characterised by clinicians' subjective experience of fear and concern regarding organisational shortcomings. Within this crisis rhetoric, the system failures were constructed as clinicians' responsibility:

Extract 9 (M7; 1078-1081)

Speaker 10	what there is in place where we can hold that information, because otherwise we're accountable for that and we're accountable for discharging someone who's not got anywhere to be discharged to. And I know that a lot of consultants are very scared about doing that. I'm a little bit scared about doing that.

The construction of accountability that Speaker 10 refers to implies acceptance of potential blame for failure at an individual-clinician level. Sewpaul and Holscher (2004) argued that in neoliberal governance, the commodification of welfare becomes embedded in the collective consciousness and turns individuals into both perpetrators and victims of potentially

exploitative and oppressive practices. Similarly, clinicians appeared to be positioned not only as responsible for resolving system issues without breaking rigid business protocols but also as needing to protect and defend themselves when the safety of service users is compromised.

When system failures were individualised, the organisational solutions for systemic problems were located at a level of clinicians, therefore implicitly characterising clinicians as lacking personal resources to deliver care to others. However, such actions were constructed to be ineffective:

Extract 10 (M2; 721-727)

Speaker 11 you can't yoga your way out of a bad rota. And there's very much this idea that we kind of sometimes put things in, you know, the the 'our aim is to support staff' and that staff really do appreciate it, but actually if their working conditions are just not right then actually you can put in all the staff support you want, it's not going to help things. And actually sometimes it just makes people feel less valued because they think 'you're trying to sort of fob us off with a yoga session'

Extract 10 illustrates how individualised system solutions were perceived to be a devise to silencing clinicians ('you're trying to fob us off'). Perceived insignificance of staff's 'working conditions' and absence of counter and system-focused rhetoric in 'care delivery in crisis' discourse likely generated a particular emotional experience, explicit expressions of which were restricted in clinicians' language. In turn, this served to reinforce the acceptance and submission to clinician-blaming constructions. Further, organisational focus on individual-level solutions to service challenges prevented system-level solutions from being discussed with client-facing clinicians.

Clinicians' distress

Extract 10 implied the clinicians' subjective distress that constructions of the insignificance of staff's 'working conditions' generated. Extract 11 illustrates a construction

of clinicians' distress due to perceived subjection to work through critical issues in struggling teams in a context of the inaction of those positioned as powerful:

Extract 11 (M2; 406-416)

Speaker 12 So not being disrespectful or anything like that, but we're going about round and round in circles here and I find it a bit frustrating. And again, we really need to address this because it's becoming a lot, because we're having very complex patients on the ward and not just… I'm having it in all the wards that I'm working with, because… due to COVID, and also the staffing as well. So I think it's what [name 1] is…and [name 2] …so…you know, reassured us of what is happening. But even though it's been good to be reassured, it still doesn't help me as a [therapist], it doesn't help [name 3] or [name 4], or [name 5] in this situation.

Here, clinicians' subjective experience justified their moral rhetoric aimed at challenging the status quo. However, despite of explicit urgency of care in crisis rhetoric highlighted in Speaker's 12 language ('we really need to address this'), little meaningful action came out of such discussions ('we're going about round and round in circles'). Further, it is unclear who 'we' are or what would constitute effective action. It is likely that the use of 'we' in this context stemmed from restricted permission to demand action from those doing the reassuring, generating a subjective experience of stuckness that 'we' found themselves in. Speaker's 12 critical way of talking about the organisation's approach to systemic issues served to socialise clinicians to challenge the system and acted as a call for a change in organisational response to critical issues. Further, whilst refusal to accept the crisis as a norm is insufficient to effect change, it is arguably a necessary aspect of resistance to power relations that maintain these issues.

Whilst the public domain often construes clinicians' dissatisfaction in economic terms regarding pay (Triggle, 2023), these findings suggest that moral distress among clinicians

was largely a response to the threat to care in services with critical work conditions. Similarly, studies identified that the most common source of moral distress among healthcare professionals was perceived inadequate care and harm to service users due to organisational constraints and suboptimal work conditions (Hamric et al., 2012; Spenceley et al., 2017; Molinaro et al., 2023). This study's findings support such claims.

Staff exodus

'Care delivery in crisis' discourse was characterised by repetitive references to staff exodus. Extract 12 illustrates how this was constructed as a strategy to minimise organisational pressures:

Extract 12 (M2; 678-682)

Speaker 13 people have found out or that… you know, that they can work agency and get twice the money for-for half the hassle. And so, so that's the route that-that many medics prefer to go. And he's saying that they're left in-in the same situation that psychology is in, where they have to readvertise again and again and again.

Speaker's 13 account illustrates the perceived benefits of 'working agency' that enabled professionals to minimise the stress associated with working in the NHS without resignation from NHS clinical duties and implied a shared subjective experience among clinicians of a conflict between organisational expectations and personal ideals. The subjective effects of working in challenging conditions, humorously referred to in this extract as 'hassle', generated constructions of difficult-to-fill posts, characterised by repetitive recruitment efforts. The latter implicitly frames current organisational recruitment measures as an ineffective solution to a staff exodus problem. Constructions of staffing issues were identified in reference to different groups of professionals ('medics', 'psychology').

Extract 13 illustrates how staff exodus rhetoric was justified by references to a number of clinicians leaving the services:

Extract 13 (M2; 1124-1126)

Speaker 14 So since I started six weeks ago, I think five people have resigned or have announced that they're leaving. So it's basically a rate of 1 per week.

