Mental Health Professionals' Experience of Organisational Change in the NHS

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Memorandum

The research for this thesis was conducted at the University of Hertfordshire, Department of Clinical Psychology, while the author was a full-time Clinical Psychology Doctoral student.

The theoretical and empirical work presented within this thesis is the independent work of the author. Intellectual debts are acknowledged within this text and referenced.

The author has not been awarded this degree by this, or any other university for the work included in the thesis.

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Abstract

A study was conducted to investigate mental health professionals’ experience of change in three NHS Trusts in England. The aim was to understand the professionals’ experience of change, applying the psychological contract as a sense-making tool using an extended contract model (Guest, 1998; George, 2009). The concept of the psychological contract was first introduced within psychoanalysis (Menninger, 1958) to explain the relationship between client and therapist. The psychological contract has evolved over the years to be applied in occupational settings to explain social exchanges between employees and the organisation (George, 2009). Semi-structured interviews were conducted with 15 mental health professionals from community NHS teams, with one participant from an inpatient ward. A hybrid thematic analysis using inductive and deductive coding was applied to capture both the theoretical framework of the psychological contract and the subjective experiences of the participants. Results revealed that the psychological contract could serve as both a cognitive and emotional sense-making tool of change for participants. Findings also revealed the influence of contextual political and social factors around change in the NHS. Novel findings included mediators in the change process such as participants feeling supported to negotiate psychological contracts and upholding personal and team values. The findings are discussed in terms of clinical implications for manging professionals’ experience of change in the NHS.

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1. Introduction

1.1 Background

The NHS has changed at both the local and national levels (Cortvriend, 2004). The release of the Francis Report (2013) implied a decrease in the quality of patient care (Everest, Fitzgerald & Tate, 2014). This suggests that work-related stress could be damaging to both staff and patients (West, Dawson, Admasachew & Topakas, 2011). Indeed, service redesigns can place staff at risk of stress and disengagement (Beck, 2014). The majority of research on organisational change has been carried out in corporate settings, with a dearth of research on the psychological impact of change on NHS staff (Cortvriend, 2004).

1.2 Change in the NHS

The NHS is based on the premise of '*Free Health Care for All*' to meet health and social needs (Rivett, 1998). However, the NHS has faced numerous changes since its creation over 60 years ago (Waterman, Waterman & Collard, 1994). Since the 1980s, private employment in the NHS has increased (Givan & Bach, 2007). A key government NHS strategy, entitled '*Liberating the NHS*', is considered one of the biggest reforms since the creation of the NHS in 1948 (Ham, 2010). The recent White Paper published by the Department of Health (DH, 2010) aimed to empower both staff and patients in terms of making choices.

The aims of recent reforms have been to innovate services, expand capacity and improve efficiency and accountability to patients (Wallace & Taylor-Gooby, 2010), through moving the NHS towards a business model (DH, 2010). Changes include the introduction of payment by results (PbR). PbR can be described as 'pay for performance', founded on a national tariff of fixed prices that mirrors the average national prices for standard hospital procedures (Arrowsmith, French, Gilman & Richardson, 2001). The price for a particular procedure has been standardised across the NHS, with adjustments for market forces (DH, 2012a). PbR was introduced in 2002 to underpin the NHS system reform agenda by the DH (2012a). PbR was implemented with the intention to reimburse hospitals for activities carried out and to ensure providers were sensitive to patient needs, whilst offering rewards for good performance and sustainability, in terms of reductions in waiting list times and making the best use of capacity (DH, 2002). However, PbR has

meant that many local services have faced increasing demands, such as the pressures of commissioning and documenting outcomes (Furlop, Protopsaltis, King, Allen, Hutchings & Normand, 2005).

Many public services have been privatised through the introduction of '*Any Qualified Provider*' (AQP) (DH, 2011). With AQP, the NHS intended to commission a variety of services to provide patients with greater choices. However, AQP has created competition amongst providers. For instance, out of the 87 providers running services under AQP, only 26 are NHS, with 18 from charities and 38 from the private sector, such as Virgin Care Ltd. (Soteriou, 2013). Further, the notion of empowerment has been stunted by spending cuts to public services since the recent financial crisis (Appley, Crawford & Emmerson, 2009).

1.3 NHS Culture Change

The NHS appears to be moving away from its fundamental institutional basis of responding to social needs towards a business model to meet increasing economic pressures. The business model is in stark contrast to the original public sector values of the NHS. Services within the NHS have often been described as being 'dependency cultures' (Halton, 1995, p.188). It has been suggested that these types of service may attract professionals who are interested in helping those who are dependent (Lewis, 2012). In mental health services, it is argued that this particular culture helps to develop the health and welfare of those who require the service (Lewis, 2012).

The organisational culture within an institution can have a substantial impact upon organisational change (Pettigrew, Ferlie & McKee, 1992). Culture can emerge in teams, families, workgroups and organisations who have a common shared experience (Schein, 1999). Although there is no clear consensus regarding the concept of organisational culture, it has been vaguely defined as, 'the way we do things around here' (Schein, 1999, p.15). The NHS is a complex structure, embedded with teams, services and individuals, and it has been suggested that it is important to study change at these different levels (Ferlie & Shortell, 2000).

Figure 1. Timeline of NHS changes (1948-2013)

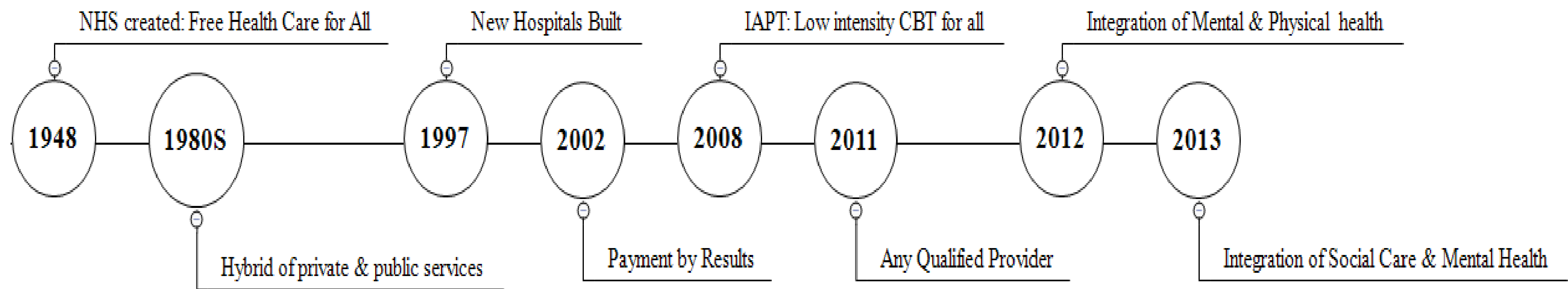


Table 1. Summary of recent key policies in NHS services

Mental Health Policy Name	Details of Policy
Clinical Governance (DH, 1997)	Accountability of NHS organisations to improve quality of services and safeguarding standards of care
Agenda for Change (DH, 1999)	Staff allocated pay bands based on knowledge, responsibility, skills and effort (NHS Employers, 2016)
National Service Framework for Mental Health (DH, 1999)	Mental health as the number one priority, including cancer and heart disease
'*NHS Plan*' (DH, 2000)	Government announced commitment to employee involvement in NHS
'*HR in the NHS*' (DH, 2002)	Focused on making the NHS a model employer, and was aimed at including staff in decision-making processes
'*Payment by Results*' (PbR) (DH, 2012a)	Producing results for the organisation and working towards a more cooperate design due to the increasing privatisation of the NHS
'No Health without Mental Health' (DH, 2012b)	Integrated mental and physical health for all
'*Crossing Boundaries*' (Mental Health Foundation, 2013)	Integrated mental health services
'*Closing the Gap*' (DH, 2014)	Long-term plan to integrate mental and physical health

1.4 Theories of Change

Since the 1950s, there has been much research on organisational change (Bamford & Foresstor, 2003). Lewin (1951; 1958) introduced the concept of planned change, which views moving from a series of planned stages, namely freezing, unfreezing and finally refreezing (integrating new values and attitudes). Planned approaches have been criticised for not being able to incorporate radical change that may happen quickly and is unplanned

(Garvin, 1994). On the other hand, emergent change proposes that organisational change is rapid and impossible to plan and control (Bamford & Forrestor, 2003). Transition theory (Nicholson, 1984; 1987) states that people may not be able to alter themselves unless they have time to adjust and stabilise to a new schema and/or identity (Marris, 1974; Parkes, 1996). In the NHS, people are experiencing constant change, which means they may never have time to fully stabilise (Cortvriend, 2004).

1.5 Impact on NHS Staff

Privatisation in the NHS may impact upon staff pay (Schulten, Brandt & Hermann, 2008) as this has created a two-tier work system, with different pay for permanent NHS staff and subcontractors (Givan & Bach, 2007). The idea of a two-tier work system may create feelings of job threat (Schulten et al., 2008). Further, the introduction of PbR has meant pressure to produce results for the organisation (DH, 2012a).

Organisational change can cause increased stress hormone cortisol levels if employees believe they lack control (Frankenhauser, 1991). A randomised controlled trial and non-blinded intervention of the psycho-social factors of change was conducted in two geriatric service wards in Sweden (Lökk & Arnetz, 1997). One ward offered a 20-week psychological intervention before and after change and the other offered no intervention. Results revealed differentiated psycho-endocrine level shifts, so that those who had received the intervention had less stress-based endocrine levels than those professional workers who had experienced involuntary change (Lökk & Arntz, 1997). Staff also believed that change would impact negatively upon the organisation in terms of economic cutbacks forcing a decline in patient care and uncertainty over work conditions. This suggests that psychological empowerment programmes may reduce stress levels during change (Lökk & Arntz, 1997).

It is argued that staff morale is essential to the NHS, to ensure the cost effectiveness of services and to improve quality and safety (Wood, Stride, Threapleton, Wearn, Nolan, Osborn, Paul & Johnson, 2011). Staff morale has been quantified by measures of burnout, job satisfaction and psychological functioning (Totman, Hundt, Wearn, Paul & Johnson, 2011). Changes to the NHS, such as an increase in demand with a non-equivalent growth in resources, have resulted in low staff morale and high stress (ProsserJohnson, Kuipers, Szmulker, Bebbington & Thorincroft et al., 1996). A study of stress and satisfaction among 160 hospital and community staff revealed that one of the

biggest stresses to staff was lack of resources, specifically a lack of people across mental health services (Prosser et al., 1996). In addition to the perceived stress of the work, the amount of work has been associated with burnout in mental health workers (Pines & Maslach, 1978).

However, there is a dearth of research on the impact of stress and change on community mental health staff (Wood et al., 2011). Reid, Johnson, Morant, Kuipers, Szmukler, Thornicroft, Bebbington and Prosser (1999) conducted a qualitative study that compared ward and community staff and found that a lack of autonomy was a stress for ward staff but a lack of resources was a key stress factor for community staff. Another study (Prosser, Johnson, Kuipers, Dunn Szmukler, Reid & Bebbington, 1999) considered stress and burnout in community staff over three years, following a move towards more community-based care. Results revealed that working in the community was more stressful for staff than working in inpatient services. Research has found that community staff often have poorer mental health than hospital staff (Carson, Fagin & Ritter, 1995). Community mental health staff are also dealing with many organisational changes (Griffiths, 1988).

Staff morale has often been linked to patient outcomes (DH, 2009). Wood et al. (2011) looked at staff morale in 100 inpatient staff, 18 crisis and 18 community mental health teams. Findings revealed that low demand and high levels of control and having supportive work relationships were invaluable for mental health staffs' well-being (Wood et al., 2011). Totman et al. (2011) carried out individual and group interviews with staff in seven inpatient wards across England. Results revealed that staff remained in their jobs due to loyalty towards and trust in cohesive ward teams. Staff also valued peer support for morale and role clarity, including organisational and structural support to maintain this. Totman et al. (2011) concluded that management strategies in mental health services should focus on increasing the sense of control. Indeed, mental health professionals may face a lack of control due to role blurring within mental health community teams from mergers (Brown, Crawford & Darongkamus, 2000). Organisational change may be particularly difficult for mental health staff as they may have fewer personal resources to cope with change (Maslach, 1978).

1.6 Impact on Patients

It is argued that negative staff attitudes towards change can create barriers to innovations to improve patient experiences and outcomes (Tansella & Thorncroft, 2009). There are social exchanges within interpersonal relationships between healthcare professionals and patients (Buunk & Schaufeli, 1999). This relationship is reciprocal, in that one is a caregiver and the other is a recipient (Firth-Cozens & Payne, 1999). This relationship has also been referred to in psychoanalytic terms as the 'therapeutic alliance' (Safran & Muran, 2001). Freud viewed the patient as a collaborator in the therapeutic process (Breuer & Freud, 1893-1895). Patient improvements have been found when therapists applied more flexible interventions and when stronger therapeutic alliances had been established (Gaston, Ring & Marmar, 1989).

A lack of reciprocity between healthcare professionals and patients within the therapeutic alliance may develop over time (Firth-Cozens & Payne, 1999). This can deplete professionals' resources and may contribute to feelings of emotional exhaustion due to an unbalanced relationship (Firth-Cozens & Payne, 1999). Healthcare professionals may cope through depersonalisation, which may balance the lack of reciprocity by psychological withdrawal (Firth-Cozens & Payne, 1999). The dual-level social exchange model (Schaufeli, Van Dierdronck & Van Gorp, 1996) states that there can be unbalanced relationships at the interpersonal level and a lack of reciprocity at the organisational level.

Correlations have been found between staff well-being and patient care (DH, 2009). Johnson, Lloyd-Evans, Howard, Osborn and Slade (2010) reviewed two studies on change in inpatient settings and the therapeutic relationship between staff and patients. One study, titled the '*Alternatives Study*' (Lloyd-Evans, Slade, Jagieslka & Johnson, 2009; Osborn, Lloyd-Evans, Johnson, Gilburt, Byford, Leese et al., 2010; Gilburt, Slade, Rose, Lloyd-Evans, Johnson & Osborn, 2010; Johnson, Lloyd-Evans, Morant, Gilburt, Shepherd, Slade et al., 2010; Lloyd-Evans, Johnson, Morant, Gilburt, Osborn, Jageiskla, 2010; Slade, Byford, Barret, Lloyd-Evans, Giburt, Osborn et al, 2010; Byford, Sharac, Lloyd-Evans, Gilburt, Osborn, Leese et al., 2010) looked at six inpatient alternatives from residential settings to standard acute wards. The second study titled '*Choices*' looked at patient preferences in randomised controlled trials to assess both the efficacy and cost effectiveness of women's crisis housing (Howard, Flach, Leese, Byford, Killapsy, Colford et al., 2010). Qualitative data at follow up suggested that the therapeutic relationship

between patients and staff was key to the positive experiences of services across studies (Johnson et al., 2010).

As a result of changes to NHS services, patients are now 'expert consumers' of services and have greater power to challenge the theory that professionals know best (Calnan & Gabe, 2001). Patient Choice, which was introduced into the NHS policy agenda in the 1990s (Bartlett, Roberts & Le Grand, 1998), and the Health and Social Care Act (2012) allowed patients more choice between NHS services (Dusheiko, 2014) and third sector or independent sector providers (Fotaki, 2014). However, patient choice can be used to generate competition, which can encourage providers to claim that treatments are more expensive than they are in reality (Fotaki, 2014). In addition, the socio-economic differences may influence different uptakes and may cause inequality in healthcare (Cookson, Dusheiko, Hardman & Martin, 2010). The quality of patient care can be difficult to quantify due to process (waiting times) and outcome in care (improve clinical outcomes) (Fotaki, 2014).

The business model requires cost efficiency through service redesigns and funding cuts, which means the quality of care for clients may reduce (Wood et al., 2010). Staff may have increased administrative workloads due to the requirement to document outcomes, which can decrease staff-patient time (Wood et al., 2010). Due to increased workloads, stress and burnout may increase (Edwards, Burnard, Coyle, Forthergill, & Hannigan, 2000). This may result in staff leaving and more agency staff being employed, which may result in attachment difficulties for patients due to constantly changing staff. Research has found a correlation between poor patient care and an increase in agency staff contracts as workloads have increased and patient time has decreased (De Rutyer, Kirkpatrick, Hoque, Lonsdale & Malan, 2008). Waiting times for clients may increase due to increased referrals and low staffing levels, and clients have reported difficulties accessing psychology services in the UK (Richards, Lovell & McEvoy, 2003; Department of Health, 2007). Average waiting list times can be up to ten weeks from referral to first appointment (Trusler, Doherty, Mullin, Grant & McBride, 2006). There may be fewer services provided by the NHS that are free at the point of use due to the introduction of AQP (DH, 2011). A series of 20 case studies showed that patients were having to purchase upgrades to their basic NHS care (Charlson, Lees & Skiora, 2007).

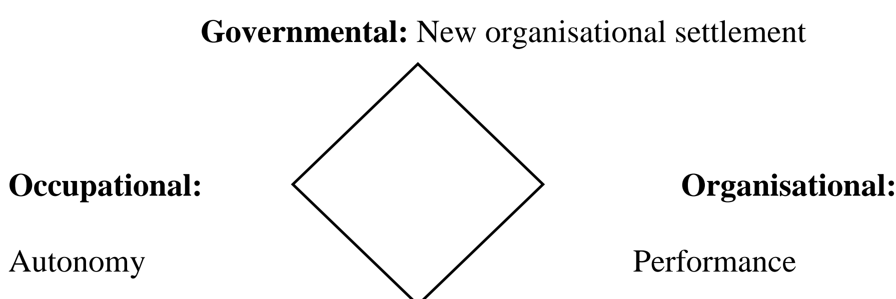
1.7 Impact of the Business Model

The business model has meant that patients have become experts in their own care and changes imply a shift in power, whereby professional-knowledge authority is challenged (Clarke & Newman, 2009). Professionals may have less autonomy within organisations due to job cuts and lack of resources. Clarke and Newman (2009) described the power dynamics of change between government, occupation and the organisation (see Figure 2 below). In this sense, the government is responsible for change and the organisation is responsible for performance. The organisation needs to know what the consumer wants in order to arrange services and manage resources (Clarke & Newman, 2009).

Organisations may cope by interpreting policy to fit with organisational structure due to having more local knowledge of public needs (Clarke & Newman, 2009). This may require the use of innovation in order to take risks and grow, including agency and autonomy to do something different (West & Farr, 1990). However, due to cutbacks, many employees may experience insecurity and are not be able to make changes (Brockner, 1988). Employees may lack agency as they perceive themselves to be helpless and lack autonomy without resources. Further, teamwork may be reduced due to feelings of competition amongst colleagues (Bies, 1987).

Figure 2. Pyramid of relationships between government, occupation and organisation (Clarke & Newman, 2009)

Governmental: New organisational settlement



1.8 Applying an Occupational Psychology Lens

The process of contracting can help professionals to maintain autonomy and agency within an organisation through informing, negotiating, monitoring and exiting (Herriot & Pemberton, 1997). Understanding the sense-making process (Weick, 1995) in a

theoretical contracting framework could help provide evidence to organisations as to what practices may support patients and professionals. This may indirectly help organisations in terms of cost efficiency so that emotional exhaustion and/or burnout of staff are prevented (Brotheridge & Lee, 2003). Applying an occupational psychological lens may help bridge the gap by explaining how individuals and organisations function (Everest, Fitzgerald & Tate, 2014). One way of investigating how individuals see change in organisations is to consider the theoretical construct of the psychological contract, which can serve as a useful framework for understanding the sense-making processes that individuals take part in during organisational change (De Vos, Boynes & Schalk, 2005).

1.9 Psychological Contract Theory

Employees have psychological contracts with their employing organisation; the contracts provide a sense of identity and attachment and can protect mental health (Selznick, 1957; Levinson, Price, Munden, Mandl & Solley, 1962; Levinson, 1965; Conway & Briner, 2002). The psychological contract is different to a formal work contract as it is subjective to the employee and not limited to a concrete written work contract (Shruthi & Hemanth, 2012). The term was first introduced by Menninger (1958), who applied psychoanalytic theory to describe a range of relational exchanges, which included both the explicit and the unspoken implicit contracts between patient and psychotherapist (Menninger & Holzman, 1973). Menninger (1958) believed that both parties were influenced through unconscious and conscious processes and this would continue until both parties felt satisfied with the contract.

Argyris (1960) applied the psychological contract to the workplace to describe an implicit arrangement between employees and managers. Argyris (1960) argued that employees and organisations created psychological contracts in order to meet the reciprocal expression and fulfilment of the needs of each (Conway & Briner, 2005, p.9). Further, if employers respected the culture or norms and allowed employees to proceed with their jobs, they would be more likely to perform (Argyris, 1960). Levinson et al. (1962, p.21) defined the psychological contract as 'a series of mutual expectations of which the parties to the relationship may not themselves be even dimly aware but which nonetheless govern their relationship to each other'. Levinson et al. (1962) stated that expectations were implicit, dynamic and often formed before or separate from the

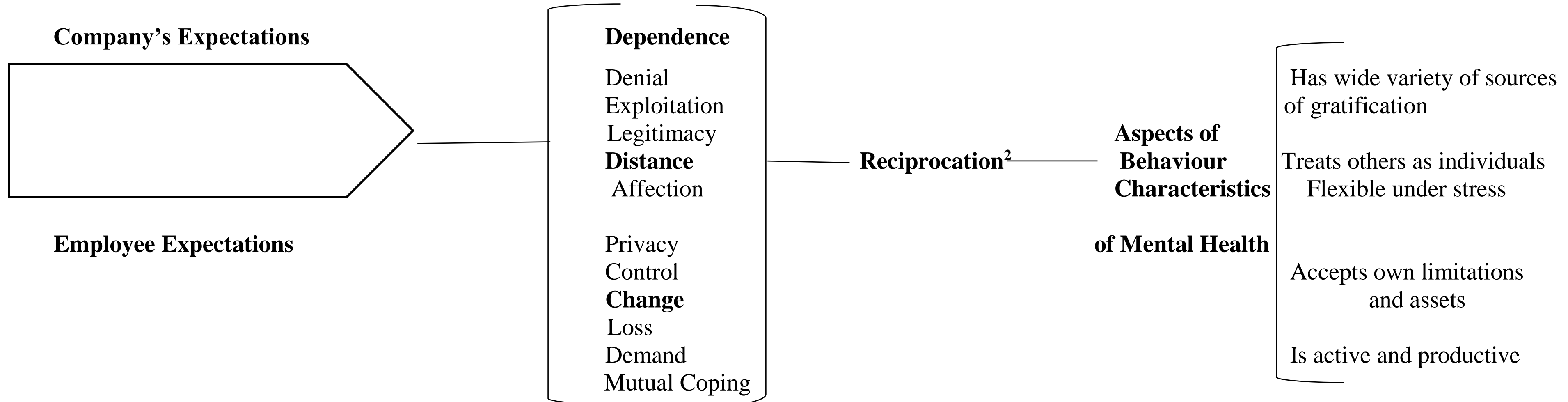
employment relationship. Levinson et al. (1962) believed the contract was related to mental health when it was balanced and that employees were able to apply renegotiation to move towards their 'preferred self'.