A matter-of-fact way of constructing staff losses that Speaker's 15 account illustrates served as acceptance of a status quo in crisis rhetoric.

Whilst explicit references to reasons justifying staff exodus were largely absent, studies in everyday resistance to power imbalances construct 'flight' as a human response to oppressive regimes and a survival strategy (Scott, 1885; Ikuteyijo, 2020). Therefore, it could be argued that staff exodus functioned as a shared rejection of the current organisational approach and resistance to power structures that clinicians positioned themselves as unable to change.

Threat to care

Social implications of a system-in-crisis constructions were evident in a collectively shared pessimism regarding the reduced quality of care, which maintained clinicians' position as powerless:

Extract 14 (M2; 1917-1919)

Speaker 15 I think we are right now at a point where beggars can't be choosers and, quite frankly, if they've got a pulse then they can come and work on the ward because we're that desperate.

Despite organisational rhetoric related to issues raised by clinicians, business-led priorities remained unchanged:

Extract 15 (M2; 1146-1149)

Speaker 16 there's a strong pressure from above to reduce the waiting list and get more people on the ward. And I think people are probably feeling quite scared, if that pressure is given into, and more people are admitted if they'll be enough staff to actually provide safe care.

Here, organisational pressures were constructed as both scary and potentially dangerous due to their direct impact on care delivery. This implied clinicians' position as helpless, which potentially restricted their actions. Holscher and Sewpaul (2006) theorised that neoliberalism privileges capital-raising strategies over social concerns, which generates power imbalances. Perhaps due to a power imbalance between NHS governance, aimed at maintaining a viable business, and individual clinician's agency, Speaker's 16 rhetoric implies a subjective experience of discomfort, likely arising from clinicians' lack of power against the neoliberal care-as-business narrative. Similar constructions of subjectivity were evident in many clinicians' accounts.

One of the key constructive consequences of unaddressed working conditions and related high staff turnover was the impact on quality of care, constructions of which were justified by clinicians' references to an increasing number of incidences in mental health wards:

Extract 16 (M2; 509-515)

Speaker 17 the incidents are becoming…Really noticing the amount of restraints and incidents.[510-511] we were kind of talking and making notes about how many [incidents] there have been in the last four or five days in terms of people in seclusion being restrained, offered [PRN]. People on wards fighting, attacking staff, attacking each other in the-in the space of three-four days. It seems there's an increase in the amount of restrain, teams being called, seclusion being used.

A rhetoric of urgency that Extract 16 illustrates served as an implicit call for organisational action. However, an unemotional tone employed in these constructions masked it and positioned clinicians as invulnerable. Such constructions produced a shared clinicians' subjectivity characterised by submission to threat, which normalised working in suboptimal conditions.

Discourse 4: Contextualised compassion

Whilst business-led discourses of care dominated clinical meetings, an alternative competing discourse based on clinicians' personal ethics and compassionate care also existed.

Care delivery as an act of compassion

In spaces dedicated to clinical training and reflection, clinicians constructed care delivery in relational terms:

Extract 16 (M5; 692-695)

Speaker 17 what mostly makes us good clinicians isn't isn't the academic learning that we've had, isn't the teaching in a in a particular therapeutic model, it's how we've learned to be with people, how we've learned to be.

Here, Speaker 17 constructed care as a creative and continuous therapeutic relationship-building process that could not be reduced to textbook criteria and that positioned service users as 'people'. Literature exploring qualities associated with positive clinical outcomes emphasises that a strong therapeutic alliance has the greatest impact on therapeutic outcomes over and above any specific clinical modality in which it occurs (Martin et al., 2000; Priebe & McCabe, 2006). Similarly, constructing clinicians as focused on compassionate relationship building was considered by Speaker 17 to be what made a 'good' clinician.

There was shared openness to individual learning among clinicians that served to prepare them for working with complex clients under challenging service conditions:

Extract 17 (M5; 1113-1117)

Speaker 18 So we spoke a bit about what, actually we found it really hard to get off the subject of what the challenges are and how if we had a magic wand, we would make staffing all OK and budget infinite and it would it would that would make it easier to do the things we need to do.

Extract 17 illustrates how clinicians appeared to share a rhetoric of protecting clients from the system's drawbacks and constructions of comradery in sharing workload stress.

These constructions implicitly contradicted a rigid business model and its subject positions.

Restrained compassion

Clinicians were restricted from compassionate acts by organisational pressures, implying the superiority of organisational goals over compassionate care:

Extract 18 (M5; 1198-1219)

Speaker 19 we find it difficult to ask a question or questions that may bring up a client's traumatic experience, particularly where we have limited time
[1200-1216]
And it all comes back to 'I know they're not helping. I know they will not be able to do anything. All they do, sit down there, have a chat in order for them to have their salaries.'

Here, the effects of organisation-over-compassion constructions on care delivery were constructed in terms of ruptures in working relationships with service users, justified by references to clinicians' subjective experience of being positioned by service users as fundamentally different to and distant from them, and attributed negative characteristics. Further, whilst this rhetoric implied clinicians' understanding and validation of service users' emotional states, similar rhetoric related to clinical staff's subjective experience in the face of challenges ('we find it difficult') was largely absent in this discourse.

Rhetoric that would include a concern for staff was only permissible in the context of seeking optimal care for complex individuals:

Extract 20 (M6; 447-452)

Speaker 21 not all of the incidents [of service users abusing staff] have been reported because I think sometimes… because her behaviour is- is so like this, that it to some extent doesn't get given… So I've encouraged staff to really report everything so we can begin to build up a picture so that when we do go to panel, we've got evidence of saying this is why we feel this young lady will need specialist support in the community and these are some of the risks.

Here talk about staff abuse was limited in expression and was reported to be subjectively experienced as not worth reporting. There seemed to be an absence of recognition of staff trauma or how it could be processed and dealt with compassionately. Similarly, the recent popularisation of healthcare professionals as 'heroes' narrative portrayed healthcare workers as self-less, obedient citizens with the outstanding moral practice for whom heroism itself was a reward (Mohammed et al., 2021). According to Mohammed et al. (2021), this way of talking serves to publicly disguise the distress that clinicians face and deflects from organisational failures and ways to improve the work conditions that lead to it.

Hope as resistance

Constructions of hope for change and compassionate leadership were present in this discourse. These constructions enabled the reframing of systemic change as a process that requires action from the highest levels of service governance:

Extract 21 (M2; 1717-1719)

Speaker 22 it's useful, hopefully, for what, what, you know, I guess I hold out hope that it's useful for us to flag these things and then for me to try and push and see where it goes.

This extract highlighted that compassionate rhetoric related to issues affecting care delivery and clinicians' wellbeing in organisational settings existed and motivated leaders to act. Here compassion and holding out hope functioned as another form of resistance to corporate power and served to rebalance power relations in organisational settings.

Study strengths and limitations

Whilst it could be argued that the discourses described in this study were limited to a small number of selected meetings at a particular time and place, from a socio-political perspective that the study adopted, all NHS directorates are subject to neoliberal ideology and associated business-model-led NHS culture. However, the author does not consider this study's findings to be universal and generalisable truths. Instead, this research presented a number of analytic perspectives that may coexist alongside other perspectives that could emerge from alternative data readings. Further, due to the nature of virtual meetings and verbatim transcription, an analysis of speakers' paralinguistic features was beyond this study's scope.

Clinical implications

In line with criticisms of neoliberal ideology in the NHS, the study findings suggest that taken-for-granted business rhetoric is largely unnoticed and unquestioned in the NHS and results in the shift of the organisation's primary task towards maintaining a viable business. Roberts (1998) argued that consciously acknowledging the tensions between individual ideals and what is required for an organisation's viability is important for the organisation's survival. Failure to do so, he argued, may result in a loss of motivation and drive to achieve the organisation's primary task, which, in turn, may cease to exist altogether. In order to reduce the confusion that misaligned perceptions of the primary task may create, this study's findings call for conscious and collaborative action across all organisational levels to redefine

the aims of the services and clarify what matters the most, in what order, and what can and cannot be traded off in care delivery negotiations.

From a Foucaldian perspective, power is an action with manoeuvres and techniques, and instead of being something that could be possessed, it is exercised in action (Foucault, 1977). Similarly, this study's findings suggested that the governmental power in the NHS dominance was evident in neoliberal-values-led services and was maintained by structures reminiscent of the Panopticon, positioning clinicians as powerless to enable change. Further, this study's findings highlighted how lack of organisational action at the systemic level resulted in moral distress among clinicians and drove them away from the services. The clinical implications of the latter are twofold. Firstly, it calls for organisational action to address conditions affecting the clinicians' work-related distress without positioning them as responsible for system failures. Secondly, this research's findings highlighted little capacity among NHS managers to acknowledge the emotional pain that care delivery task inevitably involves. Roberts (1998) argued that facilitating meaning-making among healthcare professionals could energise them to persist with the challenges of the primary task.

Lastly, the study highlighted how compassion, hope and comradery among the clinicians were all aspects of resistance to the dominant business-led mode of NHS governance. Compassion-led care delivery constructions united clinicians and energised leaders to make bottom-up changes. Hirschhorn (1990) argued that with each professional role came a power to act in line with that role and warned against the dangers of losing sight of one's professional task in challenging and disempowering circumstances. The latter, he argued, had precarious organisational consequences that were passed down the organisational line. This study's findings remind NHS clinicians of the transformative power of the

foundational value of their chosen professional role: feeling touched by another person's suffering and a desire to alleviate this pain.

Future research

Exploration of ways to refocus NHS organisational aims onto its primary task and the effects of any associated implementation strategies may benefit the researchers and NHS leaders alike in understanding the mechanism of organisational change in the NHS.

Further research into the effects of top-down systemic changes on client-facing clinicians' moral distress may bring more balance to currently individualised solutions to systemic issues and raise awareness of required systemic changes.

Conclusion

This study positioned clinicians' rhetoric regarding care delivery in a uniquely socio-political context. Exploring constructions of care delivery from a discursive perspective highlighted the broader influence of common neoliberal ideology on everyday care delivery negotiations in NHS Mental Health Services. In doing so, this research's findings challenge the taken-for-granted assumptions regarding influences that shape clinical practice in the NHS and demonstrate the need to consider socio-political factors when evaluating standards of care and facilitating service transformation.

In Foucault's rebellious spirit, this study hoped to disrupt the normative NHS practice that locates systemic failures and solutions in individual NHS clinicians, leaving the door open for transformation on an organisational level.