Levinson et al. (1962) conducted 874 interviews with employees at a US utility plant. Results revealed three categories of concerns: dependence, distance and change (see Figure 3 on the following page). Levinson et al. (1962, p.129) stated that the 'psychological contracts developed implicitly through a series of conditions in order for reciprocation to be achieved' (see Figure 3 on the following page, cited in Meckler, Drake & Levinson, 2003, p.222). Schein (1965) believed that the psychological contract was continuously being renegotiated through mutual influence and believed the contract provided a way to analyse the relationship between employer and employee. Indeed, Schein (1978, p.112) defined the contract as '… "psychological" in that actual terms remain implicit; they are not written down anywhere. But the mutual expectations formed between the employer and employee function like a contract in that if either party fails to meet the expectations, serious consequences will follow – demotivation, turnover …'.

1.10 Contemporary Psychological Contract Theory

Rousseau (1989) placed emphasis on promises rather than expectations and believed that an employee's perception of the contract was more important than the agreement between employee and employer. Other theorists believe psychological contracts were created by the relationship between an individual's perception of the dual perspectives of their behaviour and the organisation's behaviour (Conway & Briner, 2005). Another definition is 'the promises that employees believe were made to them by their employer probably prior to them entering the organisation' (George, 2009, p.3). Some theorists argue that the contract can be made up of expectations, beliefs, obligations and promises (Conway & Briner, 2005). Meckler et al. (2003) believe in the process of reciprocation, whereby a series of evolving psychological contracts was undertaken in an effort to meet the expectations and concerns of the parties. Contracts can be socially construed through the mutuality of understanding of the obligations, which are facilitated by the interactions between employers and employees (Dabos & Rousseau, 2004; Conway & Guest, 2002). Mutuality is believed to be important for employer and employee to reach interdependent goals (Rousseau, 1995).

Figure 3. Levinson et al.'s (1962) inputs and outputs of the psychological contract as mental health need (Meckler et al., 2003, p.222)



Conditions for Reciprocation[2]

- To plan at least some part of one's work life; an area of freedom in which to function
- To model oneself on authority figures in the company
- To act on the organisation, to shape it to some extent
- To experience oneself and the organisation as confronting stress together
- To obtain the gratification of psychological needs for dependence and support
- To be controlled, or to have personal controls enhanced by the demands of the company
- To have the feeling of a fair-share partnership with the compan

[2] *Conditions for reciprocation (Meckler et al, 2003, p.222).*

Failure to reach a shared agreement through mutuality can result in a contract breach or violation (Morrison & Robinson, 1997; Rousseau, 1995). Morrison and Robinson (1997, p. 3) defined a contract breach as 'the cognition that one's organisation has failed to meet one or more obligations within one's psychological contract'. Contract violation has been defined as an 'emotional and affective state that may follow from the belief that the organisation has failed to maintain the psychological contract' (Morrison & Robinson, 1997, p.230).

A breach has consequences for both the organisation and the employees (Guest et al, 1996). Attitudinal responses include reduced organisational commitment (Turnley & Feldman, 1999), reduced job satisfaction and cynicism (Robinson & Morrison, 1995). Behavioural responses can include strong emotions, such as anger and frustration (Rousseau, 1989), including anxiety and depression (Conway & Briner, 2002). Additional responses may include reduced work efficiency (Zhao, Wayne, Glibowksi & Bravo, 2007). A breach decreases trust, which means employees may no longer feel able to invest in the organisation (Rousseau, 1989).

Employees may see inequity with contract breach and reduce contributions (Robinson, Kraatz & Rousseau, 1994). Equity theory is a theory of social exchange and it has been applied at a personal and organisational level (Walster, Walster & Berscheid, 1978). Organisational unfairness can result in employees experiencing inequitable or unreasonable work conditions (Colquitt, Noe & Jackson, 2002). Injustice at work has been seen as a primary stressor in effects on health (Greenberg, 2004).

Schaufeli, Van Dierendonck, and Van Gorp (1996) believed that a violation of the contract could lead to burnout. Research with two samples of student nurses (220 and 142) found that those who believed they had invested more in their patients and hospital than they received back reported higher levels of depersonalisation and emotional exhaustion and reduced personal accomplishment (Schaufeli et al., 1996). This means that reciprocity may be an accompanying symptom of burnout rather than an antecedent (Schaufeli et al., 1996). Other studies with therapists from a forensic psychiatric clinic and staff working with clients in a learning disability setting found that burnout is related to perceptions of organisational inequity (Van Dierendonck, Buunk & Schaufeli, 1998). Overall, it appears that reciprocity is important in understanding the experience of burnout in healthcare due to its relationship with contract violation. Further, it appears that this works at both the

interpersonal and organisational levels (Firth-Cozens & Payne, 1999). It has also been found that the strength of emotional and behavioural reactions following contract breach can be moderated by how employees cognitively assess the organisational context of the breach (Morrison & Robinson, 1997; Rousseau, 1995).

1.11 Quantifying the Psychological Contract

The psychological contract has proved difficult to quantify over the years (Conway & Briner, 2009). Rousseau (1990) distinguished between transactional and relational contracts. Transactions are based on an exchange between employees and employers such as the organisation providing pay in return for work (Herriot & Pemberton, 1997). Relational aspects focus on the 'whole person' (George, 2009), such as trust in return for competent management and belonging (Maguire, 2002). Robinson & Rousseau (1994) later distinguished between implicit and explicit promises. Explicit promises can be written or verbal agreements, whereas implicit promises tend to be formed through vicarious learning (Robinson & Rousseau, 1994). Some theorists believe the contract is made up of a series of events that are dependent on the amount of time taken to reach the final outcome (Mohr, 1982). Conway and Briner (2005) valued the importance of the interpretation of these events. In this way, contracts can be seen as social exchanges such as when one party does something and the other party reciprocates and there is constant renegotiation (Schein, 1980). Table 2 (page 17 below) illustrates the common terms used in the content of the psychological contract.

1.12 Broadening Psychological Contract Theory

Meckler et al. (2003) have criticised contemporary theorists for neglecting the clinical basis of the psychological contract. Guest (1998) believed that one of the main problems in quantifying the contract was that it was neither a theory nor a measure but more a hypothetical construct. Guest (1998) aimed to construct a framework to incorporate policy and practice. Guest (1998) focused on the changing content of the contract over time such as when promises and expectations did not match reality. The interest was in the implicit assumption that behaviour was in response to a changing organisational context, and damage to the contract would result in reduced commitment (Guest, 1998). For instance, in the UK, there are many more employees engaged on part-time contracts in the NHS, whereby privatisation has created a two-tier work system (Givan & Bach, 2007). It

was believed that the contract should be balanced and that problems could occur when there was a lack of clarity about the content of the contract (Guest, 1998).

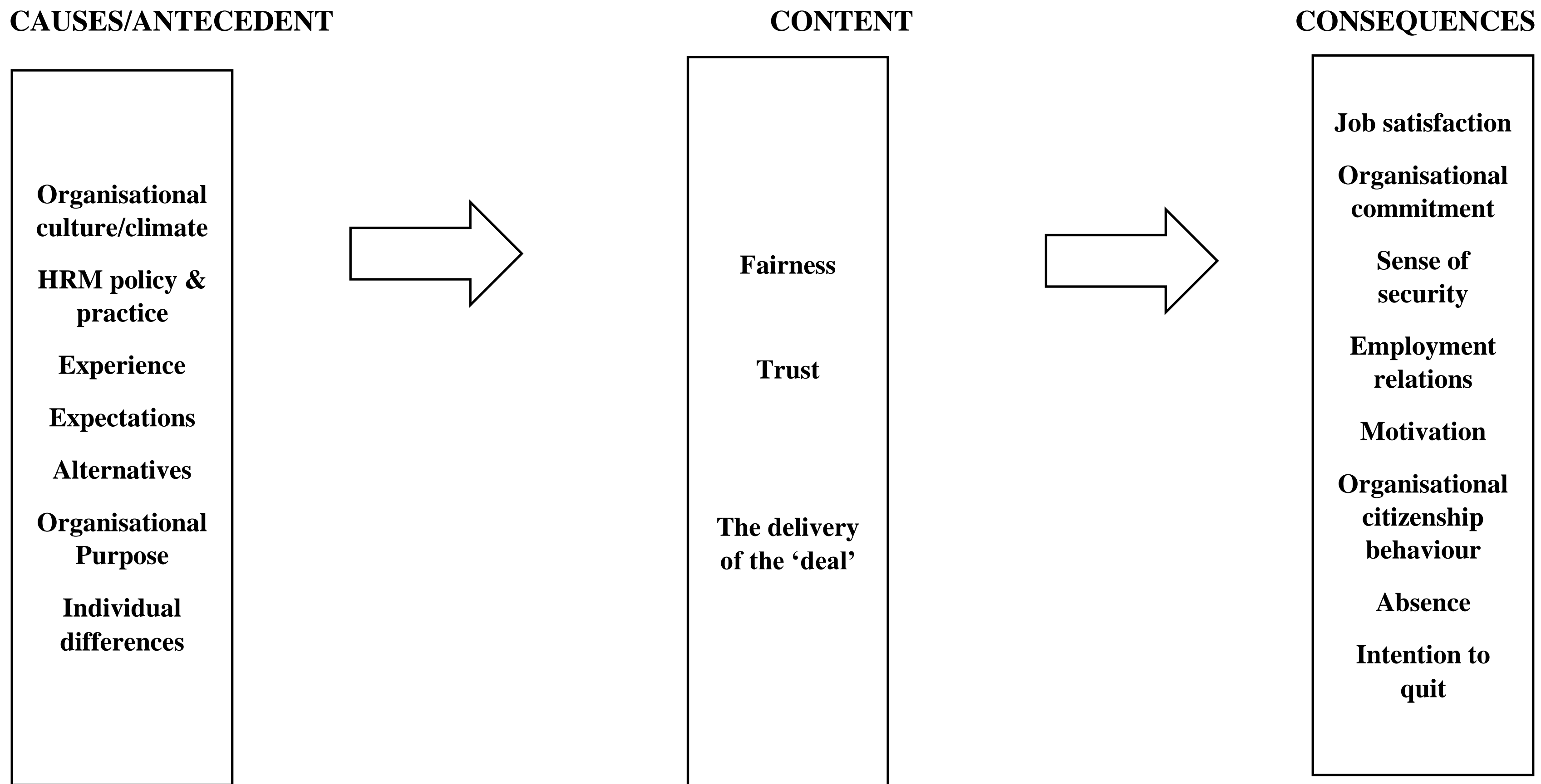
1.13 The Extended Psychological Contract Framework

Guest (1998) was interested in the wider influences on the psychological contract such as the impact of organisational culture, climate and power distribution (see Figure 4 on following page). Guest (1998) saw expectations as inputs by employees and focused on individual influences and societal norms. He (1998) focused on the state of the contract, which included trust, fairness and delivery, and he believed contract violation could occur as a result of the state of the contract at the start of employment, for example, where implicit contracts were unclear, rather than the organisation necessarily 'doing something wrong'. A survey of 1,000 employees revealed that the state of the contract could be affected by human resource management strategies and an organisational environment that involved partnership and employees anticipating future employment security (Guest & Conway, 1997; Guest, 1998, p.661). Further, psychological contract fulfilment was related to increased job satisfaction, organisational commitment and motivation and positive evaluation of employment relations, including less intention to quit the organisation (Guest, 1998, p.661). Guest (Guest, Conway, Briner et al, 1996; Guest & Conway, 1998, 2000, 2001, 2002) conducted several surveys for the Chartered Institute of Personnel and Development (CIPD). Results revealed the contract was influenced by the organisation, individual and wider societal norms (Guest, 1998, p.660). George (2009) later extended Guest's (1988) model by including organisational purpose and individual differences. For instance, the DH evaluated the organisational purpose of Health Action Zones in the UK in the late 1990s, as a whole system approach to public healthcare (Pratt, Gordon, Plampling & Wheatley, 2000). The allocation of resources to the zones required a bidding purpose by local partnerships and it was found that purpose was linked to contract type and influenced organisational culture (Springett, 2005). Research had also found personality differences in influence contract types and perceptions of breach (Raja, Johns & Ntalianis, 2004).

Table 2. Definitions of the psychological contract (Conway & Briner, 2005, p.24)

Content	Definition	Examples
Promises	'A commitment to do (or not do) something' (Rousseau, Mclean Parks, 1993, p.6) - preferred term as it is more contractual than related to obligation and expectation and is grounded in a contract (promises involve expectations)	Employer promises that employee can work overtime and can have time off the following day. Employee expects this to be delivered as a previous employer has promised this
Obligations	Mutual obligations between employee and employer. If obligation is based on experience outside then it falls outside the current contract (Morrison & Robinson, 1997). Obligations are based on implicit and explicit promises	Employee works overtime and believes employer is obliged to give time off
Expectations	'Beliefs in the probability of future events to normative beliefs' (Rousseau & McLean Parks, 1993, p.8). Based on probabilistic beliefs about future events	Employer believes they will have a pay rise at some point
Implicit Promises	Vicarious learning by watching colleagues and concepts that parties may take for granted (good faith)	Employee sees that colleagues can take a long lunch break, so does the same
Explicit Promises	Verbal or written agreement from organisation	Promise, made by manager to employee, of promotion in return for meeting targets
Relational	Long-term, open-ended promises	Support or emotional belonging from organisation
Transactional	Tangible, monetary and explicit	Pay in return for work

Figure 4. Extended psychological contract model (Guest, 1998, p.661; George, 2009, p.129)



2. Systematic Review

The systematic review focuses on the impact of organisational change on mental health professionals within the UK's NHS. The following seven concepts were used to conduct the research:

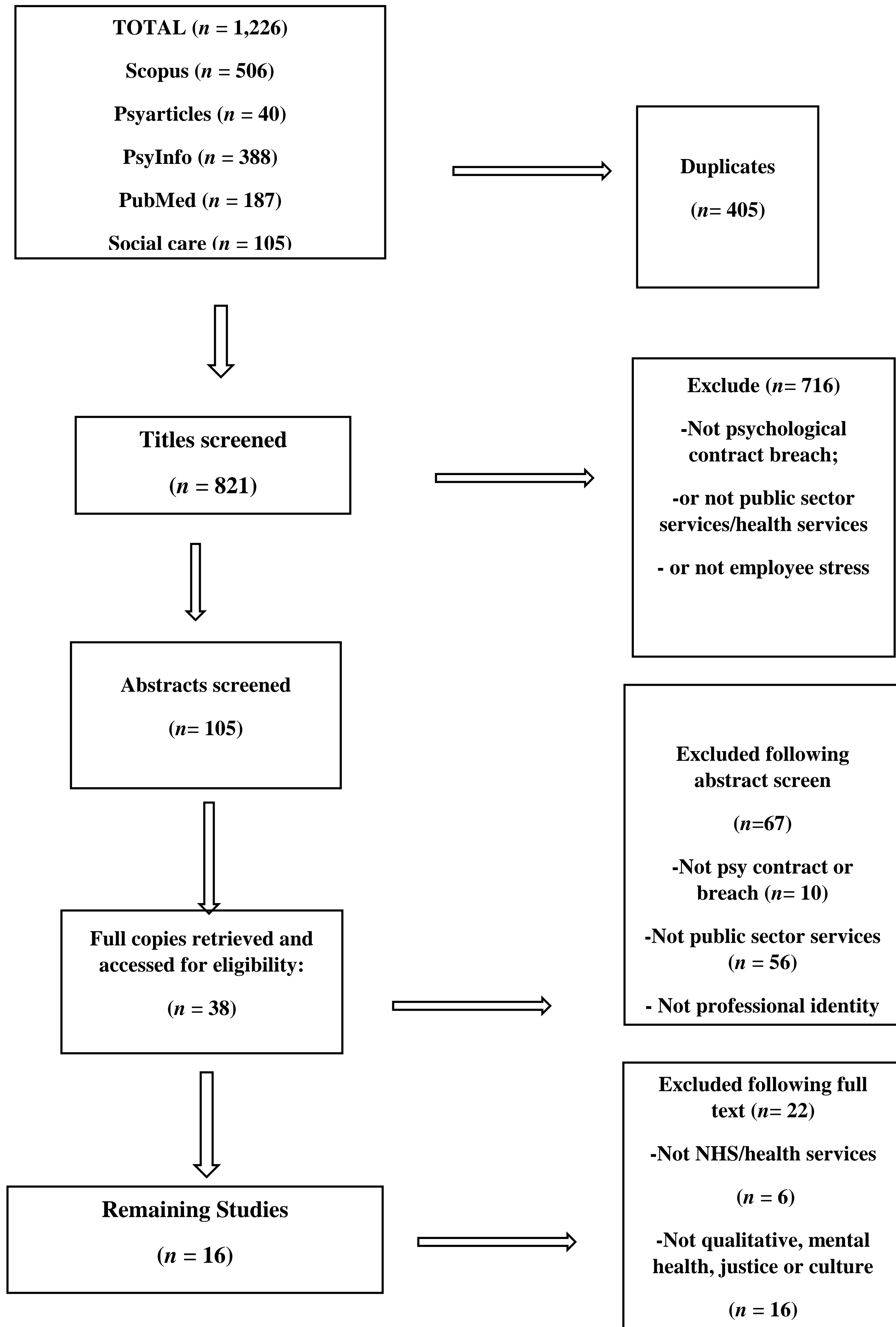
- Psychological contract – content and breach
- Contract breach – reciprocity and mutuality
- Organisational change
- Mental health professionals
- Identity – professional
- Public sector services/health services
- Organisational justice

The research terms were used in the following databases: Psych info, PsyArticles, Scopus, Social Care online and PubMed. Although the psychological contract dates back to the 1930s, the criterion in terms of years was 1948 when the NHS was first established. The search also focused explicitly on the many different definitions of the psychological contract, as well as examples of when employees had experienced a contract breach. The search also focused explicitly on when mental health professionals had experienced a contract breach within their health service and/or the NHS. It was important to keep the search term wide as it was revealed that there was a dearth of literature on psychological contracts within the UK's NHS. Therefore, this was expanded to other health services in different countries, such as the USA and Australia (see Figure 5 on following page for the full search process).

Table 3. Search terms in systematic review

AND	NOT
'psychological contract' and 'reciprocity or mutuality' or 'contract breach' or contract violation	'contracting or work contracting' or 'contract breaking' or 'work attitudes'
'public sector' or 'health service' and 'psychological contract change' or 'organisational change' or 'NHS changes'	'private sector' or 'work contract change'
'professional identity' and 'mental health teams' or 'NHS' or 'health services'	'identity' or 'work teams'
'psychological contract' and 'organisational injustice' and 'mental health'	'stress' or 'psychiatric diagnosis'

Figure 5. Systematic review process



2.1 The Psychological Contracting Process

Through understanding and exploring changes in the concept of the psychological contract, it can be applied as an analytic concept instead of a descriptive construct (Guest, 1998). Herriot and Pemberton (1997) investigated the different perceptions between employers and employees of the contract during organisational change in a major private UK organisation (see Appendix A, Table A1, p.138). Herriot and Pemberton (1997) saw the contract as an interactive process, renegotiated through changes in social and/or business contexts.

A survey revealed that employees believed the previous contract from 20 years earlier was no longer functioning. A workshop was held with 16 employees from each of the three groups (graduates, clerical workers and middle managers), to assess the perceptions of the original deal (1975) and the current deal (1995). There was some agreement between the employees on the original contract. Graduates believed the organisation presented financial perks as compensation for their loss of job safety. In return, graduates believed they offered the organisation flexibility around their work (Herriot & Pemberton, 1997). However, graduates believed the organisation had failed to keep pace with their expectations. Middle managers described their losses and were aggrieved about transitioning from a relational to a transactional contract. Clerical workers saw the deal as transactional and the organisation as more of a taskmaster.

Overall, employees felt they had not been well informed about the worth of their skills in terms of the organisation's changing requirements. Further, they were not aware of the repercussions of business change for career prospects. However, employees felt they had more clarity on the limitations of what the organisation could now provide for them (Herriot & Pemberton, 1997). Employees also saw the organisation as not being aware of the flexible contracting they believed was essential to meet different individual needs. Findings implied that explicit contracting may help to manage employee expectations. However, there were limitations as the study was conducted within one organisation, which reduced generalisability. The study was retrospective by asking employees to remember a contract from 20 years earlier, which resulted in memory biases. Further, the study failed to capture the mutual views of the organisation and employees.

2.2 Negotiation of Psychological Contracts

Research has found that psychological contracts often contain implicit beliefs (Guzzo, Noonan & Elron, 1994), which may differ within professional contexts. Dick (2006) considered both the individual and organisational relationships in a large metropolitan constabulary, with female police officers who had reduced working hours due to parenting responsibilities (see Appendix B, Table B1, p.139 for further details). In professional occupations such as policing, employees may be socialised into accepting certain norms such as working long hours (Silverstir, 2006). However, going against organisational norms such as reducing to part-time working may go against these norms (Dick, 2006).

Opportunistic sampling was applied to recruit managers and officers. Subsequently, twelve participants took part in in-depth semi-structured interviews. Findings revealed different processes that could influence the interpretation of the contract during change, which showed how difficult it was to implement a clear part-time working policy (Dick, 2006). Part-time workers appeared to have obtained beliefs implicitly about the managers' obligations from other part-time workers (Dick, 2006). The contract appeared to provide a sense-making framework for employees during changes to employment circumstances in terms of making the implicit contract explicit (De Vos et al., 2005). However, limitations of the study included the small sample size (12 participants).

Many professionals hold relational contracts (Bunderson, 2001), which may result in feelings being triggered during organisational processes and affecting employee well-being (Dick, 2010). The prospect of part-time work may draw attention to an employee's value and worth and employees who do not feel valued during transition to part-time work may perceive there to be a contract breach (Dick, 2010). Dick (2010) investigated contract changes in the police force with mothers who had recently given birth to explore the changes in personal circumstances on contract perception (see Appendix C, Table C1 p.140 for further details). Dick (2010) conducted a study over two years in three metropolitan forces. Semi-structured quantitative interviews were used with eight triads of participants, which included an officer, a colleague and a manager.

Findings revealed that employees saw reciprocity as a long-term process, which suggests that employees had relational contracts (Dick, 2010). Managers believed flexibility attributed to part-timers depended on their ability to be trusted and to do a good

job. Further, the more part-timers experienced managers keeping to their commitments, the more likely they were to demonstrate work flexibility (Dick, 2010). Although many employees saw part-time working as reducing career progression, they appreciated being able to stay in their role and saw benefits for the organisation (Dick, 2010).

Overall, the study showed that agreement about mutual obligations was influenced by implicit processes such as everyday interactions with managers (Dick, 2010). The organisation experienced difficulties assimilating part-time workers due to policy ambiguity. However, the ambiguity also created agency and autonomy in allowing more space for negotiation (Feldman & Pentland, 2003). Further, both employees and managers had equality in negotiating contracts, creating a potential for organisational transformation (Dick, 2010). However, due to the small sample size, it was difficult to ascertain why sometimes employees' needs were met and sometimes they were not (Dick, 2010).