References

Allen, R., Judkins-Cohn, T., deVelasco, R., Forges, E., Lee, R., Clark, L., & Procunier, M. (2013). Moral distress among healthcare professionals at a health system. *JONA'S healthcare law, ethics and regulation*, *15*(3), 111-118. *DOI:* 10.1097/NHL.0b013e3182a1bf33

Austin, W., Rankel, M., Kagan, L., Bergum, V., & Lemermeyer, G. (2005). To stay or to go, to speak or stay silent, to act or not to act: Moral distress as experienced by psychologists. *Ethics & Behavior, 15*(3), 197-212. https://doi.org/10.1207/s15327019eb1503_1

Brown,W. (2015). *Undoing the demos: Neoliberalism's stealth revolution.* New York: Zone Books.

Care Quality Commission. (2022, May 5). *Our purpose and role.* https://www.cqc.org.uk/about-us/our-purpose-role/who-we-are

Cheetham, J., Holttum, S., Springham, N., & Butt, K. (2018). 'I can see it and I can feel it, but I can't put my finger on it': A Foucauldian discourse analysis of experiences of relating on psychiatric inpatient units. *Psychology and Psychotherapy: Theory, Research and Practice, 91(*3), 317-331. DOI: 10.1111/papt.12162. Epub 2017 Oct 27. PMID: 29076611

Dalal, F. (2018). *CBT: The cognitive behavioural tsunami: Managerialism, politics and the corruptions of science.* Routledge.

de Bruijn, H. (2007). *Managing Performance in the Public Sector.* Abingdon: Routledge

Department of Health and Social Care. (2021). *The NHS Constitution for England.* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Farr, M., & Barker, R. (2017). Can staff be supported to deliver compassionate care through implementing Schwartz Rounds in community and mental health services?. *Qualitative health research*, *27*(11), 1652-1663. https://doi.org/10.1177/1049732317702101

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, *19*(4-5), 583-590. https://doi.org/10.1080/10503300902798375

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* Penguin.

Foucault, M. (1998). *The will to knowledge: The history of sexuality vol. I.* Penguin books.

Foucault, M. (2019). *Power: the essential works of Michel Foucault 1954-1984*. Penguin.

Foucault, M., & Faubion, J. D. (2000). *The essential works of Foucault, 1954-1984.* Vol. 3, Power. Penguin.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary.* London: The Stationery Office. https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Fulford, K. W. M., Dickenson, D., & Murray, T. H. (2002). *Healthcare ethics and human values: an introductory text with readings and case studies.* Blackwell publishers.

Greener, I., & Powell, M. (2008). The changing governance of the NHS: Reform in a post-Keynesian health service. *Human relations, 61*(5), 617-636. DOI: 10.1177/0018726708091764

Greener, I., & Powell, M. (2008). The changing governance of the NHS: Reform in a post-Keynesian health service. *Human relations, 61*(5), 617-636. https://doi.org/10.1177/0018726708091764

Greener, J., & Moth, R. (2020). From shame to blame: institutionalising oppression through the moralisation of mental distress in austerity England. *Social Theory & Health*, 1-19. https://doi.org/10.1057/s41285-020-00148-8

Hamric, A. B., Borchers, C. T., & Epstein, E. G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research, 3*(2), 1-9. DOI: 10.1080/21507716.2011.652337

Hirschhorn, L. (1990). *The workplace within: Psychodynamics of organizational life.* MIT press.

Holscher, D., & Sewpaul, V. (2006). Ethics as a site of resistance: The tension between social control and critical reflection. *Research Reports, 1*(48), 251-272. https://www.researchgate.net/profile/Vishanthie-Sewpaul-3/publication/241625625_ETHICS_AS_A_SITE_OF_RESISTANCE_THE_TENSION_BETWEEN_SOCIAL_CONTROL_AND_CRITICAL_REFLECTION/links/0a85e53cc95a0d8ba1000000/ETHICS-AS-A-SITE-OF-RESISTANCE-THE-TENSION-BETWEEN-SOCIAL-CONTROL-AND-CRITICAL-REFLECTION.pdf

Holttum, S. (2018). Research Watch: therapists' working conditions and their implications for service users' social inclusion. *Mental Health and Social Inclusion, 23*(1), 5-11. https://doi.org/10.1108/MHSI-11-2018-0038

Ikuteyijo, L. O. (2020). Irregular migration as survival strategy: Narratives from youth in urban Nigeria. *West African Youth Challenges and Opportunity Pathways*, 53-77. https://doi.org/10.1007/978-3-030-21092-2_3

Jameton, A. (1984). *Nursing practice: The ethical issues.* Prentice-Hall.

Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of health psychology*, *22*(1), 51-67. https://doi.org/10.1177/1359105315595120

Levitt, H. M., Motulsky, S. L., Wertz, F. J., Morrow, S. L., & Ponterotto, J. G. (2017). Recommendations for designing and reviewing qualitative research in psychology: Promoting methodological integrity. *Qualitative psychology*, *4*(1), 2. https://doi.org/10.1037/qup0000082

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of consulting and clinical psychology*, *68*(3), 438. https://doi.org/10.1037/0022-006X.68.3.438

Maxwell, J. A. (2015). Evidence: a critical realist perspective for qualitative research. In N. K. Denzin & M. D. Giardina (Eds.), *Qualitative inquiry – past present and future. A critical reader* (pp. 88-102). Left coast press.

McCann, L., Granter, E., Hassard, J., & Hyde, P. (2015). "You can't do both - something will give": limitations of the targets culture in managing UK healthcare workforces. *Human resource management*, *54* (5), 773-791. https://doi.org/10.1002/hrm.21701

Mitton, C., Peacock, S., Storch, J., Smith, N., & Cornelissen, E. (2010). Moral distress among healthcare managers: conditions, consequences and potential responses. *Healthcare Policy, 6*(2), 99. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3016638/

Mohammed, S., Peter, E., Killackey, T., & Maciver, J. (2021). The "nurse as hero" discourse in the COVID-19 pandemic: A poststructural discourse analysis. *International journal of nursing studies, 117,* 103887. https://doi.org/10.1016/j.ijnurstu.2021.103887

Molinaro, M. L., Polzer, J., Rudman, D. L., & Savundranayagam, M. (2023). "I can't be the nurse I want to be": Counter-stories of moral distress in nurses' narratives of pediatric oncology caregiving. *Social Science & Medicine,* 115677. https://doi.org/10.1016/j.socscimed.2023.115677

Moth, R. (2020). 'The business end': Neoliberal policy reforms and biomedical residualism in frontline community mental health practice in England. *Competition & Change, 24*(2), 133-153. https://doi.org/10.1177/1024529418813833

O'Hare, P., Coaffee, J., & Hawkesworth, M. (2010). Managing sensitive relations in co-produced planning research. *Public Money & Management*, *30*(4), 243-250. http://dx.doi.org/10.1080/09540962.2010.492188

Ordonez, L. D., Schweitzer, M. E., Galinsky, A. D. & Bazerman, M.H. (2009). Goals Gone Wild: The Systematic Side Effects of Overprescribing Goal Setting. *Academy of Management Perspectives, 23,* 6-16. https://doi.org/10.5465/amp.2009.37007999

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology.* Hove: Routledge.

Pope, R. (2019). Organisational Silence in the NHS: 'Hear no, See no, Speak no'. *Journal of Change Management, 19*(1), 45–66. https://doi.org/10.1080/14697017.2018.1513055

Prabakaran, M. (2011). *Praxis Intervention: Towards a New Critical Social Work Practice*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1765143

Priebe, S., & McCabe, R. (2006). *The therapeutic relationship in psychiatric settings. Acta Psychiatrica Scandinavica, 113,* 69-72. DOI: 10.1111/j.1600-0447.2005.00721.x

Proctor, G., & Hayes, C. (2017). Counselling for Depression: a response to counselling education in the twenty-first century. Ethical conflicts for a counselling approach operating within a medicalised bureaucratic health service. *British Journal of Guidance & Counselling, 45*(4), 417-426. https://doi.org/10.1080/03069885.2016.1274377

Proctor, G., McKelvie, S., Brown, M., & Cohen, S. (2020). Counsellors experiences of ethical conflicts working in IAPT. *British Journal of Guidance & Counselling*, 1-18. https://doi.org/10.1080/03069885.2020.1853040

Rawlinson, N. (2008). Harms of target driven health care. *BMJ*, 337. https://doi.org/10.1136/bmj.39604.711146.47

Rice, A. K. (1963). *The enterprise and its environment: A system theory of management organisation.* Tavistock Publications.

Rizq, R. (2014). Perverting the course of therapy: the fetishisation of governance in public sector mental health services. *Psychoanalytic Psychotherapy, 28*(3), 249-266. https://doi.org/10.1080/02668734.2014.933034

Roberts, V. Z. (1998). Is authority a dirty word? In A. Foster & V. Z. Roberts (Eds.). (1998). *Managing mental health in the community: Chaos and containment*. Psychology Press.

Sandu, A. (2011). Assumption of Post-structuralism in Contemporary Epistemology. *Postmodern Openings, 2*(7), 39-52. https://ssrn.com/abstract=1268545

Scott, J. C. (1985). *Weapons of the weak: Everyday forms of peasant resistance*. yale university Press.

Sewpaul, V., & Hölscher, D. (2004). *Social work in times of neoliberalism: a postmodern discourse*. Van Schaik Publishers.

Spenceley, S., Witcher, C. S., Hagen, B., Hall, B., & Kardolus-Wilson, A. (2017). Sources of moral distress for nursing staff providing care to residents with dementia. *Dementia, 16*(7), 815-834. https://doi.org/10.1177/1471301215618108

Springer, S. (2012). Neoliberalism as discourse: between Foucauldian political economy and Marxian poststructuralism. *Critical discourse studies, 9*(2), 133-147. https://doi.org/10.1080/17405904.2012.656375

Steel, C., Macdonald, J., Schröder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical: burnout in therapists working within Improving Access to Psychological Therapy Services. *Journal of Mental Health, 24(*1), 33-37. https://doi.org/10.3109/09638237.2014.971145

Step into the NHS. (n.d.). *About the NHS.* https://www.stepintothenhs.nhs.uk/about-the-nhs#:~:text=The%20NHS%20was%20set%20up,care%20it%20gives%20to%20patients.