2.3 Organisational Culture

There is a dearth of research on the antecedents of psychological contracts (Guest, 1998). Richard, McMillan-Capeheart, Bhuian and Taylor (2009) believed that psychological contracts mediated the relationship between organisational culture and affective commitment. Richard et al. (2009) compared different hierarchical cultures, considering rules, policies and clan cultures, which focused on participation in teamwork and cohesiveness (Deshapande & Webster, 1989). Surveys were administered to 250 MBA students in Atlanta and 220 were returned, 20 were discarded and 200 were part of the final sample (see Appendix D, Table D1, p.141 for further details). Findings revealed that the clan culture positively impacted on relational contracts but there was a negative impact on transactional contracts (Richard et al., 2009). Further, there was a positive relationship between relational contracts and affective commitment. Overall, there was a mediation of psychological contract types on the relationship between organisational culture and both organisational commitment and yearly earnings (Richard et al., 2009).

Overall, the findings suggested that organisations had a role in influencing employees' perceptions of the psychological contract and played a key role in the psychological contract type. These results supported the extended psychological contract model (Guest, 1998; George, 2009), which proposes that organisational culture plays a role in the formation of relational contracts. Richard et al. (2009) suggested that future

research should consider other organisational culture types as well as HR policies. However, the generalisability of the findings was limited as the sample were all MBA students.

2.4 Cognitive and Motivational Mechanisms

Previous research has identified both cognitive and motivational cultural mechanisms that can impact upon employee expectations (Thomas, Au & Ravlin, 2003, p.451). Thomas et al. (2010) suggested that the psychological contract should be investigated more broadly to see if employees are motivated by more than self-interest. Thomas et al. (2010) looked at transactional and relational contracts in symmetric and asymmetric power distributions, considering individual level processes through which national culture could influence contracts. Interviews were conducted with 57 participants from different cultures: French, Canadian, Chinese and Norwegian (see Appendix E, Table E1, p. 142 for further details).

The findings revealed that the dominant form of the contract varied amongst individuals from different countries and could be strongly influenced by cultural value orientations. However, contracts deviated from the expected cultural patterns when the initial expectations were unrealistic (Thomas et al., 2010). A breach of an expected relational contract pattern was perceived as unfair by employees and the contract became more transactional (Thomas et al., 2010). However, transactional contracts did not change when the breach was fair. Findings showed that expectations were not fully grounded in societal values. Thomas et al. (2010) also suggested that transactional contracts may be more independent whereas relational contracts would be more dependent on the long-term socio-emotional relationships between colleagues. The implications are that organisations should be realistic in terms of what is communicated within the employee-organisation relationships (Thomas et al., 2010). However, the limitations included the fact that the analysing author was not present during the interviews and may have missed some meanings. Further, organisational characteristics can be important influences on the contract and these were only partially controlled (Guest, 2004).

2.5 Societal Changes

The psychological contract is also affected by wider societal changes (Hiltrop, 1995). Parzefall (2008) investigated the impact of organisational culture through

workplace change in the Finish public sector. Changes included job uncertainty and increased scrutiny (Blom, Melin, Pyöriä 2001; Ylöstalo, 2004). Parzefall (2008) looked at the norms around reciprocity in 118 employees in a Finish public sector firm, using questionnaires containing measures of contract fulfilment (see Appendix F, Table F1, p.143 for further details). Findings revealed that the behaviour of the employer impacted on employees' perceptions of the type of reciprocity within the exchange (Parzefall, 2008). For instance, when the employer had fulfilled the contract, employees had a greater perception of generalised reciprocity (altruistic motivation). Moreover, employees' perceptions of the employer having fulfilled contract obligations was inversely associated with employees' perceptions of fixed timings for outputs (balanced reciprocity). However, there was a positive correlation of contract fulfilment and affective commitment. Further, contract fulfilment was negatively related to the intention to leave the organisation (Parzefall, 2008).

Therefore, the psychological contract framework and types of reciprocity can be useful in comprehending how the exchange relationships between employer and employee affects attitudes and behaviour in a changing workplace (Parzefall, 2008). The introduction of business from the private sector may indicate a balanced reciprocity and undermine the traditional public sector psychological contract of generalised reciprocity (Parzefall, 2008). However, this study was cross-sectional in nature and the data was obtained using self-reported measures, which may create bias. Parzefall (2008) suggested it may be best to assess employer perceptions as well in order to capture the exchange relationship. Further, it would be difficult to generalise findings internationally.

2.6 Behavioural Consequences of Change

Perceived breach occurs when employees believe the organisation has not fulfilled promises (Robinson & Rousseau, 1994). Wang and Hsiesh (2014) considered the influence of organisational context on the relationship between contract breach and attitudinal and different behavioural responses, specifically in the consequence of acquiescent silence, as previous research had found this could reduce workplace innovations (Argyris & Schön, 1978). Wang and Hsiesh (2014) investigated the perceived ethical climate (PEC) as measured by employees' awareness of the organisation's moral perspective as a moderator on the relationship between contract breach and reactions (Koh & Boo, 2001).

Participants included 273 employees from nine high-tech firms in Taiwan. The participants completed questionnaires (see Appendix G, Table G1, p.144 for further details). Findings revealed a moderation of PEC on the relationship between a breach and employees' behaviour, such as the use of acquiescent silence. The presence of PEC may have reduced acquiescent silence by providing an atmosphere of safety (Walumbwa & Schaubroek, 2009). PEC may have acted as a buffer, as a nurturing culture could induce a perception of organisational morality in employees, which may improve organisational performance (Wang & Hsieh, 2014). However, the results were limited as research took place in a single high-tech industry in Taiwan so may not be generalised to other societies or industries. Further, researchers were unable to gather information from multiple sources, which may have threatened internal validity. Wang and Hsieh (2014) also suggested that future research should be longitudinal to allow for more causal findings.

2.7 Emotional Impact of Change

There is a dearth of research on emotional well-being when a breach occurs (Cassar & Buttigieg, 2014). McGrath, Millward and Banks (2015) investigated the psychological contract to determine how employees made sense of workplace emotions (see Appendix H, Table H1, p.145 for further details). Semi-structured interviews were conducted with 30 volunteers (colleagues, co-workers) from various UK organisations, using a critical incident technique, and analysed via thematic analysis. Findings showed that the psychological contract was used by employees to make sense of emotions in relation to broken and exceeded promises (McGrath et al., 2015). Further, emotions were in line with the psychological contract type as the majority of participants had relational contracts with the organisation. In addition, those who held relational contracts had more positive emotions than those who held transactional contracts but were more likely to internalise blame or factors outside of the organisation, especially when the contract was more intrinsic (McGrath et al., 2015). Further, broken promises resulted in unpleasant emotions but some employees were able to rationalise events. Those with transactional contracts were more likely to blame the organisation.

Therefore, it appeared the psychological contract was a sense-making tool to explain the discrepancy with expectations such as uncertainty, which could contribute to the perception of a contract violation (McGrath et al., 2015). There was also a sense that regulating emotions irrespective of contract type was due to a sort of 'professionalism'

(McGrath et al., 2015). However, it was implied that the avoidance of emotion could be problematic to employees' well-being and organisational effectiveness. Instead, it was suggested that the organisational climate should adapt to emotional displays (McGrath et al., 2015). However, the findings are limited as the mean age of the participants was 26 years and a lifespan approach may have produced different results. Further, volunteer sampling was used via social media, which may have created recruitment bias.

2.8 Health Consequences of Breach

Psychological contract breach can affect employees' health, due to perceptions of unfairness (Greenberg, 2004). Some researchers have suggested that distributive injustice is a form of breach (Kickul, Neuman, Parker & Finkl, 2001). A meta-analysis of 279 studies (Robbins, Tetrick & Ford, 2012) investigated whether psychological contract breach could contribute to physical health outcomes beyond organisational injustice (see Appendix I, Table I1, p.146 for further details). It was revealed that the perceptions of unfairness were associated with physical and mental health. Further, this relationship was stronger for strain-related indicators of health than for physiological or behavioural indicators. However, a psychological contract breach contributed towards the prediction of health outcomes beyond those that were explained by injustices (Robbins et al., 2012). This suggests that the psychological contract has an impact on mental and physical health, irrespective of the perceptions of unfairness in the workplace (Robbins et al., 2012). Moreover, a psychological breach does not solely cause stress due to the perceptions of unfairness, but it may be distinctive to the individual and represent a multi-dimensional construct (Robbins et al., 2012).

However, the findings should be interpreted with some caution as the majority of participants completed self-reported measures and represented a US sample (Robbins et al., 2012). There was also a limited number of studies within the meta-analysis (Robbins et al., 2012). Robbins et al. (2012) suggested that future research should use a wider range of samples to investigate, as the majority of research on unfairness and health is from the US (Robbins et al., 2012).

Cassar and Buttigieg (2015) believed Robbin et al.'s (2012) meta-analysis had provided important findings, but argued that many of the measures confounded unfairness with breach. Cassar and Buttigieg (2015) aimed to incorporate the effects of breach, organisational justice and well-being at work (see Appendix J, Table J1, p.147 for further

details). Cassar and Buttigieg (2015) were specifically interested in HR strategies and psychological contracts as previous research has suggested that there is a link between employee well-being and performance (Baptiste, 2008). Cassar and Buttigieg (2015) administered questionnaires to 420 employees at a US automobile parts factory in Malta. The questionnaire had psychometrically valid scales of breach, justice and well-being in two separate dimensions (anxiety-comfort and depression-enthusiasm).

Results showed that psychological contract breach was a partial mediator of the association between justice and emotional well-being, which may be explained due to justice having a direct impact on health outcomes (Robbins et al., 2012). Further, the mediating role of breach was not affected by the perceived level of justice or the role of breach between justice and emotional well-being, apart from for depression-enthusiasm. Further, employees who experienced high levels of procedural and interactional justice were least likely to perceive a breach, which suggests that employees who have high levels of these types of justice may have relational contracts and experience less breach. Further, interactional justice had a stronger effect on well-being (depression-enthusiasm). Cassar and Buttigieg (2015) stipulated that the study had explored justice and emotional well-being together in the workplace, which few studies had done previously. They suggested that future research should explore more complex relationships between justice, breach and well-being in terms of the temporal role of justice development and the types of breach (power, fairness and well-being). Overall, the implications were that healthy employment relationships in the absence of a breach and justice may result in better well-being at work. This may indirectly reduce the symptoms of poor emotional well-being such as being absent and lateness.

However, the study was cross-sectional and included different job grades, such as technical and clerical, and perceptions of a breach may have differed depending on the hierarchy. Further, the research was set in a specific type of automobile parts company in Malta, so findings cannot fully be generalised.

2.9 Psychological Contract Change in Health Settings

There is a dearth of research on psychological contract breaches in healthcare settings. The lack of research may be attributed to the provision of balanced views of health cultures; but, in recent years, health settings have moved towards more business-driven contracts. The change to a business culture may inadvertently provide less agency

and autonomy to employees. A longitudinal study investigated the contract in four health care organisations in the Netherlands (Schalk & Freese, 2000, see Appendix K, Table K1, p.148 for further details). Employees completed questionnaires at three time points of six months apart (155 with complete data). In-depth interviews were conducted with 29 employees.

Findings revealed that both employers' and employees' attitudes influenced the affective commitment to the organisation, which influenced the intention to turnover. Change was constructed differently as some employees did not experience change, whereas others experienced positive and negative changes (Schalk & Freese, 2000). Employees had the strongest reaction to those changes that were salient to them (Schalk & Freese, 2000). Employees experienced satisfaction with the changes that were related to the psychological contract, which is related to affective commitment and an intention to turnover. Interviews revealed patterns of balancing, revision and desertion in the psychological contract (Schalk & Freese, 2000). Overall, findings showed that looking at a psychological contract could help to manage change by supporting employees to balance or revise their contracts in order to prevent them from leaving the organisation. Future research was advised to consider the effects of different organisational changes and to provide a link between qualitative and quantitative data (Schalk & Freese, 2000).

Freese, Schalk and Croon (2011) later applied a longitudinal design to consider the impact of organisational change on psycho-social contracts, using a mixed-methods approach, and questionnaires were administered to 450 health care workers at three time points over one year. There was complete data at all three time points for 186 healthcare workers (see Appendix L, Table L1, p.149 for further details). Three organisations in the Netherlands that had been through planned changes participated. One organisation had tried to implement a more customer-orientated approach and permanent contracts were reduced. Participants completed questionnaires five months before the restructuring, one month after the restructuring and seven months afterwards. Qualitative interviews were also conducted with 41 employees.

Findings revealed that, over time, organisational policies and rewards were most affected. For instance, as travel costs and overtime benefits were reduced, the levels of perceived commitment were also reduced. However, career development and socialising were not affected but it was explained that career development in health settings was low

prior to the change, which meant that the expectations were realistic (Freese et al., 2011). Interviews revealed that having less client time was perceived to be a violation, but job content was not affected by organisational change (Freese et al., 2011). Overall, due to the paucity of longitudinal research on the psychological contract, the findings provided a valuable contribution, but the study only looked at attitudes and intention and not behaviour. Instead, it was suggested that future research should consider absentee data and the turnover rates of staff.

Another qualitative study in a psychiatric service in Sweden explored how staff were influenced by multiple obligations during transition (Bergin & Rønnestad, 2005). A grounded theory analysis was applied with an inductive approach (Glaser & Strauss, 1967). The aim was to decipher how psychiatric staff were subject to various obligations. A secondary aim was to reach a comprehension of the processes involved (Bergin & Rønnestad, 2005). Eight employees were recruited from a Swedish psychiatric service in a county in Sweden (see Appendix M, Table M1, p. 150 for further details).

Data was collected via open-ended interactive interviews and findings revealed that organisational changes had resulted in changes to the psychological contract as employees described a 'cultural revolution' (Bergin & Rønnestad, 2005, p.365). Changes also placed staff in a dilemma between outward demands and in-house obligations (Bergin & Rønnestad, 2005). Psychiatrists believed their professional identity was being challenged and this resulted in them feeling less in control of their work. One key finding was a change in self-concept from being a high-ranking professional to being someone who performed service duties, such as prioritising a high turnover of patients (Bergin & Rønnestad, 2005). As a result, many staff mentioned wanting to withdraw from the situation and it appeared that the psychological contract was broken.

Overall, the study showed that changes involving beliefs and values can be challenging for mental health professionals as staff need to maintain their 'professionalism' for the patients (Bergin & Rønnestad, 2005). The organisational changes had been influenced by external demands, but internal obligations were founded on individual and group values. The founding of obligations in professionals is consistent with professional activities (Friedson, 1971). It was speculated that one important part of the relationship with patients is to be trustworthy and to be honest. Schein (1992) believed that changes on a large scale could result in a new organisational culture. Staff in the study

had experienced two forms of change; one consisted of economic and organisational features and the other involved a change in work systems (Bergin & Rønnestad, 2005). However, the results were interpreted with caution due to the small sample size. Further, the interviewer was a clinician, which may have influenced the interpretations. However, all participants had reviewed the findings and agreed with the results, which suggests internal validation within the organisation, but does not mean this can be generalised elsewhere (Bergin & Rønnestad, 2005).

Rodwell and Gulyas (2015) carried out a multiple regression of data from 113 allied health professionals within an Australian healthcare organisation (see Appendix N, Table N1, p.151 for further details). Allied health workers represent specialised professions with specific training (Rodwell & Gulyas, 2015). They often work within MDTs and may be subordinate to medics, which means their contributions may not be as valued (Boyce, 2006). This may represent an employer-employee exchange relationship such as organisational justice, as allied health workers may compare the difference between what medics receive to what they receive and may see inequity.

Surveys were distributed across several locations for 113 allied health professionals. Overall, the findings indicated that when an organisation broke its promises, the employees' commitment and well-being decreased (Rodwell & Guaylas, 2015). The effects of distributive justice occurred when the employee perceived inequity between their inputs compared to other employees' inputs/outputs (Adams, 1965). Employees excused a breach if they believed that the organisation's decision to go back on a promise was fair and beyond the organisation's control (Brockner & Weisenfield, 1996).

The main effects of procedural justice and interaction with a breach reflected the amount of control that the employee had regarding decisions compared to other professionals (Folger & Cropanazo, 1998). Results showed that if participants were able to provide input then the negative impact may be reduced (Rodwell & Guylas, 2015). The positive effect of interpersonal justice on well-being indicated that increased interpersonal justice may amplify the negative impact of a breach on well-being, which suggested that the closer relationships and respect from the organisation may increase the impact of a breach, as employees may consider a broken promise more personally (Rodwell & Guylas, 2015). However, the study was cross-sectional and it was suggested that longitudinal

research is needed with other countries, due to the nature of the different healthcare systems.

2.10 Psychological Contract in the NHS

Cortvriend (2004) highlighted the need to implement qualitative research to understand the impact of organisational change as structured survey methods do not always adequately capture people's thoughts and feelings. Cortvriend (2004) conducted five focus groups with 31 participants in a Primary Care Trust (PCT) in the north of England (see Appendix O, Table O1, p.152 for further details). There was a stratified sampling method, which included administrative staff, senior managers, middle managers and allied health professionals and nurses. The questions in the focus groups were focused on the management of change, initial reactions and future changes.

The results revealed that there was an impact of management and leadership styles during the PCT merger and an autocratic style associated with more negative attitudes. Further, the differences in leadership and management styles appeared to impact upon peoples' experience of change, attitudes and behaviour as measured by the psychological contract. It was also found that culture impacted on participants and their coping difficulties. Further, staff perceived incongruence and perceived expectations as unmet and this resulted in them leaving the organisation. Implications were that staff were experiencing a constant cycle of change within the NHS Trust, and the psychological contract appeared to change over time, with exit occurring when employees felt there was a contract violation (Cortvriend, 2004). However, this was an exploratory study with a small sample size, making it difficult to generalise. Cortvriend (2004) suggested that future research should further investigate the effect of change upon psychological contracts within the NHS.

A study in the NHS of 67 professional staff was conducted using both qualitative and quantitative methods (Fielden & Whiting, 2007, see Appendix P, Table P1, p.153 for further details). The aim was to assess whether the NHS could meet the staff expectations regarding work and employment. Participants were recruited from a Community Mental Health Team (CMHT) and specialist rehabilitation trust in England. Findings revealed that fulfilment of the psychological contract depended on job satisfaction, intention to leave, organisation commitment and trust between the employees and the respective managers (Fielden & Whiting, 2007). The majority of respondents reported job satisfaction. One of

the factors mentioned as an intention to leave was changes to pay, such as within the '*Agenda for Change*' (DH, 2004). Further, 28% of participants reported positive levels of commitment and this was correlated with less intention to leave (Fielden & Whiting, 2007).

The survey (Fielden & Whiting, 2007) addressed the idea of the NHS as being a model employer. For instance, the '*NHS HR Plan*' (DH, 2002) had recommended offering better working conditions, employment, practices and work-life balance, job security, lifelong learning, fair pay, staff involvement and good communication. Findings showed that it was important for an organisation to meet employees' expectations. Moreover, employees were not satisfied by all aspects, which suggested the organisation was not meeting all expectations, but it was unclear what had been originally promised (Fielden & Whiting, 2007). This highlighted the importance of strategy at a local level by managers and how promises at a national level may not be met locally, which may result in the perceptions of contract violation (Fielden & Whiting, 2007).

The findings indicated that NHS employees were most satisfied with team-working and working with clients. The two most important commitment factors included the organisation making the employee feel wanted, which emphasises the reciprocity of the relationship between the employee and the employer (Fielden & Whiting, 2007). In spite of changes to the NHS, the levels of trust remained at a good level (Fielden & Whiting, 2007). Further, those who had been in the service longer showed higher levels of trust and individual perceptions of injustice

2.11 Gaps in Literature

Health professionals in the NHS have experienced organisational changes, but there is a lack of research on the psychological impact of change. The findings from corporate settings have revealed that the psychological contract is a multi-dimensional construct. Much of the research has used survey-based methodologies concerning general beliefs about obligations in corporate settings and has not focused on specific critical incidents or employed qualitative research (Conway & Briner, 2005; Herriot, Manning & Kidd, 1997). It is also important to consider both employers' and employees' perspectives (Herriot et al., 1997). Conway and Briner (2005) believed that it was essential to have a definition to improve the clarity of researching the psychological contract. Contemporary theorists have viewed the contract as a theoretical construct, neglecting psychological

theory and not separating the content from the process (Conway & Briner, 2005). Meckler et al. (2003) believed there was a disregard in the exact reciprocal exchange taking place and too much focus on transactions.

2.12 Rationale

Research is required to develop clarity around the impact of organisational changes to the psychological contract amongst mental health professionals within an NHS health setting. The majority of studies have tended to assume causality, but this has not been empirically tested (Conway & Briner, 2005). This could be achieved by considering the perspectives of mental health professionals and their views of change to the contract. The extended contract model (Guest, 1998; George, 2009) may provide a broader framework for understanding the contracting during organisational change as it captures the influence of culture, purpose, prior expectations and consequences. Further, the systematic review has found support for the model. Reaching an understanding on the perspectives of change and its impact could help inform staff interventions within the NHS, which may help clinical psychologists to manage changes to encourage agency and autonomy during contracting within teams and to allow innovation to continue.

3. Methodology

3.1 Epistemology

A critical realist position was adopted that acknowledges that 'reality exists independently of the researcher's mind and that there is an external reality' (Ritchie, Lewis, McNaughton, Nicholls & Ormston, 2003, pp 4-5). This position also accepts that concepts in society may be socially constructed through discourse (Burr, 2015). The critical realist view can be described as being in between the social constructionist and realist positions. Indeed, the critical realist position acknowledges an external reality but also acknowledges that people may interpret this reality differently as with social constructionism (Joffe, 2012). It was hoped that the critical realist approach would encapsulate the theoretical framework of the psychological contract but also acknowledge the individual processes and how concepts may be viewed differently by participants.

3.2 Design

The design was cross-sectional in order to capture different participant views of change in the NHS at one point in time within three different NHS Trusts. A qualitative

design was used to allow participants to discuss their individual experiences of change. To date, there has been a lack of qualitative research on the psychological contract, and previous research has tended to approach questions using a quantitative methodology. Therefore, a focus group methodology was applied to explore participants' understanding of change as measured by the psychological contract. Altogether, six focus groups were planned across three NHS Trusts (two focus groups per NHS Trust) with a maximum of eight participants per group. Indeed, six participants has been advocated as an ideal focus group size (Albrecht, Johnson & Walter, 1993; Wilkinson, 2003), and recruiting eight participants would allow for drop out.

However, time restraints and unforeseen logistical problems such as participants' heavy caseloads and being unable to coordinate enough staff members to be in the same place at once to run the focus groups caused problems. Therefore, the design was modified to include semi-structured interviews instead. The interviews were administered to explore the psychological contract theoretically, but also to enable participants to put forwards their own viewpoints.

Thematic analysis was applied as it offered a flexible approach that could be used with the existing theoretical framework of the psychological contract (Braun & Clark, 2006). Thematic analysis involves encoding of qualitative information through firstly codes and then themes. Boyatzis (1998, p.4) defined the coding and themes within thematic analysis as '… indicators and qualifications that are causally related … A theme is a pattern found in the information that at minimum describes and organises the possible observation and at maximum interprets the aspects of the phenomenon'. Within thematic analysis, there are different methods of developing codes: deductive codes may be developed using a theory-driven interpretation and/or prior research; inductive codes may be derived from the raw data (Boyatzis, 1998). Deductive (theory-driven) thematic analysis is based on the assumption that there are laws that can be applied to data (Guest, MacQueen & Namey, 2012). Inductive code development is most frequently applied to coding within social science research (Boyatzis, 1998). Deductive thematic analysis starts with a theory and then searches for evidence from transcripts to support the theory, resulting in the codes founded in theoretical elements (Boyatzis, 1998), whereas inductive thematic analysis starts from the transcripts and codes are developed to describe the data.

A hybrid of qualitative, theory-driven (deductive) and data-led (inductive) coding was applied (Fereday & Muir-Cohrane, 2006). The hybrid design was undertaken to code the content of the contract into pre-existing theoretical codes, as reviewed in the literature (Boyatzis, 1998). Inductive codes were applied to investigate the processes of the contract and change that the deductive codes could not capture.

A hybrid thematic analysis was conducted in line with the critical realist epistemological position. The critical realist approached allowed both the exploration of theory around psychological contracts but also acknowledged that this may differ between individual participants. A quantitative analysis of data was not applied as there were already many quantitative survey-based studies on the psychological contract. Further, although quantitative approaches have been associated with realist approaches, this approach involved investigating participants' subjective experience. An interpretative phenomenological analysis (IPA) (Larkin, Watts & Clifton, 2006) approach was considered but was not applied as IPA involves exploring lived experiences in the first instance and then integrating this with theory. However, this study required working from a theoretical basis of the psychological contract to investigate participants' experiences. A grounded theory methodology (Glaser & Strauss, 1967) was not suitable as, although it is effective for theory development, the purpose of the study was to consider the relevance of the existing theoretical approach in a healthcare setting rather than developing new theory.

3.2.1 Reliability of Design

As the research was qualitative in design, reliability guidelines (Elliot, Fischer & Rennie, 1999) around qualitative research were followed. This included seven steps (see Table 4 on following page).

3.3 Participants and Recruitment

There were fifteen mental health professionals from multidisciplinary (MDT) CMHT within three local NHS Trusts in Bedfordshire and Hertfordshire. All the Trusts had experienced organisational restructuring within the last two years. The sample size was deemed adequate for hybrid thematic analysis (Kuzel, 1992). Purposive recruitment was employed in order to provide approximately equal representation of the different MDT professions. The following six stages were employed in the recruitment process.

Table 4. Evolving guidelines for qualitative research (Elliot et al., 1999)

Guideline	Procedure conducted
1. One's own perspective	State epistemological position
2. Situate the sample	Provide relevant participant demographics
3. Ground in examples	Provide examples of themes through data
4. Provide credibility check	Pilot test materials and check data coding
5. Coherence	Present findings in a way that provides coherence
6. Accomplish generic versus specific research tasks	Acknowledge limitations of generalising or specifying findings
7. Resonate with readers	Present accurate description of findings

3.3.1 Stage 1: Gaining University Ethics Approval and Study Amendments

The University Ethics Department was contacted with study details and consent was obtained in July 2015 (see Appendix Q, p.154-155). The study procedure was then modified slightly to include individual interviews and not focus groups in September 2015 due to unforeseen difficulties with recruitment, as described earlier in the study design (see Appendix R, p.156 for amended ethics form). A risk assessment was also completed (see Appendix S, pp.157-160). However, the risk assessment was not updated as changes to the study did not pose any increased risk to participants. For instance, amendments were minimal such as requesting permission for interviews to take place at the University library in bookable rooms (see Appendix T, p.161).

3.3.2 Stage 2: Gaining Ethical Approval from the Three Different R&D Trusts

The local Trust's Research and Development (R and D) department was then contacted to obtain approval for the recruitment of the participants (see Appendix U, p.162 for generic email). The procedure for recruitment differed slightly for each NHS Trust (see Figure 6 on following page). The generic procedure involved sending materials[3] involved, such as the university ethics approval form (see Appendices Q & R, pp.154-156); study protocol form (see Appendix V, pp.163-167); information sheet (see Appendix W, pp.168

[3] *All participant materials (consent form, information sheets, interview schedules etc.) were submitted to a service user consultation session to obtain feedback*

-170) and consent form (see Appendix X, pp.171-172). Once these were received, the Trusts granted ethics approval in different ways depending on the R and D policies. Trust 1 was first approached in July 2015 when focus groups were still included in the design (see Appendix Y, pp.173-175). Following university approval of the amendments, Trust 1 was then reissued the consent form to include study amendments to the individual interviews only (see Appendix Z, pp.176-178). Trust 2 required written consent via email (see Appendix A1, p.179). Trust 3 involved using the online NHS NOCLOR system (see Appendix B1, pp.180-181) to assess whether further consent needed to be sought via IRAS. Once it was revealed that further consent was not needed, Trust 3 issued written email consent (see Appendix C1, p.182).

3.3.3 Stage 3: Identifying Teams and Introducing Research Study

Once consent was obtained via the Trust R and D departments, the line managers within the teams were then approached via email (see Appendix D1, p.183). Mental health professionals from teams within the Trusts were approached, identified via the psychological service leader. Mental health professionals who had been identified as eligible were also emailed directly (see Appendix E1, p.185). Team leaders were then contacted and visits were arranged to visit these teams. On these visits, further information about the study was provided to the mental health professional (see Appendix F1, pp.186-187) team members, such as time commitment and eligibility to participate.

3.3.4 Stage 4: Identifying Participants

Team members who were eligible and wanted to take part then approached their line managers. They then gained verbal consent from their line managers to participate in interviews during work time. Once their line managers had provided verbal consent, they were sent a written letter (see Appendix G1, p.187) and completed the participant list to provide the following information: their role and preferable time and location.

3.3.5 Stage 5: Obtaining Consent from Participants

The participants were then emailed or posted an information sheet (see Appendix W, pp.168-170) and consent form (Appendix X, pp.171-172). Participants signed and returned these to the researcher, either in a password-protected file or by post.

3.3.6 Stage 6: Arranging Interview Times

Subsequently, a suitable time and date was arranged for the participants. If they had any queries in the meantime, they would be able to contact the main investigator either by phone or email.

3.3.7 Summary of Pathways of Recruitment for Three NHS Trusts

The recruitment steps differed slightly according to the regulations at each NHS Trust. Figure 6 below shows the different recruitment pathways for each NHS Trust.

3.3.8 Inclusion and Exclusion Criteria

Table 4 below lists the various inclusion and exclusion criteria for the mental health professionals who were recruited.

Figure 6. Recruitment pathways of three NHS Trusts

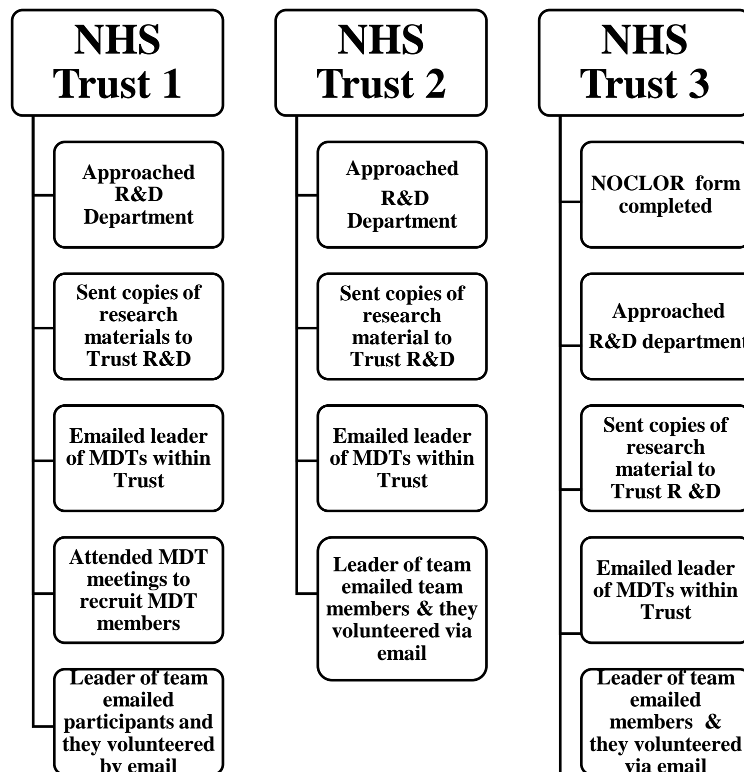


Table 5. Inclusion and exclusion criteria of participants

Inclusion criteria	Exclusion criteria
Health professional in area of mental health and/or learning disabilities	Health professional who does not work in mental health and/or learning disabilities
NHS Trust that has experienced change in last four years	NHS Trust that has not experienced change in last four years
Worked in Trust for minimum of six months (agency staff who have worked for one year)	Worked in Trust for less than six months or agency staff who have worked less than one year
Worked in NHS for a minimum of two years	Worked in NHS for less than two years

3.4 Measures

3.4.1 Semi-structured Interview Schedule

A semi-structured interview schedule was constructed in line with the critical realist epistemological position. Indeed, the critical realist position acknowledges the collaborative process of collecting data but having a belief in knowledge beyond the social world in which the context of the interview has occurred (Banfield, 2004).

3.4.2 .Stage 1: Identifying Areas of interest

The semi-structured interview schedule (see Table 7, pp.43-46) was developed according to the overarching research question of the mental health professionals' experience of organisational change in the NHS.

3.4.3 Stage 2: Linking Areas of Interest to Theoretical Constructs

The interview schedule involved tailoring questions into key areas that were underpinned by theoretical orientations from the literature (see Table 6, p.42). Having a deductive thematic approach meant that the main aim was to investigate how participants' understanding of their psychological contract and the impact of change upon the contract could be underpinned by existing theory. From the review of the literature, key areas of interest were identified.

3.4.4 Stage 3: Identify Gaps in Literature

Gaps in the theoretical positions were identified and questions were generated to explore gaps in the current research. For instance, it was hoped that the process of contract breach could be explored in more depth as opposed to previous quantitative measures (Conway & Briner, 2005). There were also questions around the impact of change on mental health professionals to explore how changes may have affected working relationships and the ability to relate to clients, including the effects of stress on health. Questions were included to assess how mental health professionals viewed changes from their colleagues' perspectives in order to assess the reciprocal roles involved and the mutuality of understanding. There were also questions about the layers of identities within the MDT team, the organisation, the profession and the wider NHS.

3.4.5 Stage 4: Deconstructing Theoretical Constructs

The key areas were then linked to existing theoretical concepts. The theoretical constructs were then deconstructed to see how they could be translated into questions.

3.4.6 Stage 5: Generating Questions

The schedule included key aims and corresponding theoretical perspectives. As well as these main questions linked to theory, follow-up questions were included in order to prompt participants and generate richer data. These prompt questions had the function of keeping conversation going in between questions and allowing participants to have more flexibility when answering more challenging questions (Leech, 2002).

3.4.7 Stage 6: Checking the Reliability of Questionnaire

The interview schedule was then developed using guidelines from Wengraf (2001) and then pilot tested with trainee clinical psychologists to ensure reliability. The effectiveness of the semi-structured interview is believed to rely on both the structuring of questions (Clough & Nutbrown, 2007) and the ability to build rapport (Opie, 2004). The questions posed in one transcript were also checked against the final format to check the reliability of the questions asked.

3.4.8 Stage 7: Review/Reformat Questionnaire

Once the semi-structured interview had been pilot tested, it was then reviewed and reformatted accordingly in terms of phrasing around questions (see Figure 7 below).

Figure 7. Summary of procedure for developing semi-structured interview

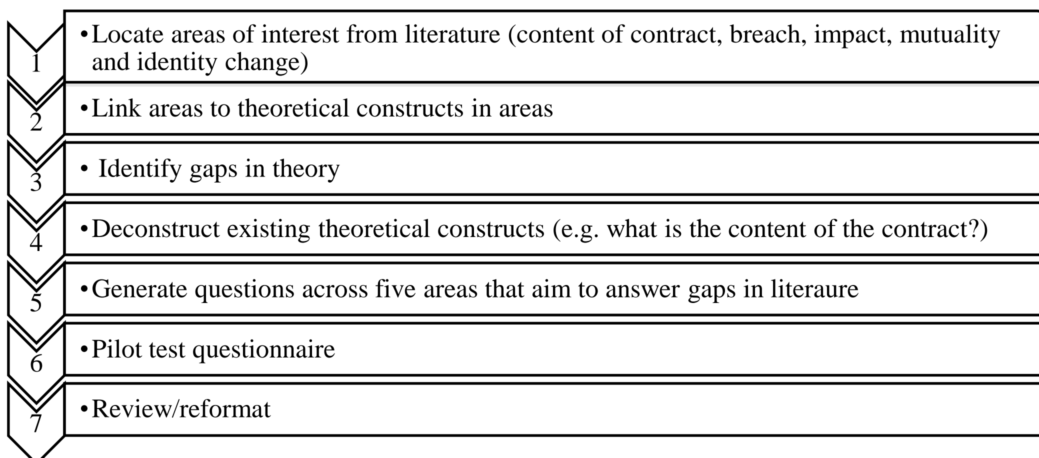


Table 6. Aims, theoretical positions and initial questions of semi-structured interviews

Aim	Theoretical/inductive construct	Initial questions generated
To understand mental health professionals' views of the psychological contract	- Content of the psychological contract (obligations, promises and expectations) - Implicit and explicit contracts	- What is in the content of the contract? - How is the contract formed? - Is this with implicit or explicit contracts?
To understand mental health professionals' perceptions of changes to the contract	- Distributive and procedural justice - Contract breach/fulfilment and violation - Reciprocity and mutuality	- Why do some participants experience the same organisation change but do not experience breach? - Does this depend on referents for breach and justification (fairness) of this? - Do employees perceive breach when roles are not reciprocal?
To understand mental health professionals' perceptions of the impact of changes in the contract	- Health, stress and burnout - Procedural and distributive justice	- What is the impact of the contract breach on employee well-being? - Does citizenship behaviour decrease/increase and, if so, why? - Does this depend on participants' original expectations?
To compare mental health professionals' perceptions of changes in the contract with their team colleagues	- Distributive and procedural justice - Team contract breach/fulfilment violation - Reciprocity and mutuality	- Do employees have a mutual understanding of colleagues in terms of contract breach?
To explore layers of identity change to the NHS Trust, the team, the profession and the NHS	- Social identities	- How does organisational change impact upon identity within the organisation/NHS/profession/team?

Table 7. Semi-structured interview schedule

Topic/Aims	Semi-structured Interview Script
1. Setting the scene	The introductory stage will involve informing participants about what will be expected of them and also set ground rules. The script is as follows: *Thank you for agreeing to take part in the interview. I would just like to set a few ground rules: everything here we discuss is confidential, which means that I will not discuss any material with anyone else other than the principal supervisor and field supervisor. This will be only be broken if we feel you or someone else is at risk. You may leave the room at any point. Any questions you have following the group will be answered at the end.*
2. Individual introduction	This will involve the researcher introducing themselves to participants: *I would like to introduce myself. I am a Trainee Clinical Psychologist at Hertfordshire University. This interview will contribute towards my Main Research Project (MRP).*
3. Opening topic	This will involve a general neutral opener that is related to the research topic. Participants will be given a brief overview of the topic: *I would just like to give you an overview of the topic, which is around* ***your*** *experience of change in the NHS. One way of accessing attitudes about change and the impact of this is to look at people's understanding of their contract with the employing organisation. The term 'psychological contract' has been defined differently over the years. It can refer to mutual expectations between the person and organisation. This can also include obligations towards the organisation and vice versa. The contract has also been defined as the promises that employees believe were made to them by their employer, probably prior to them entering the organisation.* *Contracts involve reciprocal exchanges between yourself and the organisation, i.e. working for pay or working overtime in return for time in lieu. Contracts are both transactional and relational. Transactions include economics such as hours, pay and work flexibility. Relational aspects focus on more emotional aspects such as trust in return for competent management and belonging.* *Contracts can be implicit as well as explicit. For example, you may have explicit written items in your job contract such as working five days a week. You may also have implicit items that you have learnt vicariously through colleagues, such as noticing that if someone works overtime, they can claim this back, etc.* *The holder of the contract is usually a representative of the organisation such as your line manager. However, you can have different contracts with both your MDT and the organisation itself.*
4. The discussion	*This is the main body of the interview, with the key issues discussed and explored. This stage will aim to cover the aims of the research, which include the following aims and questions:*

Aim/Topic	Semi-structured interview script
Aim 1: **To understand mental health professionals' perceptions of the contract**	**Q.1 How long have you been employed by the organisation?** **Q1.2 Can you describe your understanding of the 'deal' in terms of exchanges between yourself and your employer?** • *Can you describe any obligations, promises and expectations between yourself and the employer?* • *Can you describe any concrete exchanges such as work for pay? Can you describe any emotional exchanges, for example, you work hard in return for support/sense of belonging?* • *Do you think you have different contracts with the organisation and your team?* **Q1.3 How did you come to have this view of the deal?** *Can you describe any explicit exchanges? For example, you are contracted to travel so many miles per week. Can you think of any implicit exchanges, i.e. you noticed that a colleague is allowed to have a one-hour lunch break on Fridays so you assumed you were entitled to the same?* **Q1.4 Do you think your colleagues and employer viewed this differently to yourself?** *Do you think that you view aspects of the contract differently to your colleagues, i.e. do you think they have the same implicit contract exchanges?*
Aim 2: **To understand mental health professionals' perceptions of changes to the contract**	**Q.2 Some changes have occurred in the organisation over the years; do you think this has changed the 'deal' between you and your employer? Or do you think things are the same?** *If so, what do you think has changed? I.e. do you think you have to work longer hours? Do you feel you have less or more support from the organisation/team? Do you think your colleagues and employer viewed this differently to yourself?* **Q.2.1 Do you think this has changed over the last two years?** **Q.2.2 Can you think of a specific exchange that has changed between you and the organisation?** • *Is there something you did before but now do not do for the organisation and vice versa? I .e. do you no longer work overtime?* **Q.2.3 Can you think of any times when your organisation or team hasn't lived up the contract?** • *If so, why? Can you give a specific example, i.e. you worked overtime but did not get any praise?* • *Are there any times when you haven't lived up to the contract?* **Q.2.4 Can you describe what triggered this change?** • *What happened before, during and after this event?* • *Was there a tipping point of this process for you? I.e. did you become emotional?* **Q.2.5 What happened afterwards?** • *Are there any positives/benefits of these changes?* • *Do you still feel the need to go beyond what is explicit in your work contract?* • *Why do you still do this? Why have you stopped doing this?*

Aim/Topic	Semi-structured interview schedule
Aim 3: To understand mental health professionals' perceptions of the impact of change to the contract	**Q.3 How have these changes affected your 'deal' with your employer?** • *Have any specific social exchanges been renegotiated with your employer? I.e. relational or transactional?* • *Do you think this has been renegotiated fairly?* • *Are any of these changes positive/negative?* • *Has your identity with the organisation changed?* **Q.3.1 What you do think your employer thinks about this?** • *Do you think your employer has noticed these changes?* **Q.3.2 Do you think these changes have impacted on your working relationship with your employer?** • *Do you feel less loyalty towards your organisation than before? Do you feel less inclined to go out of your way at work than before?* **Q.3.3 Do you think these changes have impacted on working relationships with other staff and/or clients?** • *Have you noticed an increase in any interpersonal difficulties amongst the staff team? Have you noticed an increase in colleagues' sick leave due to work-related stress?* • *Have you taken any leave due to work-related sickness?* • *Have you noticed work efficiency decreasing in terms of client case load?* • *Do you feel less able to deal with clients emotionally? Have you experienced work-related exhaustion or burnout?* **Q.3.4 Can you describe how your employer managed these changes?** • *Do you think that the way employers communicated changes helped or hindered the process? For example, would it have been better not to exaggerate promises and not be disappointed?* • *Do you think changes to specific contents of social exchanges has been handled in a fair way by your employer?* • *How were new promises communicated?* • *In your opinion, was there anything your employer could have done to lessen the impact of these changes?*
Aim 4: To compare mental health professionals' perceptions of change on the contract with their team colleagues	**Q.4 Do you think these changes affected your team's 'deal' with your employer?** • *If so, what do you think has changed? I.e. do you think your team has to work longer hours? Do you feel they have less or more support from the organisation/team?* *Do you think your employer views this differently to yourself?* **Q.4.1 Do you think this has changed over the last two years?** **Q.4.2 Can you think of a specific exchange that has changed between a/your colleague(s) in your team and the organisation?** • *Is there something you think your team did before but now do not do for the organisation and vice versa? I.e. do you thinkg they no longer work overtime, etc.*

Aim/Topic	Semi-structured interview schedule
Aim 4: To compare mental health professionals' perceptions of change to the contract with their team colleagues	**Q.4.3 Can you think of any times when your organisation hasn't lived up to the team's contract?** • *If so, why? Can you give a specific example, i.e. team members worked overtime but did not get any praise?* • *Are there any times when your team hasn't lived up to the contract?* **Q.4.5 Can you describe what triggered this change?** • *What happened before, during and after this event?* • *Was there a tipping point of this process for you? I.e. did your team become emotional?* **Q.4.6 What happened afterwards?** • *Are there any positives/benefits of these changes?* • *Do they still feel the need to go beyond what is explicit in their work contract?* • *Why do you think they still do this? Why have they stopped doing this?*
Aim 5: To compare changes to mental health professionals' identity with changes to their organisational identity	**Q.5** Did you identify with your organisation prior to the change? **Q.5.1** Did you identify with your team prior to the change? **Q.5.2** Do you identify more or less with your organisation/team following the change? **Q.5.3** If so, why do you think this is the case?
6. Debrief (ending the discussion)	This stage will involve letting participants know in advance that the discussion will be ending and gradually moving away from the main research questions. Participants will then have a chance to ask any questions and be thanked for their participation. The script will be as follows: *Thank you for taking part in this interview around change and the psychological contract. I hope that you found the discussion helpful. Please note that if any distressing material came up for you, then please notify me. Please note that all transcriptions will be stored securely in line with the Data Protection Act, 1998. If you wish to withdraw your data, you will be able to do this. If you have any questions now, please stay behind. If you have questions later, please contact either myself or supervisors on the contact details provided.*

3.5 Procedure

The procedure consisted of the following eight stages.

3.5.1 Stage 1

Participants were recruited from three different NHS Trusts (see Figure 6, p.39).