Triggle, N. (2023, 16 March). *NHS 5% pay offer may end bitter dispute in England.* BBC News. https://www.bbc.co.uk/news/health-64977269

Williams, R. D., Brundage, J. A., & Williams, E. B. (2020). Moral injury in times of COVID-19. *Journal of health service psychology, 46,* 65-69.https://doi.org/10.1007/s42843-020-00011-4

Willig, C. (2013). *Introducing qualitative research in psychology* (Third edition). McGraw-hill education (UK).

SECTION C: Appendices of supporting material

Appendices

Appendix A: NICE qualitative studies checklist

Checklist

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature?	Clear Unclear Mixed	Comments:

• Are underpinning values/assumptions/theory discussed?		
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:

Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		

8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant?	Reliable Unreliable Not sure/not reported	Comments:

• Were negative/discrepant results addressed or ignored?		
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic?	Adequate Inadequate Not sure	Comments:

• Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**		
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments:

++ All or most of the checklist criteria have been fulfilled; where they have not been fulfilled the

conclusions are very unlikely to alter(met more than 10/14 criteria).

+ Some of the checklist criteria have been fulfilled; where they have not been fulfilled or not

adequately described, the conclusions are unlikely to alter (met more than 5/14 criteria).

– Few or no checklist criteria have been fulfilled, and the conclusions are likely or very likely to alter (met five or fewer criteria).

Appendix B: Information sheet

Study Information Sheet

Hello, my name is Kristina, and I am a trainee Clinical Psychologist at CCCU. Thank you for considering the research project *[the content has been removed from an electronic copy]* as part of my DClin programme.

Study Title:

Clinicians' perspectives on standards of care in the current socio-political NHS context

Project team:

The project is supervised by *[The content has been removed from an electronic copy.]*, and is co-produced with *[The content has been removed from an electronic copy.]*. In order to help you decide whether you agree to take part in this study, this Information Sheet will explain why the research is being done and what it would mean for you if you got involved.

Research overview and study aims:

Research suggests that clinicians working in the NHS experience competing demands of care and efficiency in the everyday running of the services that can be challenging to negotiate. Broader socio-political influences that shape the NHS are often overlooked in research but may have important influences on day-to-day working, including the way we understand, frame and talk about our work. The research method of 'discourse analysis' enables us to look at recurrent ways of talking that we do not always notice, and to reflect on how they might be shaping our experiences.

The specific discourses (ways of talking) I am interested in are those relating to standards of care. I would like to collect and analyse naturally occurring conversations in the day to day running of the services to highlight different ways of talking, that clinicians may use within the current NHS context. In order to achieve this, a I will select, record and process the content of between five and seven different organisational meetings.

This study design's limitation is that non-verbal communication will not be recorded, and this data will be potentially missed. Another limitation is that identifying ways of talking will depend on researchers' understanding of the matter. Therefore, the study findings will not be presented as 'scientific facts'.

Benefits of taking part:

By taking part in this study, you will contribute to a growing understanding of how commonly used ways of talking may have influence in the day-to-day work of clinicians in the NHS. Becoming more aware of these ways of talking can potentially empower NHS staff to question some ideas that might be 'taken for granted' and to be able to make a more conscious decision about how and when they can be helpful or less helpful in day-to-day communications.

Your involvement:

You are being contacted because you take part in one of the meetings, <INSERT MEETING TITLE and DATE> . I would like to access this ONE meeting for the purposes of this study. This will enable me to look at ways of talking about standards of care in this meeting.

Including <INSERT MEETING TITLE> in this study will only be possible if all meeting attendees agree to participate in this study. If all attendees agree to take part, then the meeting will be recorded via in-build Microsoft Teams software. As I aim to research naturally occurring conversations that take place within the NHS context, there will be no changes to the standard content of the meeting. The only difference to your regular practice will be that the meeting is recorded and transcribed for the purpose of this research.

Participation in this study is voluntary, and it is up to you if you agree to take part. I will ask you to indicate your decision via an electronic consent form sent to you in this email. If I do not receive your response prior to the meeting, I will join the very beginning of the meeting and ask you to inform me of your decision via a private message before the meeting commences. You have a right to withdraw from the study after you consented to take part in it before the transcript data is anonymised and the recording that would help me identify individual speakers is destroyed, at which point it will no longer be possible for me to trace your input.

Once the study has been completed, I will offer a presentation on the research analysis and discussion to all colleagues who took part in the study. Your feedback will be reflected in the final written report. A full copy of this study will be available upon request. This study may also be published in an academic journal, in which case the published article will be accessible via the research team, NHS library services and online.

Confidentiality:

All information collected during the course of this research will be held as strictly confidential and processed in accordance with the Data Protection Act and the NHS Data Protection requirements. Information containing your personal details (i.e. copies of consent forms) and meeting recordings will be stored on an encrypted USB stick.

Although this is not anticipated, I would have to breach our confidentiality agreement to report an incidence of malpractice or a risk of significant harm to an appropriate third party. If this happens, you will be informed at the earliest opportunity.

Once the transcription process is completed, the recording will be destroyed. All identifiable information pertaining to you, your service or any individuals you may discuss will be anonymised or removed from the transcript and will not feature in the study's write-up. Research data will only be accessible to the research team, who will follow data protection and confidentiality guidelines at all times.

Pseudonymised data from the study will be kept for 10 years in a secure format by CCCU and destroyed after 10 years.

Further information:

This study has been approved by the NHS Ethics Committee (IRAS Project ID 303995).