3.5.2 Stage 2

If they agreed to participate, participants were sent information sheets via email or post, which contained a brief summary of the interview topics (see Appendix W, pp.168-170). Participants were also sent consent forms via email or post (see Appendix X, pp.171-172) by the main investigator. Participants completed and returned the consent forms via post in an SAE to the university address or password-protected documents via email.

3.5.3 Stage 3

Participants were approached by the main investigator via email or phone and a time and location was arranged for the interviews. The interviews took place either at a bookable room on NHS Trust premises where the participants worked or at the university library in a bookable room.

3.5.4 Stage 4

Upon arrival at the interview premises (NHS Trust or library), participants were asked if they had read the information sheet and understood the confidentiality reports and their right to withdraw.

3.5.5 Stage 5

Once participants confirmed that they had read and understood the information sheet, they were read a brief overview of the research, which lasted approximately two minutes. The overview included a brief description of the theory around psychosocial contracts, transactional and relational aspects, implicit and explicit contracts and the holder of the contract.

3.5.6 Stage 6

Participants were asked questions from the interview schedule by the main investigator to cover the five key aims. Participants were asked questions about the schedule from the list, but the wording of questions and follow-up questions differed

slightly, depending on the responses. The duration of the interviews was between 40 minutes and 65 minutes per participant and each interview was audio recorded.

3.5.7 Stage 7

Following the interviews, participants were debriefed as part of the interview schedule (see Table 7, pp.43-46 above) and any questions were answered. Participants were informed that they could contact the main investigator, principal supervisor or field supervisor via email or phone if they had questions afterwards. Participants were also informed that they could take part in a free CPD workshop provided by the principal and field supervisors.

3.5.8 Stage 8

Ten of the interview recordings were then transcribed by the main investigator, using relevant software (FTW Transcriber)[4] and one-third were also sent to a professional transcription service. All transcriptions were stored securely in encrypted files and the professional transcription service was sent a confidentially agreement (see Appendix H1, p.188).

3.6 Ethics

The British Psychological Society (BPS) Code of Ethics (2009; 2014) was adhered to at all times, which related to the following areas.

3.6.1 Informed Consent

Participants signed a consent form in order to consent to participation in the study. They were entitled to opt out of the interviews at any point prior to or during the study. Participants were also informed that their responses would be recorded for the purpose of transcription.

3.6.2 Confidentiality and Anonymity

The data was anonymised by assigning a unique code to each participant.

[4] *FTW is a free transcription software that is compatible for word processing documents*

The six key principles within the Caldicott Report[5] (1997; Crook, 2003, p.426) were adhered to at all times around the confidentiality of personal identifiable information (PII). Participants were informed that their answers would remain confidential within the organisation.

3.6.3 Data Storage

The data was stored securely in line with the Data Protection Act (1998). Access was restricted to the researchers involved by password protecting the data files. The data was stored for the amount of time stated within the British Psychological Good Practice guidelines for the conduct of psychological research within the NHS (2004, p.11): 'if the project is to submitted for publication, the transcripts will be kept for five years. If it is not to be published then the data will be kept for one year'.

3.6.4 Withdrawing Data

A personal identifiable code was matched to the recordings of the transcripts so that participants' data could be retrieved and they could withdraw the data. Participants were informed that they could withdraw their data up to six months after the study had finished.

3.6.5 Registration with University Ethics Departments

Ethical approval was sought and obtained through the University of Hertfordshire Ethics Department. Amendments were later made to the design of the study to change from the original design of conducting focus groups to individual interviews (see Appendix R, p.193).

3.6.6 Registration with NHS Trust Ethics Department

Ethics approval was sought and obtained from the local NHS Trust R&D department. The procedure was different for each NHS Trust. One Trust provided a formal written agreement of ethics approval (see Appendices Y, pp.173-178 & Z, pp.176-178). However, the other two NHS Trusts provided written agreement via email (see Appendices A1, p.179 & B1,pp.180-181).

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[5] *The six principles of the Caldicott report (Crook, 2003, p.426): justify the purpose(s) of every proposed use or transfer; don't use it unless it is absolutely necessary; use the minimum necessary; access to it should be on a strict need-to-know basis; everyone with access to it should be aware of their responsibilities, and understand and comply with the law.*

3.6.7 Benefits of Taking Part

Participants were informed that they had the opportunity to attend a free Continuing Professional Development (CPD) workshop, which would take place on the Trust premises. The workshop was organised by the principal and field supervisors. Participants were given a choice of workshop topics that were relevant to their professional skills areas, such as 'leadership'. The workshop contained strategies to aid professional development in the relevant chosen areas. The facilitators aimed to organise workshops so that professionals were able to attend a workshop with fellow professionals that was suitable to their skill areas (i.e. occupational therapists attending the same workshop). However, it was noted that the same workshop theme was not possible in all cases.

3.7 Checking Data Validity and Reliability

Firstly, the questions asked in each interview were checked according to the questions in the interview schedule. Questions were checked to assess the consistency of the questions asked across the interviews. Indeed, qualitative data collection has been known to deviate from the topic as it is a flexible and dynamic process (Guest, 2012). However, due to the question order format with some transcripts, there were some questions that were worded differently or omitted. Further, some questions were worded differently but covered the research topics.

3.8 Consultation of Data Analysis

A pre-analysis consultation via email was conducted with Professor Richard Boyatzis, an organisational theorist who has conducted numerous thematic analyses in organisational research. Following the consultation, a hybrid inductive/deductive approach was decided upon in order to keep to the theoretical framework of the contract but allow inductive themes to emerge to capture the subjectivity of the participants' responses.

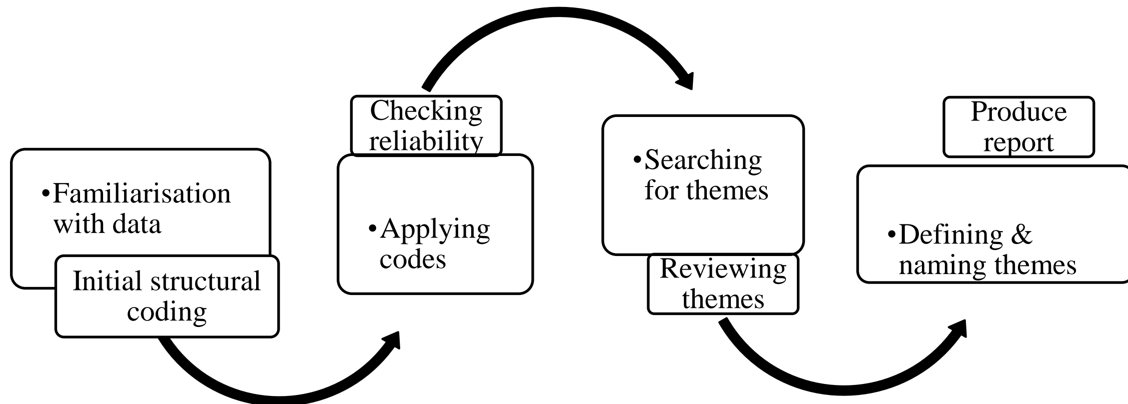
3.9 Data Analysis

Data from the fifteen transcripts was submitted for a hybrid thematic analysis (Fereday & Muir-Cochrane, 2006). A deductive lens was applied as the theoretical content coding framework. The following processes were followed as advocated (Braun and Clarke; 2006; Joffe & Yardley, 2004; Boyatzis, 1998). See Figure 8, on the following page, for a summary of the data analysis process.

3.9.1 Familiarisation with Data Set

Familiarisation with the data involved immersion in the data set. Immersion was achieved by reading and re-reading through the entire corpus of data. Familiarisation involved repeated reading as advocated by Braun and Clark (2006). Annotations were also made on the data to relate to future codes.

Figure 8. Summary of the Thematic Data Analysis



3.9.2 Initial Coding

Initial codes were then applied to the transcripts to segment the raw data. The initial coding was semantic in that the surface level meaning of the data was coded without inferring latent meaning. The segments were sentences and paragraphs and not single words, as the coding was broad due to the large sample (see Appendix J1, pp. 196-206 for example of coded transcript and Appendix K1, p.207 for diary extract).

3.9.3 Applying Deductive Codes

A structural coding framework (Guest et al., 2012) was developed according to the structure imposed by the research questions and theoretical thematic design. The structural framework was developed by designing a coding table that contained three columns: the first column contained the interview topic, the second column contained the structural code name and the final column included a full and brief definition with instructions on when to use and when not to use a code for each of the five topics within the coding framework (content of contract, contract change, impact of change, contract change for the team and identity change) (see Appendix I1, Table I1.1, pp.189-195 for structural codes). Each code was related to a particular interview question and topic with a full and brief definition for each code, which reflected the language of the semi-structured interview. A systematic review of the first eight transcripts was carried out to segment and assign the

structural codes from the coding table. From the structural coding framework, a total of 25 deductive codes were applied altogether (see Appendix L1, Table L1.1, pp.208).

3.9.4 Applying Inductive Codes

An NVIVO software package was applied so that the initial codes from the transcripts could be segmented and tagged into inductive codes to reflect meaning that the deductive codes could not capture. NVIVO has been recommended for thematic analysis for large datasets (Guest et al., 2012). The coding involved looking at both latent and semantic codes within the first eight transcripts and then the remaining seven transcripts. A total of 93 inductive codes were applied across all transcripts (see Appendix M1, Table M1.1, pp.209-213).

3.9.5 Checking Reliability of Coding Frame

Reliability was ascertained by two independent coders (main investigator and fellow trainee clinical psychologist), who checked the application of the codes to the data for 10% of the data as advocated (Joffe, 2012). One participant was also given their coded transcript to read through for agreement. Any discrepancy between the coding was discussed between the coders. Following reliability checking, the coding framework was reviewed to provide more clearly defined inductive codes in NVIVO so that the coding frame could be more consistently applied for inductive coding.

3.9.6 Searching for Themes

Once the coding framework was finalised and eight transcripts (half data set) had been coded, both the inductive and deductive codes were arranged into potential themes in three key areas: content, process and impact to reflect the topic areas within the interviews (see Appendices N1, O1 & P1, pp.214-216). Themes were defined as 'a phrase or sentence that identifies what a unit of data is about and/or what it means' (Saldana, 2009, p.139). The grouping of themes also involved returning to the understanding of the analytic objectives and then re-reading the data towards addressing the objectives (Braun & Clark, 2006). The application of the themes involved applying thematic or linguistic cues, as suggested by Ryan and Bernard (2003), which included: repetition of phrases; indigenous categories/typologies; metaphors and analogies; transitions; constant comparison/similarities and differences; linguistic connectors; silent/missing data; and theory-related material.

Essentially, the themes were designed to capture the importance of the data in terms of the occurrence of the theme across the data set in terms of prevalence. The themes also had 'keyness' (Braun & Clark, 2006, p.10) in terms of capturing the main theoretical position of the research question. The codes were grouped into both overarching and sub-themes and some codes were then discarded.

Following the arrangement into themes for the first eight transcripts, the same processes, of assigning both deductive and inductive codes and then arranging into themes, were applied to the remaining seven transcripts. A total of 25 deductive codes (see Appendix L1, Table L1.1, p.208) and 93 inductive codes were applied altogether (see Appendix M1, Table M1.1, pp.209-213).

3.9.7 Reviewing Themes

All themes from the fifteen transcripts were then refined and reviewed and data was assessed for both internal and external heterogeneity at this point (Patton, 1990). Reviewing involved ensuring the data within the themes was coherent and that there were clear distinctions between the themes. There were two levels to this process. One level involved the level of the coded data extracts by reading through the collated extracts of the themes to check that they formed a consistent pattern. If the pattern was not consistent, then the theme was reviewed. The second level involved looking at the entire data set to consider the validity of individual themes (Braun & Clark, 2006) and to see whether the candidate themes could meaningfully capture all of the data. For the final superordinate and subordinate themes, including coding and example participant extracts, see Appendices Q1–V1 (pp.217-250). Further, any additional data was captured that may have been overlooked at previous stages. This process continued until there was a 'thematic map' (see Figure 9, p.55).

3.9.8 Defining and Naming Themes

Defining and naming themes involved identifying the 'essence' of each individual theme as well as the themes overall. This was achieved by returning extracts for each theme to the collated data and organising these into an internal and consistent account with a complementary narrative (Braun & Clark, 2006). This stage also involved identifying sub-themes in order to give structure to larger themes. The map was then refined so that there were six thematic categories altogether with subthemes (see Figure 10, p.56).

3.9.8 Step 7: Produce the Report

This stage involved producing the final analysis and write-up of the report. The data was presented in a way that would tell a coherent story of the data within and across themes. Particular extracts from the transcripts that supported the themes were included where relevant.

4. Results

4.1 Participant Demographics

The following professions were represented: six psychologists (40%); three nurses (20%); two psychiatrists (13.4%); two occupational therapists (13.4%); one art therapist (6.7%); and one mental health practitioner (6.7%). Participants were aged from 24 to 54 years of age. There were 13 females (86.6%) and two males (13.4%). Twelve of the participants (80%) were White British; one was British Indian (6.7%); and two (13.3%) were White Other. In terms of years worked within the organisation, this ranged from below one year (eight months) to 22 years (*M* = nine years and nine months, *SD* = 6.9). Years worked within the NHS ranged from 3.5 years to 28 years (*M* = 14 years and eight months *SD* = 7.9). Fourteen of the participants worked in community settings and one (6.7%) worked on a forensic inpatient ward but had previously worked in a community team.

4.2 Summary of Themes

The inductive and deductive hybrid thematic analysis revealed the following six themes across the 15 interview transcripts (see Figure 9, p. 55 for initial map, and Figure 10, p.56 for full thematic map).

- **Theme 1:** Implicit content of psychological contracts
- **Theme 2:** Contextual influence on psychological contract change
- **Theme 3:** The role of organisational culture change
- **Theme 4:** Deal breakers in the process of change
- **Theme 5:** The experience of strong emotions as a result of change
- **Theme 6:** The protective role of deal

Figure 9: Initial Thematic map

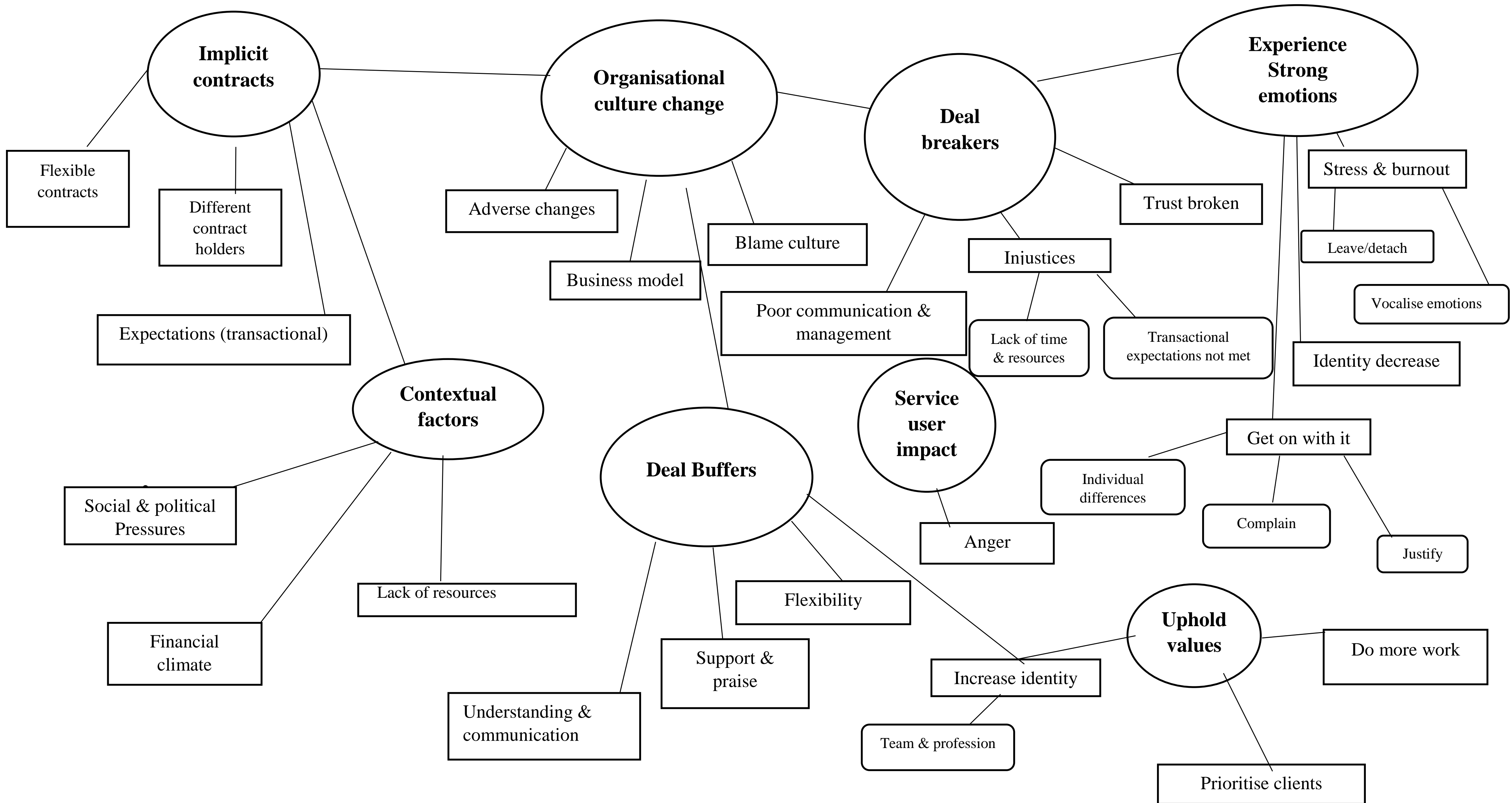
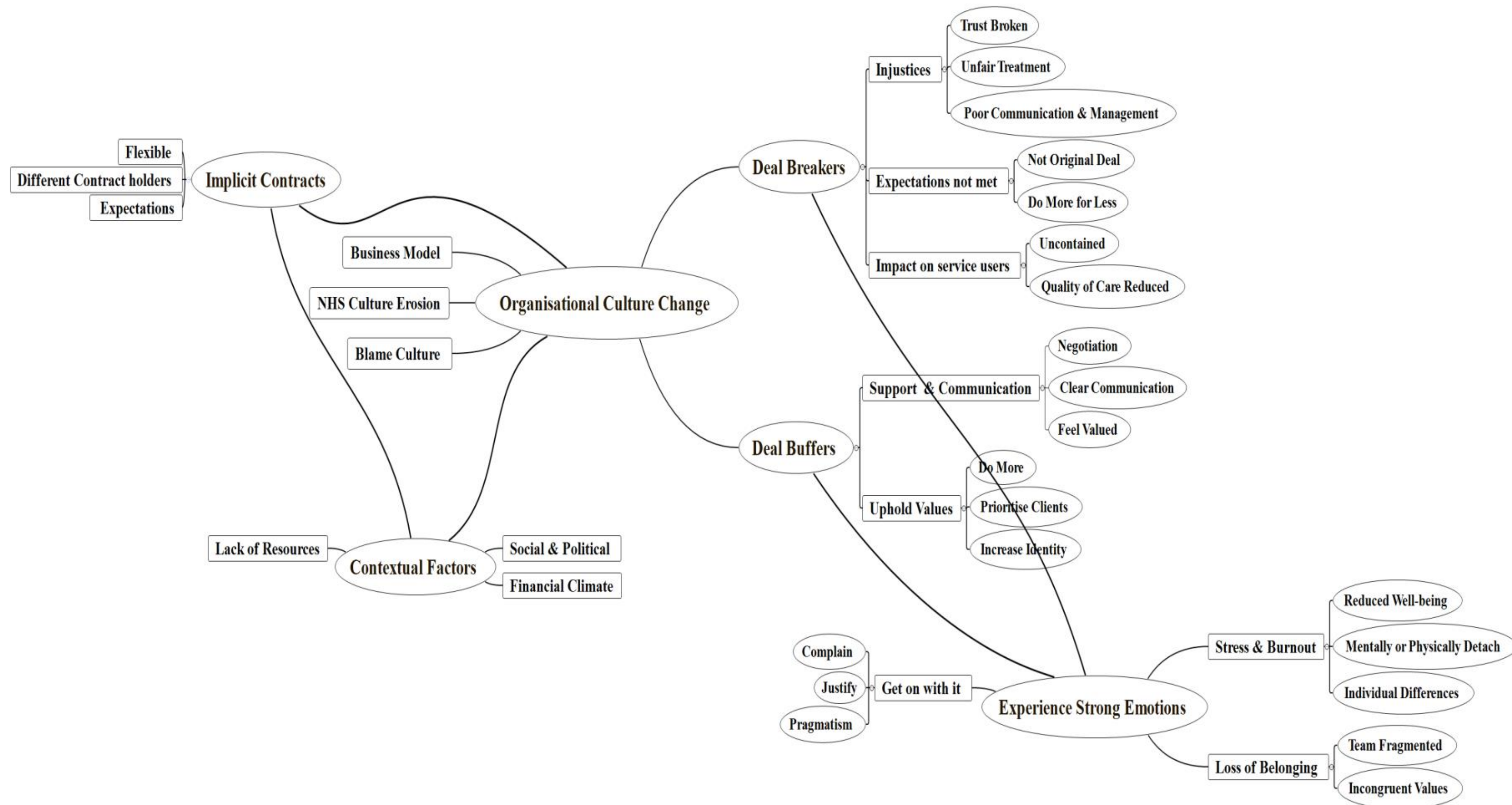


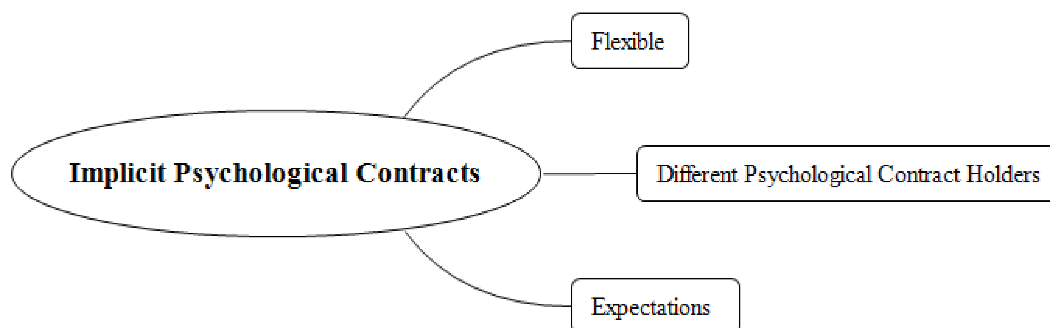
Figure 10. Final Thematic map



4.3 Theme 1: Implicit Psychological Contracts

This theme describes how participants tended to view the contents of their psychological contracts as implicit and different to work contracts. For instance, work contracts were reported as factual, whereas participants trusted that the organisation or manager understood the contents of the psychological contract. Subthemes also emerged, such as seeing the psychological contract as flexible and open to negotiation. Further, participants often described how there were different psychological contract holders. However, many participants also described 'transactional expectations' with the psychological contract such as concrete exchanges (see Appendix Q1, Table Q1.1, pp.217-219 for further details).

Figure 11 below illustrates the superordinate theme 'implicit psychological contracts' and associated subthemes. **Figure 11. Thematic map of Theme 1: 'Implicit Psychological Contracts' and subthemes: 'Flexible'; 'Different Psychological Contract Holders' and 'Expectations'**



The implicit nature suggested a more relational psychological contract that was different to the work contract. One participant saw the psychological contract with the team as emotional.

'*... but the sort of emotional contract is with the team, more implicit kind of stuff, relational*' (Participant 13, p.2, line 66).

Whereas, work contracts were described as more factual and concrete.

'*... under Agenda for Change so my hours were 37.5 hours a week in every post and annual leave entitlement up to five years was ...*' (Participant 3, p.1, line 10).

'*... for me it's about coming to work, working my working hours and fulfilling what was on my job plan and the expectations of my role, that's what I always think my contract is ...*' (Participant 14, p.1, line 20).

4.3.1 Subtheme 1.1: Flexible Psychological Contract

In terms of the implicitness of the psychological contract, many employees believed that their psychological contracts were often flexible and they had room to negotiate terms.

'*... I'm allowed to make it flexible but it's also flexible in terms of the organisation so ... there's flexibility in both, in both ways*' (Participant 8, p.1, line 14).

'*I feel like ... a lot of it is open to interpretation really depending on the manager and how much they ... are interested or do get involved in the day to day processes*' (Participant 4, p.1, line 15).

4.3.2 Subtheme 1.2: Different Psychological Contract Holders

Participants believed that they had different psychological contract holders within the organisation.

'*... so people can see the employer as different, some people might see the line manager as the employer, some people might see the Trust and some people might see the NHS so ... it really depends*' (Participant 2, p.8, line 242).

'*That's fluctuated as well sometimes ... I feel a lot more micro-managed so it's really fluctuated over the years, depending on who my manager's been really*' (Participant 4, p.1, line 13).

'*There's a kind of expectation that there's always a manager above you and they are always taking responsibility above your responsibilities ...*' (Participant 14, p.2, line 45).

4.3.3 Subtheme 1.3: Expectations

Psychological contract expectations were primarily transactional in nature and centred on exchanges that were not explicitly within psychological contract.

'*I think for years and years we've been very fortunate in having parking on site and all of our sites you just turn up at ten to nine and you're guaranteed a space pretty much ...*' (Participant 6, p.3, line 79).

'*I don't remember really working much extra hours in my first few years but I was pretty junior then and I don't think anyone really expected … I did a few extra hours here and there but it wasn't anything major …*' (Participant 15, p.1, line 31).

One participant described the expectation of meeting the needs of service users.

'*… well I suppose my expectation would be to … my service users always come first, so I always make sure that I meet their needs*' (Participant 7, p.1, line 9).

Some participants discussed expectations as being a two-way reciprocal process between them and the organisation.

'*… I can work flexi hours so I can work longer days and shorter days and as long as I* [sighs] *but in turn, I have to meet … targets and … clear expectations set out by the organisation*' (Participant 13, p.1, line 33).

'*Well they expect us to be quite clear about what we do but I don't think the organisation is always clear about what their vision is and what they expect of us*' (Participant 5, p.6, line 178).

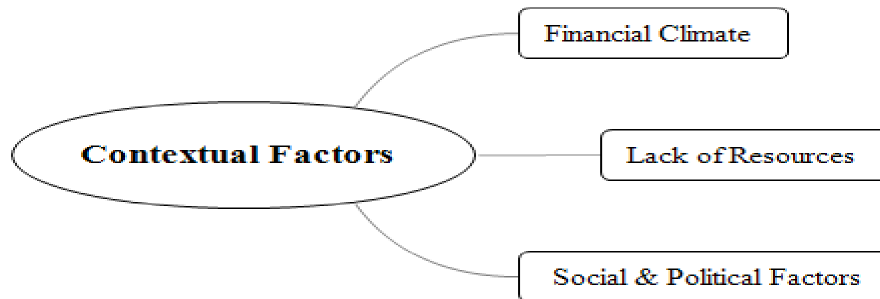
One participant described the start of a transition towards a new less implicit psychological contract.

'*… people were within the old contract, they were still expected to fulfil the obligations of the new contract and that was quite a challenge for me, I was thinking for those people, how did that work, how did that transaction work?*' (Participant 10, p.3, line 147).

4.4 Theme 2: Contextual Factors

Theme 2 describes the contextual background factors of organisational change. These included lack of resources and financial shortages, compounded by cuts to social care that may have impacted upon the additional expectations of the NHS. The theme also describes how the NHS is portrayed in the media due to it being a large public service (see Appendix R1, Table R1.1, pp.220-222 for further details). Figure 12 on the following page illustrates the superordinate theme 'contextual factors' and associated subordinate themes.

Figure 12. Theme 2: 'Contextual Factors' and subthemes: 'Financial Climate', 'Lack of Resources' and 'Social and Political Factors'



4.4.1 Subtheme 2.1: Financial Climate

This subtheme describes the influence of the financial climate such as cost savings on the NHS.

'*The thing is you know, the last, certainly the last five years, you know the NHS has been so squeezed with … so-called efficiency savings …*' (Participant 15, p3. line 92).

'*I think change within the organisation which is affected by broader change within the NHS and the financial climate … I think has directly affected the deal* [laughs] *between the organisation and employers and I don't think it's necessarily … that the deal has changed dramatically …*' (Participant 11, p.2, line 90).

4.4.2 Subtheme 2.2: Lack of Resources

This subtheme describes the general lack of time and resources in terms of clinical and administrative pressures.

'*… I feel personally really kind of protective now over any sort of time that I might have that I can give to things like formulating, thinking, breathing (three seconds) it feels like it all gets taken up so quickly*' (Participant 12, p.10, line 494).

'*… having time and space for reflection has definitely changed, like we used to be able to do a visit, come back, reflect, write up, you know discuss …*' (Participant 5, p.19, line 626).

'*... it's just become even more of a given that you just are not going to have enough time and resources to do all the things that you want to do ... that need doing as part of your job within the hours that are given because there is a shortage of people so therefore there's more for us to do and less time to do it in ... so I think the change in the organisation has affected how our jobs look at this point compared to two years ago*' (Participant 11, p.2, line. 96).

'*... the ever-growing list of paperwork that you have got to fill in ... for people at the expense of actually like seeing them or doing anything with them ... you think well that doesn't really incentivise you to see someone for five minutes because on the basis of having known them for five minutes, you've got to do all of this stuff ... and agency staff notoriously just don't tend to do all of that stuff ...*' (Participant 1, p.12, line 364).

The lack of resources also raised fears in terms of the sustainability of the NHS.

'*I see it as the NHS and the Trust and it does give me concern for the long term ... you know you just think how sustainable is this for all of us? ... it does worry me as I say for the future*' (Participant 3, p.4, line.110).

4.4.3 Subtheme 2.3: Social and Political Factors

One participant discussed the political policy 'Agenda for Change' as a catalyst.

'*... I think part of the process started with 'Agenda for Change' so years ago ... I think that started the thinking process of what is it that I am expected to do as a psychologist within this team?*' (Participant 13, p.3, line 132).

One participant described the global process of change across NHS Trusts.

'*I think most of the changes are driven by external pressures, i.e. by government and cos I have friends in lots of Trusts, I, I just see it happening everywhere ... Obviously some Trusts do it slightly better than others but it's hard everywhere*' (Participant 15, p.13, line 410).

Participants also voiced their pessimism about how the government may not always have the best interests of the NHS at heart.

'*No, increasingly pessimistic, I think that the government is out to, politicians are out to destroy it and fragment and the fragmentation has already started, five or six years ago and … when the services were being cut down and you know anyone could come and tender for them, and the values are being completely eroded at last …*' (Participant 10, p.21, line 1122).

'*… because they are under a lot of pressures wherever, government or NHS England or whatever … to meet these targets or commissioners because commissioners will just say well if you can't meet this, we will get somebody else to do the job for us … I think what has changed is that they are clearer in their expectations*' (Participant 13, p.4, line 232).

Another participant described the cycles of change he/she had experienced due to politics.

'*… we keep going through the cycles, we went through GP fund holding years ago and then you come back again to it and I think that's when you work here longer, you just realise, you are just a bit of "political football" …*' (Participant 9, p.19, line 929).

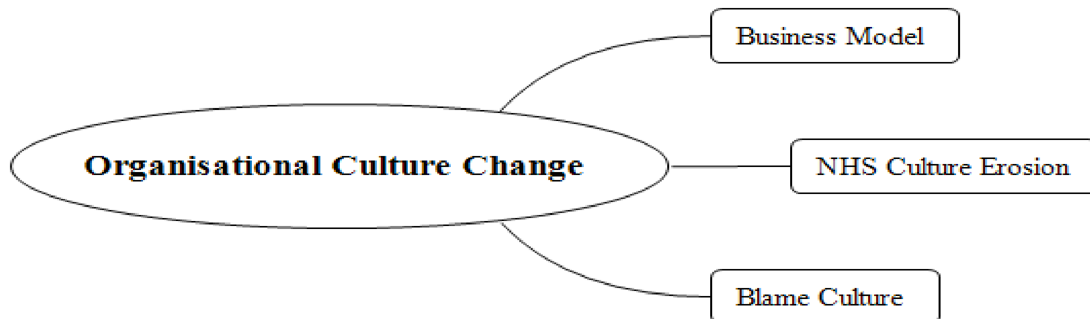
The influence of negative media coverage was also discussed.

'*… so I think the media has contributed to it cos the publicity has been so bad for the NHS and I think that in itself places the organisation in a climate of fear … therefore they then drive those things*' (Participant 8, p.3. line 116).

4.5 Theme 3: Organisational Culture Change

Theme 3 describes the erosion of the previous values associated with the NHS to become more target-driven and outcomes-based in reaction to the financial climate. This included subthemes, such as change towards a 'business model' based upon outputs and hierarchy. Participants also mentioned noticing a new 'blame culture' due to increased scrutiny from internal and external sources (see Appendix S1, Table S1.1, pp.223-226 for further details). Figure 13 on the following page illustrates the theme of 'organisational culture change' and associated subthemes.

Figure 13. Theme 3: 'Organisational Culture Change' and subthemes: 'Business Model', 'NHS Culture Erosion' and 'Blame Culture'



4.5.1 Subtheme 3.1: Business Model

This subtheme describes how the NHS changed to a business model. This change was seen by one participant as the NHS no longer being an independent public service. '*I've just come to a position now thinking actually these are a group of loosely affiliated private organisations bidding and tendering for each other's money …*' (Participant 12, line 888, p.18).

However, three participants believed that change could transform the NHS. '*I think the NHS has changed a lot and I think the shift towards business focus … has potential to transform some aspects of the NHS that needed to change and needed updating but I think it also undermines some of the core values of the NHS and the reason it was set up …*' (Participant 11, p.18, line 880).
'*… the NHS has always needed to sort itself out a bit in terms of how efficient it is and how it operates … and I think it's becoming more business minded …*' (Participant 11, p.8, line 388).

'*… we became more of a … corporate … so I think it's because they were more, they were clearer in their expectations of us …*' (Participant 13, p.9, line 423).

Other participants mentioned the change of culture to becoming more capitalistic and corporate.

'*… over the past say probably four or three years* [three-second pause] *… for example, the, the PDP process, through … insisting that we have job plans, through … insisting we have a contract* [laughs] *for a written contract, which, in the past, I think we had but we never saw, so it's through those processes … the Trust having more of a corporate identity*

… being more visible in terms of their values, being more visible in terms of what training they want us to do, being more outspoken about the targets and I think through those processes …' (Participant 13, p.3, line 108).

'*… Implicit contracts are exactly that, they are implicit and, and that means people don't have to live up to them … maybe, we, we're becoming more a kind of cruel society … I certainly feel that the NHS is … acquiring a capitalistic ethos in the sense that it's much more … ruthless than it used to be … commissioners just aren't that understanding about services, that don't work properly, therefore managers aren't that understanding about workers who don't perform, etc. … I don't think you can get away from playing an implicit game, you know …*' (Participant 15, p.7, line 208).

4.5.2 Subtheme 3.2: NHS Culture Erosion

This subtheme describes how there were different narratives around the erosion of the NHS culture.

'*… people are always trying … put these people in boxes and people don't read these boxes and come to, you know the attention of clinicians so … I think we've lost out on that flexibility, everybody has become, sort of, quite narrow within their … clinical situations … and we've also lost the flexibility to work I think with external agencies*' (Participant 10, p.4, line 197).

Another participant described a change around his/her career in the NHS.

'*… it's a whole different landscape now. I mean when I started in the NHS it was definitely a kind of "job for life" and … I wouldn't say it was an easy job but … you know, the workload was okay and … the Trust was stable, they had, they had a kind of solid platform of contracts …*' (Participant 15, p.4, line 101).

4.5.3 Subtheme 3.3: Blame Culture

This subtheme describes how participants believed changes had created a 'blame culture' as they were under more scrutiny from inside and outside the organisation.

'*I think the team now feels under much, much more scrutiny … from the employer and the employer's masters so the commissioners really, yeah … which makes it feel a bit harder*' (Participant 10, p.7, line 310).

'*Now we've got a CQC inspection and suddenly they are worried about your PDP so everybody goes off and does PDPs or now everybody has to do mandatory training …*' (Participant 13, p.20, line 973).

'*it's the external pressures … I think it just makes everybody much more aware of everything, people are aware of how much work they're doing and that makes them aware of how much work other people*' (Participant 8, p.16, line 805).

One participant stated how he/she believed that everything was now based on outcomes.

'*It's less tolerant, used to be … if you don't do it, that's a disciplinary issue, we, you know, we'll deal with you … we've become a kind of neo-liberal* [sighs] *set of services, it's all about data* [yawns] *… and outcomes … so if your data is rubbish, it looks like your services are rubbish even if your services are great …*' (Participant 15, p.14, line 451).

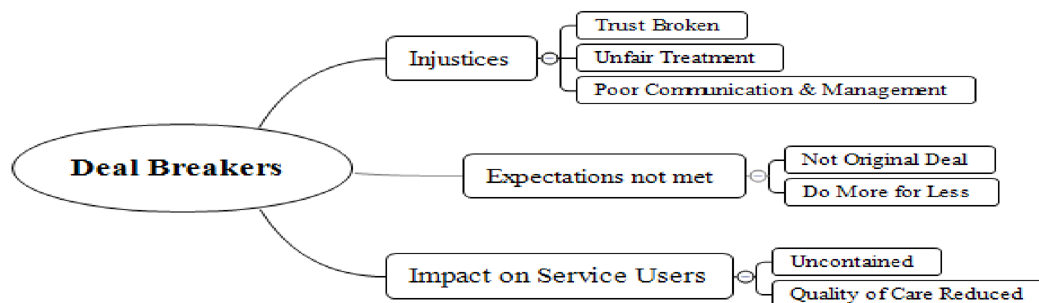
One participant mentioned how the relational aspect of team was now lost.

'*… we used to laugh a lot and we don't anymore. And we used to do a lot of socials, we don't anymore … I used to organise socials. I lost my motivation …*' (Participant 5, p.20, line 679).

4.6 Theme 4: Deal Breakers

Theme 4 describes how participants felt their original deal with the organisation had been broken due to organisational changes and their expectations were no longer met. The theme also discusses injustices, such as having to do more for less and the impact of change on service users in terms of less time and a reduction in the quality of care. Participants also described poor communication from the organisation (see Appendix T1, Table T1.1, pp.227-235 for further details). Figure 14 on the following page illustrates the theme of 'deal breakers' and associated subthemes.

Figure 14. Theme 4: 'Deal Breakers' and subthemes: 'Injustices'; 'Expectations not met'; and 'Impact on Service Users'



4.6.1 Subtheme 4.1: Injustices

This subtheme describes how many participants expressed a lack of trust in the organisation and NHS due to injustices. For instance, two participants described having a bleak outlook for organisations and feeling that their trust had been broken throughout the process of change.

'*I don't think the organisation is honest anymore because they under a lot of pressures*' (Participant 13, p. p.5, line 229).

'*... I think there were a couple of private companies ... we, we were led to believe that we were ... all going to keep our jobs and then, there came the time when actually we were led to believe that we really weren't going to keep our jobs after a lot of work had been put in which was really quite difficult to take …*' (Participant 12, p.7, line 306).

The injustices appeared to centre on unfair treatment towards participants and colleagues.

'*... just in terms of the expectations, pressure, stress, the inflexibility but yet they want you to be flexible, the sort of unfairness between what's expected of us and what they sort of expect. It's just completely different*' (Participant 5, p.9. line 290).

'*… the NHS used to be very* [6.8] *... understanding around sickness and less so now, there's a large drive to get people not to be off sick and to really put pressure on them ... so yeah*' (Participant 15, p.3, line 149).

Participants discussed how they felt that the organisation could have communicated the changes more appropriately and supported them in decisions.

'*I think, I think its mixed actually, I think there were so many changes, so quickly that messages couldn't be communicated as … freely, and as clearly as we'd want to be so I think lots of big messages did but then I think the myriad tiny little exchanges weren't communicated, yeah*' (Participant 12, p.11, line 507).

'*Some did, the more vocal ones did but I don't think they felt listened to. I think they felt it was a fait accompli and whatever their view was, some …*' (Participant 6, p.14, line 467).

'*… I haven't felt involved, think when managers have made decisions and just pushed it down to the clinicians, without involving the clinicians*' (Participant 14, p.9, line 272).

4.6.2 Subtheme 4.2: Expectations Not Met

This subtheme describes how participants felt that their original psychological contract expectations were no longer met by the organisation.

'*… I think why it was so unexpected was not the response of that person that I knew for quite a while, which, it wasn't the response I would have got from that person prior to the changes in the NHS over the last five or six years cos I knew that person for a long number of years and as I say, it's wow, it's …*' (Participant 3, p.6, line 173).

'*… I was working to the contract, working to what is expected of me, above and beyond and all I ask for is a bit of flexibility, which is allowed in the contract and they basically said no*' (Participant 5, p.8, line 251).

It appeared that the new psychological contract was unrealistic and it was impossible to live up to the new expectations.

'*… if I don't have a clinical space I can't work and if it's not appropriate, safe and contained and then I can't do my work and actually it felt like to save a quick buck they decided to move the team out to be moved to a place where there wasn't a clinical space and so I wasn't able to work and they found me some work which wasn't safe actually. There were needles outside …*' (Participant 4, p.6, line 189).

'*… so you are constantly in that place where you think, I'm not meeting my targets, I'm not … doing all my reports, I'm not putting the* [three-second pause] *the right stuff in there, right folders. I'm not printing off the last risk assessment … I'm not seeing enough people in the community, travelling too much* [laughs] *constantly feel, 90% of the time,*

that you are not living up to the contract because it's the impossible' (Participant 13, p.8, line 396).

4.6.3 Subtheme 4.3: Impact on Service Users

This subtheme describes how participants believed the changes had impacted on service users and their ability to work with service users.

'*... I think for some service users who are really vulnerable you know they stop coming ... it's not contained enough, they don't feel safe ... the fact that I'm the same therapist doesn't you know isn't enough for them*' (Participant 4, p.14, line 461).

'*I don't, I think they like it if you work a bit extra and I think they like it if you add pressure to you because then you feel guilty because you're not meeting the needs of your service users*' (Participant 5, p.3, line 79).

'*I would say it's become some of the decisions made by the Trust are maybe not around service users are much more about promotion of the Trust and expansion and taking on other Trusts, and I think that could be seen as a break of contract because our mission is to be the provider of XXXXX and mental health services ... within XXX*' (Participant 6, p.4, line 130).

One participant discussed the impact on the therapeutic relationship between them and service users.

'*... I couldn't take on like really complex people or, I did cry once in front of my clients as well which I never do cos ... I was already on edge, that tipped me over, just the hearing that, would have been fine but, cos I was already up here it sort of tipped me over the edge emotionally*' (Participant 5, p. 16, line 516).

Two participants described how service users were becoming upset due to changes.

'*It's sort of the impact it has on the service users and you end up having to cope with a lot of anger in sessions ... I was forced to finish with people ... you know they needed more support but I had to finish with them because there was no clinical place to work with. And you end up with a lot of anger in sessions, you end up with a lot of frustration and a lot of fall out. People just stop coming*' (Participant 4, p.7, line 232).

'*... because they just don't have the capacity to do it anymore ... I sort of have the fortune/misfortune of meeting lots of disgruntled patients, service users* [sighs] *...*' (Participant 15, p.1, line 351).

Participants discussed the lack of resources and increased pressures.

'*... I think next five years, I think it will change very differently, again looking at more closures of beds, I think that will continue, that's where the pressure is, much more complex people in their own home because of the Winterbourne Programme, much more complex people coming back ...*' (Participant, 6, p.26, line 888).

Participants discussed how the quality of care had been reduced.

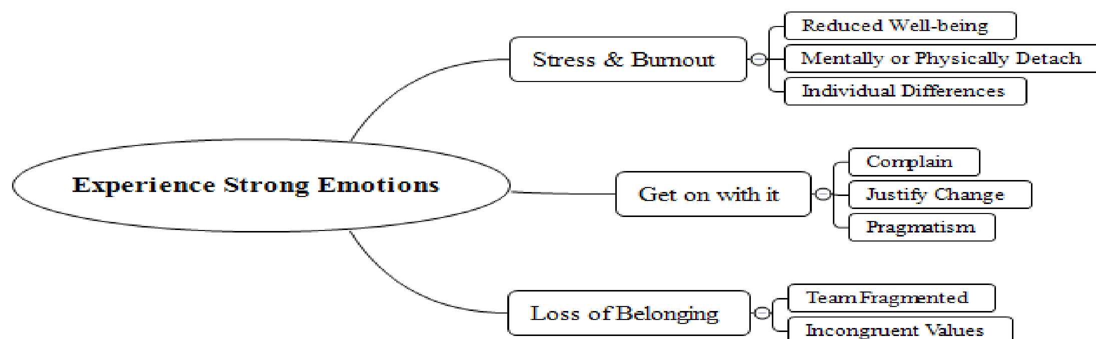
'*I think probably it does compromise my clinical work ... you know when, if a patient calls up, I'm not there and they have to wait usually three or four days before I'm back in the office to call them*' (Participant 14, p.5. line 160).

'*... it's simple, they pay tax, the NHS is there, the NHS should help them but sometimes, the NHS chooses not to help certain people with certain problems*' (Participant 15, p.11, line 353).

4.7 Theme 5: Experience Strong Emotions

This theme describes how participants experienced a range of strong emotions as a result of stress experienced by the changes. Stress is managed in various different ways as some participants choose to switch off, others choose to either leave or stay and complain. Whereas, others are more stoic and get on with things. However, others reported a sense of loss, such as no longer belonging and not identifying with new organisational values (see Appendix U1, Table U1.1, pp.236-242 for further details). Figure 15 on the following page illustrates the theme of 'experience strong emotions' and associated subthemes.