If you have any questions or wish to discuss this study further, you can leave me a message on 24hr voicemail service at 01227 927070 (please clearly state that the message is for

Kristina Argustaite and leave your contact number for me to get back to you on) or email me directly at ka354@canterbury@ac.uk. I will get back to you as soon as I can.

Concerns and complaints:

If you have a concern or a problem about any aspect of this study, please contact me via email address ka354@canterbury.ac.uk. If you wish to speak with my principal supervisor, cYou can also contact *[The content has been removed from an electronic copy.]*. We will do our best to resolve any issues that may concern you as soon as possible.

If your concerns remain and you wish to make a formal complaint, you can contact Salomons Research Director *[The content has been removed from an electronic copy.]* or calling *[The content has been removed from an electronic copy.]* and asking to speak with him.

What next?

If you are satisfied with the information provided in this Information Sheet, please let me know your decision regarding taking part in this study via responding to the Consent Form provided via email to ka354@canterbury.ac.uk. In order to help us plan this study, I would highly appreciate a response within three working days.

Thank you,

Kristina Argustaite

Appendix C: Consent form

Consent Form

Study title: Clinicians' perspectives on standards of care in the current socio-political NHS context

Principal researcher: Kristina Argustaite

Please indicate your response by deleting the incorrect answer. Please return your completed consent form to ka354@canterbury.ac.uk within the next three working days.

I agree to take part in this study.	Yes/No
I confirm that I have read and understood the Information Sheet for the above study.	Yes/No
I have had an opportunity to consider the information and ask questions. I have had these answered satisfactorily.	Yes/No
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my rights being affected.	Yes/No
I give permission to the research team to process and use the information collected for the purposes of this study as outlined in the Information Sheet and in line with the confidentiality and data protection requirements.	Yes/No
I understand that anonymised data, including my quotes, may be used in the write-up of the study. I agree with this.	Yes/No

Date:

Name:

Signature:

Appendix D: Foucauldian Discourse Analysis

Six stages in the FDA as set out by Willig (2013)

Stage 1: Discursive constructions

Identifying different ways in which the discursive object is constructed. This requires highlighting all instances (both implicit and explicit) of reference to the discursive object in the text.

Stage 2: Discourses

Identifying different constructions of the discursive object within the text and locating these constructions within broader discourses (e.g. biomedical discourse, psychological discourse, romantic discourse).

Stage 3: Action Orientation

Examining contexts within which different constructions of the discursive object are deployed and what is achieved from this. This includes identifying gains associated with constructing the discursive object in a particular way at a particular point within the text, and reflecting on the relationship between different discursive object constructions.

Stage 4: Positioning

Examining 'subject positions' from which to speak and act that different constructions of the discursive object offer and that are taken up by different subjects (i.e. people) within the text.

Stage 5: Practice

Exploring the relationship between discourse and practice by identifying possibilities for action contained in different constructions and subject positions in relation to the object. This includes identifying ways in which different discursive constructions and subject positions open-up and limit what can be said and done.

Stage 6: Subjectivity

Exploring the relationship between discourse and ways of seeing and being in the world (i.e. subjectivity). This involves tracing the consequences of different subject positions on personal experiences, such as what can (and cannot) be felt, thought and experienced.

Appendix E: Initial analytic observations

The content has been removed from an electronic copy.

Appendix F: Example of identified discursive constructions

Different constructions of discursive object grouped into discourse 'care as business'

The content has been removed from an electronic copy.

Appendix G: Summary of analytic notes

The content has been removed from an electronic copy.

Appendix H: Methodological integrity framework

The concept of research trustworthiness reflects a degree to which the reader and the researcher alike have confidence that the study has captured significant processes related to the topic of study (Levitt et al., 2017). Levitt et al. (2017) proposed the concept of methodological integrity as the foundation for establishing research trustworthiness in qualitative research methods. Within this framework of methodological integrity, two core concepts of fidelity and utility were identified.

Fidelity to the subject matter is described as the degree to which the researcher can form a deep understanding of the phenomenon being studied. Authors recommend methods that enhance research fidelity.