Figure 15. Theme 5: 'Experience Strong Emotions' and subthemes: 'Stress and Burnout', 'Get on with it'; and 'Loss of Belonging'.



4.7.1 Subtheme 5.1: Stress and Burnout

This subtheme describes the mental and physical health effects as a result of experiencing stress due to change. The subtheme discusses the impact of this and the different ways in which people manage this by either mentally or physically distancing themselves. One participant mentioned that anxiety was having a negative impact on work.

'*... at the time my work sort of, I think cos I was quite stressed and feeling quite low, I couldn't put much, like to write a report would take me all day to see somebody, I had to cancel a few visits because I was too upset to see them, I was having full blown panic attacks and sometimes I had to cancel visits*' (Participant 5, p.16, line 494).

One participant described the impact of stress on staff absences.

'*... the rest of the team are dropping like flies, yeah I, I am sure that, I am sure that the rate of illness and the rate of stress are correlated*' (Participant 12, p.9, line 443).

It appeared that some participants were trying to mentally distance themselves.

'*... in fact people have divorced themselves from it. They are not working on any emotional level at all and I can't bear, but you know something, that's not how you work, that's not how I work anyway so I find it really, really frustrating*' (Participant 2, p.11, line 359).

'*... that's why I just divorce myself from that and just get on with what I can do, what I can do is I can help people and get them better and I'm good at that*' (Participant 9, p.19, line 933).

One participant described how colleagues were feeling pressurised to come into work even when they were unwell.

'*... what I see a lot of is what's now called, what do they call it? "presenteeism", which is a different, which is sort of similar to absenteeism so its people who come to work but they are not productive*' (Participant 15, p.12, line 369).

Participants also spoke about physically leaving the organisation.

'*I decided to leave ... to leave that job ... but ... I think what, what got to me there was the fact that I just, I, I, I put so much work in and so much time and effort and it, it just never seemed to be good enough and I just realised I can't actually win this game, this can't be won ... and probably I became extremely unproductive after that actually ...*' (Participant 15, p.8, line 239).

'*... the team has completely changed, which is why I left but I didn't want to leave cos I love the job. I had to leave because of the team and because of the way that I was treated and the way that it's going*' (Participant 5, p.9, line 285).

One participant spoke about seeing colleagues taking early retirement.

'*Well I have noticed that there are more people who suddenly seem ... to have firmed up their retirement dates that could be coincidence but I don't think it is ...*' (Participant 1, p.14, line 448).

There were also clear differences between individuals in terms of how they coped with stress.

'*Everybody went into their own particular chosen methods for dealing with stress so some people became a lot more vocal, some people became a lot more angry, some people became a lot more withdrawn ...*' (Participant 12, p.12, line 766).

4.7.2 Subtheme 5.2: Get On With It

This subtheme describes how participants experienced strong emotions but appeared to be getting on with things through vocalising emotions or just keeping going.

'*... so people leave and then some people just get angry all the time, you know, and they're angry at the system, angry at this, angry at that. I don't know, you avoid going to meetings or you're just angry ... and it's hard to express that I suppose in a positive way*' (Participant 4, p.4, line 117).

Others appeared to find ways to justify changes as they believed change was influenced by external factors.

'*... but with the team it just doesn't feel like it comes from them again it feels like it's a wider, more Trust and more NHS and then beyond that to whoever the hell it is who is responsible for commissioning*' (Participant 1, p.10, line 314).

'*... I think they are aware of it but ... I don't think they can do anything about, that's just where they are, there isn't the money and ... you know nobody is going to say you don't have to see anybody in 28 days*' (Participant 13, p.5, line 271).

'*I am just an employee like everyone else and I might have done a great job but you know if there's no money, there's no money and some big decision has to be made and that's that*' (Participant 15, p.10, line 324).

Other participants took more pragmatic approaches and appeared to continue as normal with the work.

'*... there was a period of celebration particularly, it felt like a period of trudging on and getting going through, yeah it didn't feel particularly happy at the time*' (Participant 12, p.17, line 800).

'*... I'm sort of pragmatic in a sense that I* [pause], *you know just got on with it and tried to do it as best I could and ... made the most out of it ...*' (Participant 15, p.9, line 275).

'*... but it's more about the practical ways in which you do that and acceptance as well, just accepting that I can't do everything ... and I can't always do things exactly how I want, how I'd like to do them in an ideal world and that that's ok ... and that doesn't mean that that family won't get a good service*' (Participant 8, p.10, line 466).

4.7.3 Subtheme 5.3: Loss of Belonging

This subtheme describes how participants reported a sense of loss of belonging. One participant described how he/she felt that teams were no longer cohesive.

'*... not being based with our teams, so we all live in one big open plan office now so we've lost that sort of sense of belonging and you don't feel you're part of a team, you're just part of a big call centre ...*' (Participant 6, p.5, line 145).

'*... as a psychologist ... now I'm much more like part of an organisation. Whereas, before I felt I was part of a team, as a psychologist, having much more individual identity and freedom of choice* [laughs]. *Not necessarily good, I'm not saying that was better but that had definitely its value*' (Participant 13, p.12, line 384).

Participant 15 described how he/she felt it was difficult to identify with the new values of the new culture of the organisation and NHS.

'*I think if you come to work and you get a chance to do a good job and you see people benefiting from what you do, you are willing to put in some hours. I think if you, if it's all rubbish and ... you can't see the benefits and your manager is always giving you a hard time, then you're, you're going to lose heart, you know*' (Participant 15, p.16, line 513).

'*... but I think I probably identify a little less cos I feel like the NHS cos it doesn't exist, doesn't have any loyalty to me ... so it's hard to be loyal back*' (Participant 15, p.18, line 579).

Another participant described how the new finance-focused culture went against his/her professional identity.

'*Yeah, it was to help with their finances and I think it went against a lot of people's professional sort of identity really. We're here to care for people not to try to make money out of people*' (Participant 6, p.9, line 295).

However, another participant described how, although his/her identity to the organisation had reduced, his/her professional identity had increased as a result of change.

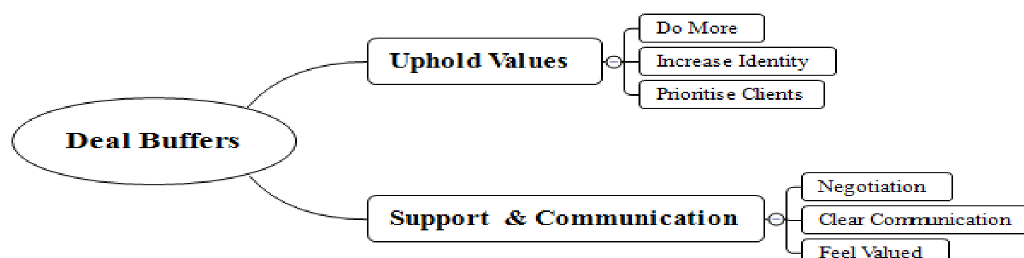
'*I can identify but I don't, it's not what I want, because I think theirs, is just language, you know, its words, I don't think it's real actually, I don't think you can just put words and then close teams and take away money and say you can't do things to support people, it doesn't work like that, it's got to be real but my own internal identity in terms of being an XX has strengthened*' (Participant 2, p. 14, line 435).

4.8 Theme 6: Deal Buffers

Theme 6 describes how participants were able to discuss what helped them cope. It appeared that feeling they were still being supported and had permission and choice to negotiate the new contracts helped. This was a two-way process as they appreciated the organisation communicating clearly with them about change as well. Further, they also

drew on their own resources, such as being able to uphold values and get on with work (see Appendix V1, Table V1.1, pp.243-250 for further details). Figure 16 below illustrates the theme 'deal buffers' and associated subthemes.

Figure 16. Theme 6: 'Deal Buffers' and subthemes: 'Uphold Values' and 'Support and Communication'



4.8.1 Subtheme 6.1: Uphold Values

This subtheme describes how participants also tried to support themselves by upholding their personal values.

'*I think and also because most people want to do a good job, I think most people are in this business, definitely not for the money … but they want to do a good job and I think that sort of motivates them and there …*'

One specific value appeared to be putting service users as a priority.

'*… wanting to do the best for the clients because feeling that if we, if we didn't then the clients would be in a much worse position, yeah, yeah I think that's, that's a big thing*' (Participant 12, p.15, line 739).

'*The team leader said to me once that she lies awake at night sometimes thinking of the unallocated clients …*' (Participant 1, p.16, line 519).

'*Well patients are always the priority, the safe ward is always the priority but you know … that is quite a situation, which, when nationally there are shortages of staff*' (Participant 3, p.3, line 91).

'*… all the CAMHS clinicians I know are working … themselves into the ground and services are on their knees and I'm trying really hard here but what's the, you know, where's the benefit?*' (Participant 8, p.15, line 732).

Participants also spoke about an increased sense of identity to their team and the NHS.

'*... the new service, so everybody ... feels very emotionally connected to the service ... I think probably because of that, because of the emotional buy-in into the team really*' (Participant 12, p.1, line 45)

'*... think it's with the NHS and with my team than the organisation. I've never thought of loyalty to the organisation other than feeling guilty because I'm not doing what I'm supposed to do but I feel my loyalty is to the NHS and definitely to my team*' (Participant 13, p.13, line 719).

'*... but then when things are really stressful and you feel like you're on a hamster wheel and you're just never getting anywhere, in some ways that ... so I think the first, the team feeling increases my loyalty to my team and to the Trust and there's very much a ...*' (Participant 8, p.14, line 687).

Participants spoke about identity with the core values of the NHS as a way of coping with change.

'*... it's easy to then and I think there is a bit of a culture within the NHS, that we can be ... martyrs some of the time and people think "oh, I'm so hard done by" and I think it's really important to remind ourselves, we do this job for a reason and it's our choice, it's my choice to work in the public sector, I could work in the private sector but ... I believe in public service so you just roll with the punches and have a laugh about it ...*' (Participant 8, p.16, line 765).

'*... we are not working in a private industry, we are working ... in a national health service where people you know expect a certain level of service ... hopefully get that ...*' (Participant 14, p.16, line 500).

'*I very much identify with the value that healthcare should be free at the point of delivery, I come from a context where it isn't, wasn't free at the point of delivery, necessarily and when it was, it was such a bad quality that ... The disaster and the heart ache caused by healthcare that is unavailable to big parts of the population so I really identify and strongly with that value that it should be a good service at the point of delivery*' (Participant 13, p. 18, line 1068).

4.8.2 Subtheme 6.2: Support and Communication

This subtheme describes protective factors from the organisation such as feeling supported. One way participants felt supported was by voicing concerns and negotiating the new psychological contract. For instance, Participant 13 mentioned that he/she had previously received poor communication (deal breaker) but appreciated that the psychological contract could be negotiated.

'*I don't think that, I'm sure there are other ways of communicating but or you just get an email to say, now you have to do this mandatory training, two emails on … this is your 28-day … targets … next email is this is how many clients you are seeing and you think well okay, the person sending this email, are they actually thinking about how I'm going to fit all of this in?…* '(Participant 13, p.14, line 789).

'*I would think that was normal with any organisational change for people to sort of renegotiate roles and responsibilities and opportunities and in a way that, that's just what happened*' (Participant 13, p.15, line 879).

One participant reported that staff were able to express views.

'*I suppose although people felt it was a done deal, the opportunities were there for people to raise their concern … I don't, I think it had to happen but I think they tried to take people's views into account as much as possible*' (Participant 6, p.15, line 504). The importance of internal communication within the organisation was also mentioned.

'*I think it's, it's a bit, it's a mixed picture … there's quite a lot sort formal support … I think the Trust, certainly in the last couple of years has been very … aware that if their staff are happy, they'll do better and, and that's … that does sort of, they, they notice that … what they've formally sort of added I don't know, I think there's quite a lot more, communication, you know, internal communications … that sort of thing which, which helps and makes you feel better about the organisation you work for …*' (Participant 15, p.13, line 420).

However, Participant 13 described how the image communicated a clearer sense of expectation.

'*… but the bigger … changes that I think is positive like the organisation being more of a corporate image and sort of more kind of open with what their expectations are although*

they are not realistic. I think that is good in the sense that it is clear' (Participant 13, p.12, line 677).

Participant 14 spoke about the importance of effective communication and how this made him/her feel valued.

'*... it's come down to the communication really, making sure communication is really effective and that everyone's in the loop all the time ... you can't get that right all the time ... but I think that is significant in managing change, being able to communicate where you're at and where you're going*' (Participant 14, p.11, line 349).

'*... definitely, good supervision and support ... I've, I have got a really good supervisor who I can just go and go "blahhh!" to, which ... just helps being able to go and vent stuff and get some perspective and talk things through and ... yeah, I think that, that, that's really important*' (Participant 14, p.10, line 327).

Another participant commented how the manager had been supportive so that he/she could support service users.

'*... she was a very sort of relaxed like you need to look after your health and wellbeing otherwise you can't look after the clients. She, you know, she recognised when you were working over and would like tell you either to ensure that you take the time back or not to do it kind of thing but said it in a really nice way*' (Participant 5, p.1, line 27).

5. Discussion

5.1 Summary of Findings

There appeared to be a clear narrative from participants about their experience of change in the NHS. Participants noticed that their implicit psychological contracts had become more explicit and business-outcome orientated. Some participants related these changes to contextual factors. As a result, participants believed they now face increased scrutiny and this resulted in them feeling that their psychological contracts with their employers no longer reflected the deal. They also named perceived injustices, such as being asked to do more with fewer resources. Others noticed the impact on client work. As a result, participants experienced strong emotions and coped in different ways, with some either mentally or physically detaching, whereas others spoke about being able to 'get on

with things' and were able to renegotiate contracts. Others spoke of living by their values and prioritising clients.

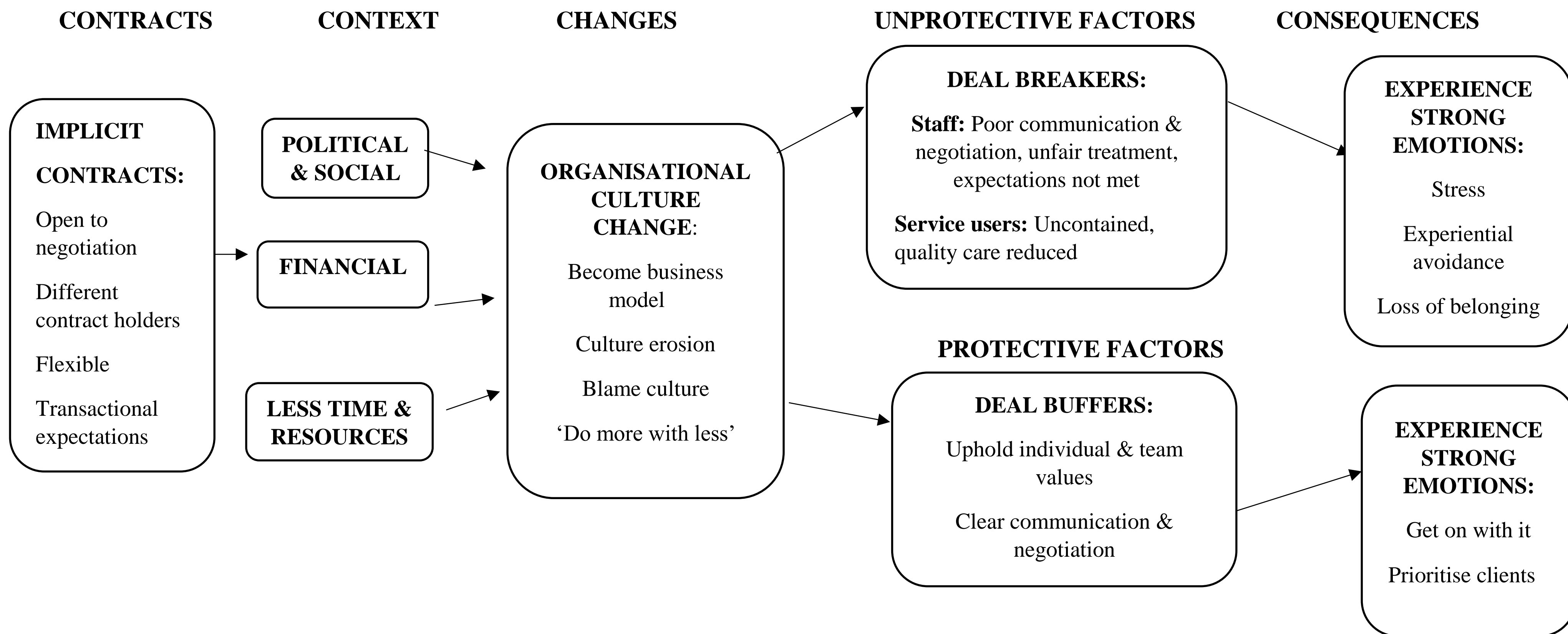
Hence, the concept of the psychological contract, drawing on the extended contract model (Guest, 1998; George, 2009) has served as a useful framework from which to interpret participants' emotional and cognitive experience of change. The six themes and the practical and theoretical implications of these will be discussed in more detail. Figure 17 on the following page illustrates an adapted model of the extended model (Guest, 1998; George, 2009) to incorporate the six themes from this study.

5.2 Theme 1: Implicit Psychological Contracts

One finding that emerged was the perceived implicit nature of the psychological contract, which supports earlier research on the psychological contract as primarily an implicit construct (Menninger, 1958; Arygris, 1960; Levinson et al., 1962; Schein, 1978). Contrarily, contemporary research has conceived the contract as containing both explicit and implicit concepts (Rousseau, 1989; George, 2009; Conway & Briner, 2005). Implicit promises have often been defined as 'interpretations of patterns of past exchanges, vicarious learning as well as through various factors that each party take for granted (goodness or fairness)' (Robinson & Rousseau, 1994, p.246). The implicit psychological contract makes sense, considering the three core NHS principles: 'meeting the needs of everyone'; 'free at the point of delivery'; and 'based on clinical need, not ability to pay' (NHS Choices, 2016).

Therefore, it would make sense that those employed in the NHS would assume these values applied to staff as the psychological contract is subjective (Rousseau, 1995; Anderson & Schalk, 1998) and consists of individual cognitions (Morrison & Robinson, 1997). Hence, participants may have had different perceptions of the contract when it was originally negotiated, which were subject to individual interpretation.

Figure 17. Adapted extended psychological contract model (Guest, 1998; George, 2009) of change in the NHS incorporating six themes from the study



5.2.1 Psychological Contract Flexibility

Participants described the psychological contract as flexible, which supports previous research of the contract as dynamic with a tendency to change over an employee's organisational lifetime (Hiltrop, 1995; Cassar, 2001). Participants also saw the psychological contract as open to negotiation, which suggests that there was autonomy and agency within the organisation. The ambiguity of the psychological contract may have provided participants with more space for manoeuvre (Feldman & Pentland, 2003). Indeed, a study of implicit and explicit negotiations between parents and nannies at the point of hire was found to have a positive impact on the perceptions of trust following initial interviews (Millward & Cropley, 2003). This suggests that participants' implicit psychological contracts had allowed a framework in contrast to fixed explicit contracts (Conway & Briner, 2005).

Participants named different psychological contract holders, which supports previous research of multiple contract holders (George, 2009). Some theorists believe the contract is between the employer and employee (Guest & Conway, 2004), whereas others believe that the employee holds the perspective (Morrison & Robinson, 1997). Further, employees can anthropomorphise the organisation as a person (Levinson et al., 1962).

5.2.2 Transactional Expectations

Participants also named transactional expectations, such as having an allocated parking space. This finding may be explained in terms of participants trusting that the organisation would provide these exchanges due to having trust in the values of the organisation and the NHS. The fact that participants discussed transactional expectations may reflect the process of change towards a business culture. Indeed, expectations related to transactional contracts suggest an emphasis on an increased investment of time and energy, which is more reflective of a business culture (George, 2009). Relational psychological contracts reflect 'having a job for life' and tend to be associated with implicitly negotiated contracts (George, 2009).

The extended contract model (Guest, 1998; George, 2009) implies that it is not the organisation's failure to meet expectations that causes a perceived breach but the original 'poor content' of the psychological contract. Therefore, if participants believe they hold implicit psychological contracts based on specific transactions, they may have started

employment with a misunderstanding of the psychological contract, making renegotiations problematic.

5.3 Theme 2: Contextual Factors

Participants described the contextual catalysts of the change process, such as government policies (e.g. Agenda for Change) and the NHS image portrayed by the media. Political influence is supported by research from Fielden and Whiting (2007) who found that participants cited 'Agenda for Change' as a reason to leave the NHS. The extended contract model (Guest, 1998; George 2009) also supports contextual factors as antecedents of change such as wider social norms. For instance, economic changes took place in the 1980s and 1990s such as globalisation, which increased competition and financial accountability, resulting in redundancies and restructuring (Herriot et al., 1997; Coyle-Shapiro & Kessler, 2000). Changes during this period also resulted in expectations of performance improvement and increased efficiency, moving from the 'old' to the 'new' psychological contracts in the private sector (Guest, 1998). There have been similar changes in the NHS since 1997 with an increase of private contractors (Givan & Bach, 2007).

Some participants in this study believed that change was out of the government's hands and needed to meet the demands of the financial climate. Previous research in a healthcare setting also found that mental health employees described external demands on changes in psychological contracts from politicians, social services and law courts (Bergin & Rønnestad, 2005). The findings of the financial influences support the link between the psychological contract type and the organisation's financial performance (Springett, 2005). The focus on saving finances suggests that participants believed the NHS was developing a more 'cost-defender' business strategy (George, 2009). Indeed, in a review of the literature of human resource practices on contracts (Aggarwal & Bhargava, 2009) found that contracts with cost-defender business strategies were related to more transaction-based contracts.

Participants vocalised the increased administrative and clinical workloads without additional support. This supports findings from Parzefall (2008) who found that the privatisation of public sector services affected the psychological contract content to become defined in terms of balanced reciprocity so that exchanges were equal. Previously,

contracts had been more generalised and were based upon altruistic motivations (Parzefall, 2008).

5.3.1 Externalising Change

Participants were aware of the external influences of psychological contract changes, which supports the extension of Guest's (1998) model by George (2009) to include organisational purpose. A narrative approach would view participants externalising the problem of change (White, 1989) from societal sources rather than the organisation. Indeed, narrative therapy draws on the work of Foucault (1965, 1975, 1979, 1980, 1982) on the power of oppressive labels within society. The act of externalising locates problems outside of the self, which can enable a person to use better problem-solving skills (Carr, 1998). Due to the nature of their work in mental health, the participants may already possess effective externalising skills.

5.4 Theme 3: Organisational Culture Change

Organisational culture change was described by participants as the erosion of the original NHS values. Healthcare organisations may have a particular culture due to institutional values (Scott, Mannion, Davies & Marshall, 2003). Organisations can be influenced locally by individuals, which may explain why a national organisation such as the NHS may be run differently, depending on the local culture of the individual Trusts. Scott et al. (2003) argued that different subcultures within the NHS added to the organisational complexity. In healthcare, organisational culture could describe attitudes towards risk, outcomes or process orientation and communication patterns (Davies, Nutley & Mannion, 2000).