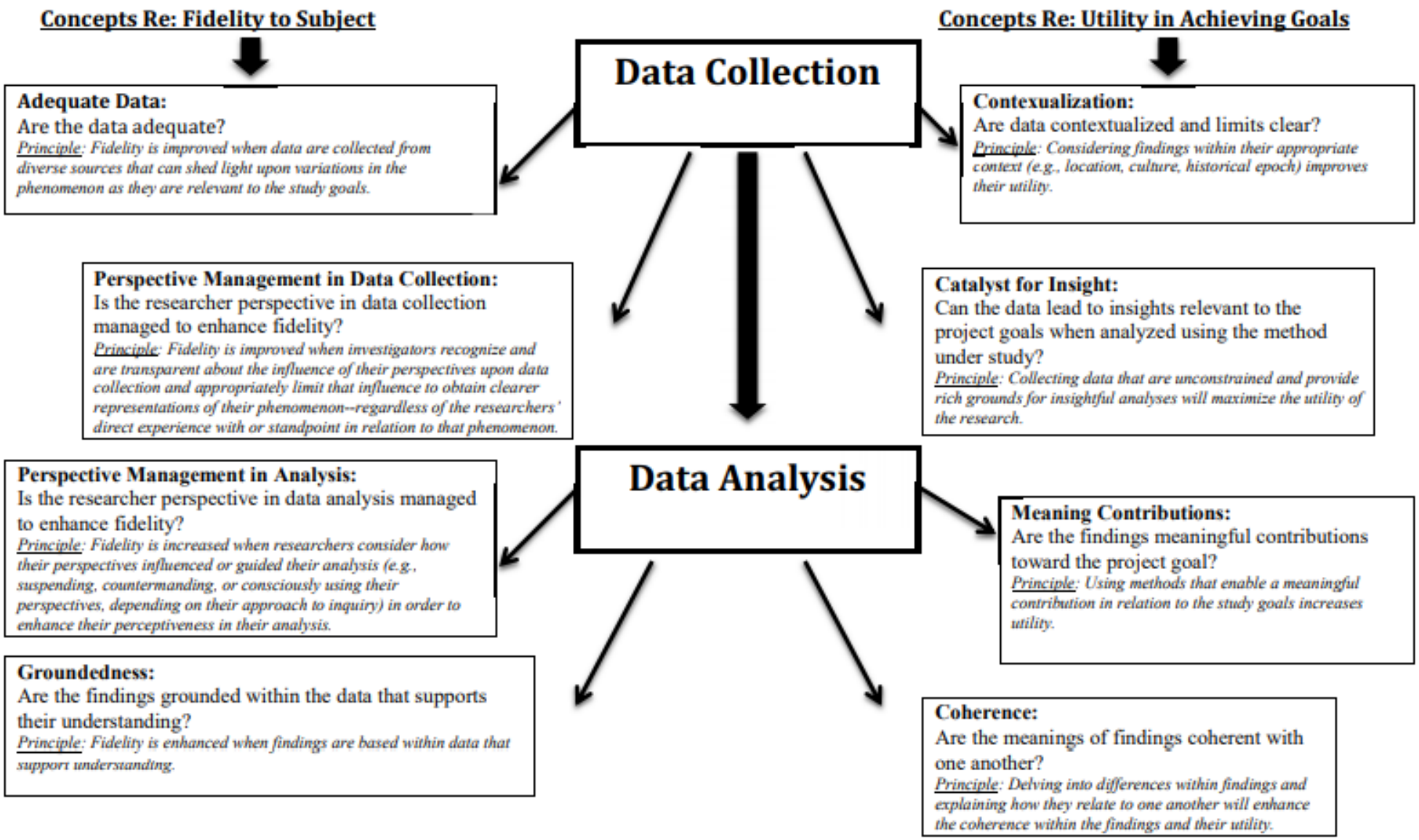
The concept of utility refers to methodological effectiveness in answering research question and achieving wider goals of the study. Just like fidelity, researchers are advised to make research utility considerations in all research stages.

According to this framework, methodological integrity is achieved when the study's design and procedures support the researcher's approach to inquiry and research goals, and concerns all aspects of the research from the researcher's philosophical positioning, literature review, data collection and the analytic steps, including researcher's reflexivity. Figure 1 (see below) outlines key principles and considerations for achieving research fidelity and utility in qualitative research.

Figure 1

Flowchart illustrating considerations for research fidelity and utility in the methodological integrity framework

[The content has been removed from an electronic copy.].


Concepts Re: Fidelity to Subject
Concepts Re: Utility in Achieving Goals
Data Collection
Adequate Data:
Are the data adequate?
Principle: Fidelity is improved when data are collected from diverse sources that can shed light upon variations in the phenomenon as they are relevant to the study goals.
Contexualization:
Are data contextualized and limits clear?
Principle: Considering findings within their appropriate context (e.g., location, culture, historical epoch) improves their utility.
Perspective Management in Data Collection:
Is the researcher perspective in data collection managed to enhance fidelity?
Principle: Fidelity is improved when investigators recognize and are transparent about the influence of their perspectives upon data collection and appropriately limit that influence to obtain clearer representations of their phenomenon--regardless of the researchers' direct experience with or standpoint in relation to that phenomenon.
Catalyst for Insight:
Can the data lead to insights relevant to the project goals when analyzed using the method under study?
Principle: Collecting data that are unconstrained and provide rich grounds for insightful analyses will maximize the utility of the research.
Data Analysis
Perspective Management in Analysis:
Is the researcher perspective in data analysis managed to enhance fidelity?
Principle: Fidelity is increased when researchers consider how their perspectives influenced or guided their analysis (e.g., suspending, countermanding, or consciously using their perspectives, depending on their approach to inquiry) in order to enhance their perceptiveness in their analysis.
Meaning Contributions:
Are the findings meaningful contributions toward the project goal?
Principle: Using methods that enable a meaningful contribution in relation to the study goals increases utility.
Groundedness:
Are the findings grounded within the data that supports their understanding?
Principle: Fidelity is enhanced when findings are based within data that support understanding.
Coherence:
Are the meanings of findings coherent with one another?
Principle: Delving into differences within findings and explaining how they relate to one another will enhance the coherence within the findings and their utility.

Appendix I: Research journal extracts

The content has been removed from an electronic copy.

Appendix J: HRA approval

The content has been removed from an electronic copy.

Appendix K: Service user notification poster

The content has been removed from an electronic copy.

Appendix L: End of study notification letter

The content has been removed from an electronic copy.

Appendix M: Author guidelines for prospective journal

JOURNAL OF COMMUNITY & APPLIED SOCIAL PSYCHOLOGY: MANUSCRIPT CATEGORIES AND REQUIREMENTS

The content has been removed from an electronic copy.