Participants in this study described the change towards a more structured business model in order to tackle funding deficits due to societal expectations of financial efficiency. This change was perceived to increase competition amongst providers and introduce a more 'blame-focused', less compassionate culture with tighter monitoring. Indeed, the practices within private sector services have traditionally been viewed as more market orientated with an increased scrutiny of performance (Parzefall, 2008). This change may be more visible where employees are accustomed to being more autonomous and having tasks that are not well defined (Alvesson, 2004).

The impact of culture change was also discussed as an antecedent within the extended contract model (Guest, 1998; George, 2009). Richard et al. (2009) found that the type of organisational culture can impact upon the contract type. For instance, transactional contracts were more often linked to a hierarchical business-based organisational culture, especially in the development phase of the contract (Richard et al., 2009). Indeed, Wainwright (2014) suggested that culture is much wider than the organisation itself and reflects contextual issues such as social devaluation in society. This, in turn, may explain the introduction of a 'blame culture' from society that was not previously associated with the NHS.

5.4.1 Introduction of Consumerism

The move towards a NHS business model has resulted in a shift to viewing service users as consumers. Although reforms in healthcare have generally tried to include service users' views, some have argued that consumerism has become the main focus of healthcare policy changes (Crimson, 1998). The concept of service users having more choice and access to more services is paradoxical with professionals having less choice and working in less flexible services. Ironically, service users may be less empowered as managers have the final say about decisions around access to services (Calnan & Gabe, 2001). The business culture may have reduced professionals' sense of agency and ability to manage changes as previous research has found these conditions are necessary for service innovation (West & Farr, 1990). The lack of agency may reduce staff ability to manage the stress of organisational change as research has found that stress hormone levels increase when the perceived control is low (Frankenhauser, 1991). Indeed, the destruction of organisational culture and change to a new culture can be a traumatic process (Schein, 1992).

5.5 Theme 4: Deal Breakers

Following organisational culture change, participants experienced 'deal breakers'. Many believed the psychological contract did not reflect the original deal, which suggests a perceived contract breach (Morrison & Robinson, 1997). However, there are two pathways to breach; one involves poor performance by the organisation in terms of breaking promises, named 'reneging', and the other describes ineffective organisation socialisation, which may lead to a misunderstanding between employees and the organisation, named 'incongruence' (Morrison & Robinson, 1997). Participants had relied

on the idea of the psychological contract being negotiated via different contract holders. Therefore, it appeared that any change to the psychological contract may be perceived as a breach, but it was difficult to disentangle a breach from an ambiguous contract. This finding supports research that found that changes to the contract during organisational culture change may cause implicit elements to become explicit (Dick 2006; 2010).

The 'new' psychological contracts appeared to reflect pressures such as having to do more with less resources. Previous research found that mental health workers became more aware of internal demands during organisational culture change, such as patient turnover and efficiency (Bergin & Rønnestad, 2005). This factor appeared to be a deal breaker for many participants as they felt this was not realistic with many participants feeling overstretched and under-resourced.

5.5.1 Less Time and Resources for Service Users

Participants mentioned there was a visible impact on service users. More specifically, some spoke of service users not feeling contained and of the impact on the therapeutic relationship. This finding echoes of the work of Safran and Muran (2001) on the therapeutic alliance, which encompasses a form of psychological contract as it involves a set of agreed expectations between the service user and the therapist (Firth-Cozens & Payne, 1999). The concordance of the psychological contract reflecting the relationship between employer and employee (Bergin & Ronnestad, 2005) with that of the contract between therapist and client is unsurprising given that the early work on psychological contracts emerged from the application of psychoanalytic theory – the description of interpersonal exchanges (Menninger, 1958). Service users may have become more aware of the psychological contract in a similar fashion to the way in which participants became aware. Again, this may have caused service users to revaluate and question the original contract they had with professionals. This process may have resulted in service users feeling they did not have their needs met due to discrepancies between the original and new contracts.

The theme of 'doing more with less' also appeared at odds with the original NHS values in terms of the quality of care for service users. In this sense, participants were experiencing a type of ethical dilemma and moral distress (Kävlermark, Höglund, Hansson, Westerholm & Arnetz, 2004). Moral distress has been defined as occurring when 'one knows the right thing to do but institutional or other constraints make it difficult to

pursue the course of action' (Raines, 2000, p.30). Indeed, research on personnel in the psychiatric sector in Sweden found conflict between employees' self-perceptions and what they were expected to do post-change (Bergin & Rønnestad, 2005). In addition, Springett (2005) suggested that an organisation that promoted the values of loyalty and stability encompassed in a relational contract (such as the NHS) would have a higher moral purpose than when there was just a transactional contract.

Hence, participants in this study may have experienced a sense of discomfort and cognitive dissonance (Festinger, 1957) in relation to their continuing employment within an organisation in which they felt they no longer agreed with the values exemplified by the new psychological contract. However, participants may also have felt disempowered to negotiate the psychological contract due the hierarchical culture now enforced. This meant that participants were frustrated and they did not feel they had power to improve the quality of client care. Indeed, the dual-level social exchange model (Schaufeli et al., 1996) believes there can be unbalanced interpersonal relationships and a lack of organisational reciprocity. This finding is contrary to suggestions to the follow-up to the Francis Report (Francis, 2014), which advised the creation of an open and honest NHS culture. Indeed, Wainwright (2014) argued that organisational ethics can become compromised and wider social and political factors may need to be considered.

5.5.2 Injustices

Participants in this study also discussed the perceptions of procedural injustice (Kickul et al., 2001) such as receiving unfair treatment directly, or vicariously witnessing the unfair treatment of colleagues. For instance, some professionals discussed how they had remained flexible but had not received reciprocal praise from the organisation for their efforts or sacrifices. This can be understood in terms of reciprocity as participants no longer felt that there was an equal exchange between how they were treating the organisation and how they were being treated in return. This is consistent with the concept of distributive injustice (Kickul et al., 2001) and supports previous research, which found that change to a 'business culture' impacts on generalised reciprocity within an organisation (Parzefall, 2008).

However, it was difficult to distinguish whether perceived breach or injustice had the strongest impact on the participants' views of the organisation. Indeed, previous research found that psychological contract breach has a stronger impact than injustice

(Robbins et al., 2012). However, perceived breach partially moderates the relationship between justice and wellbeing (Cassar & Buttigeig, 2015).

5.5.3 Lack of Communication

Some participants reported a lack of communication from the organisation and felt they did not have a say in decisions, which suggested the new psychological contracting process was unbalanced. Indeed, Herriot and Pemberton (1997) believed that four conditions were necessary for the process of contracting: informing, negotiating, monitoring and renegotiation and/or exit. Herriot and Pemberton (1997) believed these conditions must be present for individuals to achieve autonomy and agency in their relationship with the organisation. The importance of communication is supported in a study of occupational psychologists, where 68% did not report breach when there was effective communication (Sutton & Griffin, 2004). Tekleab and Taylor (2003) argued that communication during contract change can affect employee reactions as this can promote mutuality in understandings, while Guest and Conway (200) noted the particular role of the line manager in communicating promises. However, communication should be realistic as line managers can exaggerate the extent of promises during organisational change, which may lead to false expectations (Grant, 1999; Greene, Ackers & Black, 2001).

Findings confirm the cognitive element of the contract (Thomas et al., 2010). Previous research suggests that employees may process information through work schemas (Markus, Smith & Moreland, 1985). Research has found that people may develop work self-schemas independently of cultural self-schemas but adjust expectations to obey the principal form, which suggests organisations should endeavour to present a realistic picture of the employment relationship (Thomas et al., 2010).

5.5.4 Loss of Trust

Regarding the long-term effects of deal breakers, participants in this study appeared to have lost trust in the organisation and the NHS. Trust in the organisation appears to be a significant factor in staff retention (e.g. Totman et al., 2011). Rousseau (1989) argued that without trust, it can be difficult for professionals to imagine a future in the organisation. Further, restoring trust is more challenging than restoring equity, as future actions by the organisation are likely to be subject to suspicion (Conway & Briner, 2005). Herriot and Pemberton (1997) suggested that one way to prevent distrust is for the

organisation to start with a clear contracting process and build explicit contracts so parties can be clear about what they are delivering.

The findings on deal breakers support the extended model of contract change (Guest, 1998; George, 2009). Hence, findings showed that when participants did not feel that original expectations were met and they were not treated fairly, it could be difficult to trust in a future with the organisation or the NHS.

5.6 Theme 5: Experiencing Strong Emotions

Participants in this study experienced a range of strong emotions, which may be attributed to psychological contract violation (Morrison & Robinson, 1997). Previous research has shown that, in addition to a cognitive sense-making tool, the psychological contract can also be used as an emotional lens through which to understand change (McGrath et al., 2015). Emotional responses following violation have been found to be more consistent when the contract is perceived to be relational as there is more emotional investment and many professional workers hold relational contracts (Bunderson, 2001). Relational contracts are more dependent on long-term social emotional exchanges between colleagues (Thomas et al., 2010).

5.6.1 Mental and Physical Health Effects

Participants experienced stress, which impacted on their ability to work with clients and caused sickness. This finding supports research from the meta-analysis by Robbins et al. (2012), which revealed an impact of breach upon employees' mental and physical health. McGrath (1970) first introduced the term 'work stress' to define the imbalance between a perceived demand and the ability to meet the demand. The perception of the ability to meet demand may have increased due to participants feeling less able to have the power to negotiate contracts within the organisation. However, mental health staff may have more awareness of their own psychological distress compared to other health professionals, which may mean that they were more attuned to their symptoms (Walsh & Walsh, 2001).

5.6.2 Different Coping Strategies

Participants had different ways of coping with stress as some mentally detached themselves from change, which echoes the concept of depersonalisation in which therapists withdraw psychologically from patients (Firth-Cozens & Payne, 1999). Other

participants intended to leave the organisations or had seen colleagues leave and retire early. The intention to quit following contract violation is common, as, when employees no longer see reciprocity, their well-being may reduce (Maslach, Schaufeli & Leiter, 2000). This finding is supported by the health of the psychological contract related to job satisfaction and intention to leave the NHS (Fielding & Whiten, 2007). This finding regarding the intention to leave both supports and expands on the extended contract model (Guest, 1998; George, 2009), by showing that employees can also 'psychologically leave' the organisation.

Another way of coping with strong emotions appeared to be by justifying changes. Referent Cognitions Theory (RCT) (Folger, 1986) discusses how people make sense of injustice in terms of high or low justification. Folger (1993) believed that employees were concerned about whether the organisation had met the moral obligations of providing enough explanation for particular outcomes. Participants may have believed the organisation was acting in a fair way if they felt external conditions, such as government policies and economics, were beyond the organisation's control. Other participants adopted more pragmatic stances by keeping going. This feeling of stoicism resonates with the context of austerity and social change post-World War II, when the NHS was created (Rivett, 1988).

5.6.3 Loss of Belonging

Some participants experienced feelings of a loss of belonging. Team belonging has been found to be a reason for staff remaining in their roles due to loyalty and trust towards cohesive ward teams (Totman et al., 2011). Participants also experienced having incongruent values to those of the organisation and being unable to identify with the new 'tick-box' culture. This supports research during a restructuring of a hospital, that individual and group values could counteract organisational values if they were different (Taft, Hawn, Barber & Bidwell, 1999). Indeed, it appeared that 'doing more with less resources' may be contrary to professionals' value of the quality of care. Further, previous research found that healthcare staff may lack commitment and motivation to change processes when they feel they cannot identify with new values (Franco, Bennett & Kanfer, 2002). Sveningsson and Alvesson (2003) suggested that staff may experience tensions with their self-identity if they do not relate to the new values.

It appeared that participants had coped with loss in different ways, which supports the findings regarding individual reactions to grief and loss (Gilbert, 1996) and confirms that the process of loss is rarely linear (Kübler-Ross & Kessler, 2005). The dual process model of loss (Stroebe & Schhut 1999; 2001; Stroebe, Schut & Stroebe, 1998) recognises that grief is based on personal, cultural and contextual factors. The model believes that adapting to loss involves shifting between facing and evading stressors along two dimensions, named 'loss and restoration and loss orientation' (Stroebe & Schut 1999, 2001; Stroebe et al., 1998). The idea of individuals' differences in coping with loss supports changes to the extended contract model (Guest, 1998) by George (2009).

5.7 Theme 6: Deal Buffers

Participants explained what helped them, which included support and communication from the organisation together with feeling empowered to uphold their own values and prioritise service users. It appeared that having this support reminded professionals of why they had chosen to work in the NHS and in their particular professions. This element of 'buffers' is not present in the extended contract model (Guest, 1998; George, 2009) but appears to be a form of contract fulfilment (Turnley, Bolino, Lester & Bloodgood, 2003). Contract fulfilment is also based on social exchange theory, which suggests that employees may alter organisational citizenship behaviour when they feel their employment relationship is based on a fair level of exchange (Organ, 1990). Research has also shown that employees may react if they feel the contract has been over-fulfilled (Turnley et al., 2003). Further research has found that interactional justice from the organisation has an impact on employee well-being (depression-enthusiasm) (Cassar and Buttigeig, 2015).

5.7.1 Negotiation

Clear communication from the organisation appeared to reduce the sense of uncertainty about change. Research has found that communication during change can affect employees' reactions as this can promote mutuality in understanding (Tekleab & Taylor, 2003). However, the communication needs to be clear so that professionals do not receive mixed messages or exaggerated promises. Indeed, Herriot and Pemberton (1997) argued that explicit contracts can help to build trust.

Participants also drew support from the sense of autonomy in the fact that they could renegotiate their psychological contracts. Conway and Briner (2005, p.11) believed

that reciprocation allowed employees to continue to access things from the organisation and renegotiation allowed employees to work towards their preferred selves. In this sense, it was believed that the contract could relate to psychological well-being, which supported the early work of Levinson et al. (1962, cited in Conway & Briner, 2005). Indeed, research has found that a sense of autonomy is part of the contracting process (Herriot & Pemberton, 1997) and professional autonomy is valued during the change (Bergin & Rønnestad, 2005). This sense of autonomy may have enabled participants to carry on. Participants also appeared to appreciate feeling valued and research has found that employees who do not feel valued may experience contract breach (Dick, 2010).

5.7.1 Upholding Values

Subsequently, participants felt they could continue to uphold values through prioritising clients. In this respect, one positive aspect of change could have been to clarify professionals' value systems as the contract became more explicit. Increased awareness and adherence to personal values is a core component of acceptance commitment therapy (ACT) (Harris, 2009). ACT is based on treating experiential avoidance (Hayes, Wilson, Gifford, Follette & Strosahl, 1996), which involves behaviour that is negatively reinforced through avoiding discomfort. A correlational review of ACT revealed the association of experiential avoidance with various psychological disorders (Hayes, Luoma, Bond, Masuda & Lillis, 2006). Experiential avoidance is also associated with trauma (Kashdan, Morina & Priebe, 2009; Marx and Sloan, 2005; Morina, Stangier & Risch, 2008; Tull, Gratz, Salters & Roemer, 2004) and symptoms of prolonged grief (Boelen & van den Bout, 2010). Research has found that ACT can substantially reduce experiential avoidance (Ruiz, 2010).

The second aspect of ACT is to increase value clarification and actions in accordance with values and to promote defusion to live by values even when privately feared events are around (Ruiz, 2010). Clarifying values can help people realise what is important in their lives and to behave in accordance through committed action (Ruiz, 2010), which can alleviate depression (Harris, 2009). For instance, participants in the study appeared to be reconnecting with their values of prioritising clients and continued working through committed action. This presents an encouraging message against the backdrop of the economic, political, social and organisational gloom that appears to be surrounding change in the NHS. This finding further expands the extended contract model (Guest, 1998; George, 2009) by suggesting that 'deal buffers' may potentially moderate

the impact and consequences of deal breakers and suggests the importance of early intervention management strategies.

Attraction selection attrition (ASA) theory (Schneider, Goldstein & Smith, 1995) states that personality and values become increasingly linked over time. This means that employees may be attracted to the NHS due to the NHS values but attrition may occur due to value incongruence. Socialisation theory (Cable & Parsons, 2001; Bauer, Martz, Dolen & Campion, 1998) has also been applied to see how individuals may internalise the values of an organisation over time (De Cooman et al., 2009; Maierhoffer, Griffin, & Sheehan, 2000; Ostroff, Shin & Kinicki, 2005). Indeed, this study has shown that the initial negotiation and understanding of the psychological contract are essential to prevent the perception of contract breaking later on.

5.7.2 Upholding Team Values

Team values also appeared important for participants to uphold. According to social identity theory (SIT) (Tajfel & Turner, 1979; Turner, 1982; Hogg & Abrams 1988), people may gain a sense of belonging from membership with a group. Social categorisation theory (Turner, Hogg, Oakes, Reicher & Wetherell, 1987) occurs when people define themselves as part of a category, which can minimise differences between the in-group, and exaggerates those in the out-group (Voci, 2006). Self-enhancement involves in-group bias to raise self-esteem by favouring the in-group over the out-group. However, it has been argued that social identity to a group is never secure (Grant & Brown, 1995) and the presence of threat may enhance group identity causing inter-group differentiations (Brown & Ross, 1982; Maass, Ceccarelli, & Rudin, 1996). There are also different types of threat that exist as research has also found that the presence of value threats may result in strengthened in-group identification, out-group distrust and derogation, but group distinctiveness does not change in-group identification (Voci, 2006). Value threats to previous team values can be affected during organisational change due to the imposition of new values. Indeed, research has found that in-group identity increased during an organisational merger (Terry & Callan, 1998; Forsyth & Mason, under review).

Therefore, it appeared that participants may have experienced threats to the values of their team and were seeking to raise self-esteem by seeking a positive identity through their in-groups (MDTs) through in-group favouritism. This also resulted in a loss of trust for the organisation and derogation for the NHS (out-groups). This in-group team

identification may have been a protective factor for participants' sense of self-esteem during organisational change. However, it has been noted that larger organisations, which are complex, such as the NHS may provide multiple potential identities for professional workers (Ashforth & Johnson, 2001). They describe this as having nested identities that can be seen in relation to the job, work group, department and division of the organisation (Ashforth & Johnson, 2001).

5.8 Theoretical Implications

5.8.1 Support for Extended Psychological Contract Model

The concept of the psychological contract in the literature is used in simple terms of transactions and relations and also in terms of a complex, often ambiguous phenomenon (Guest, 2004). This has made the process of applying the concept as a theoretical framework in which to understand change a difficult task. However, drawing upon an extended framework (Guest, 1998; George, 2009) has allowed a clearer understanding of how the concept can be applied.

Firstly, the findings have revealed support for the extended contract model (Guest, 1998; George, 2009) by acknowledging that the contract does not exist in isolation from the organisational context in which it was created, but is subject to external contextual influence. Indeed, an institution such as the NHS is very much public property due to state funding, meaning that it cannot escape the impact of political change. However, the psychological contract is under-researched in the field of healthcare; therefore, it is difficult to compare findings (Cortvriend, 2004). The extended contract model (Guest, 1998) was based on research conducted through surveys by the Chartered Institute of Personnel and Development, which is the professional body for HR and people development (Guest et al., 1996; Guest & Conway, 1998, 2000, 2001, 2002).

5.8.2 Therapeutic Contract

The findings suggest that the psychological contract has links to the original psychoanalytic theory upon which it was based (Menninger, 1958). Indeed, there are many similarities between the therapeutic relationship and the processes of the contract. Safran and Muran (2001) believed in four conditions of the alliance: interdependence, providing a framework for interventions in a flexible way, consideration of the client's personal sense making of events and continuous negotiating between therapist and patient. This suggests

that the initial process of contracting with clients may be similar to professionals' experience of contracting with their employer.

Therapeutic rupture is similar to the concept of contract breach as rupture can occur due to either patients' lack of understanding or mistrust (Safran & Muran, 2001). Consequences can lead to patients feeling blamed if the therapist tries to locate responsibility in the patient rather than in the therapeutic relationship (Strupp, 1993). Indeed, the findings in this study suggest that patients were indirectly affected through organisational change as they mirrored the feelings of professionals by expressing strong emotions. This could have occurred through the process of transference as professionals also felt uncontained. Some patients even appeared to be demonstrating experiential avoidance through refusing to attend therapy, which was similar to professionals' desire to quit the organisation.

In terms of resolution of therapeutic rupture, it has been suggested that, as with organisational negotiations, interpretations from the therapist can enable the patient to engage in a collaborative process of meaning construction (Safran & Muran, 2001). Further, it has been suggested that therapists should share with patients how they reached interpretations as with clear organisational communication to avoid countertransference reactions from the therapist (Safran & Muran, 2001). This process can also make implicit or intuitive sense that something has taken place in the therapeutic relationship or in order to create an explicit enquiry (Safran & Muran, 2001). This process is similar to how implicit contracts can become explicit during the contracting process (Dick, 2006, 2010).

5.8.3 Novel Method of Finding Deal Buffers

There were novel theoretical findings of how factors could moderate the impact of the experience of deal breakers. Although previous contract research has focused on the facilitators of contract fulfilment through balanced social exchanges (Turnley et al., 2003), few contract theories have included mediators. Through the inclusion of moderators, the psychological contract can serve as a type of clinical formulation tool to show how having clear communication and negotiation is important both in therapy and in employment relationships. Findings have also shown that the contract is a process that is being constantly renegotiated in order to adapt to new environmental demands. Although it is subjective to the employee, it is influenced by the contract holder, the organisation and wider societal norms (Guest, 2009). Through meeting the needs of professionals and

patients, there may be better psychological well-being and hence less emotional and physical exhaustion, which may indirectly help save on sickness leave (Brotheridge & Lee, 2003). Overall, these findings support a clinical theoretical basis for the contract theory.

5.9 Methodological Implications

5.9.1 Extends on Qualitative Research

Methodologically, these findings extend previous methodologies by investigating the psychological contract qualitatively to the investigation process. Guest (1998) believed that one of the main problems in quantifying the contract was that it was neither a theory nor a measure but a hypothetical construct. Previous research that had tried to encapsulate the contract as a quantified concept had been accused of making the concept too linear (Conway & Briner, 2005). Some theorists believed the contract was made up of a series of events or processes (Conway & Briner, 2005). Conway and Briner (2005) believed that the majority of the research into psychological contracts concerns variance theories, which are linear in nature (Langley, 1999), whereas process theories are more concerned with discreet states and events and the length of time to reach the final outcome (Mohr, 1982).

The qualitative investigation of the psychological contract has allowed an understanding of how the psychological contract is renegotiated (Schein, 1980) as opposed to remaining as a static concept. Through allowing more flexible qualitative methodology, the findings have confirmed that the contract is a process that reflects the organisation and context in which it is negotiated and cannot be separated from these factors in a reductionist manner.

5.9.2 Application of Psychological Contract to Healthcare Settings

The application of the psychological contract in a healthcare setting has broadened the application of this as a sense-making construct (Weick, 1995). Indeed, previous research has discussed a dearth of research on the contract in a healthcare setting and has suggested that further research is needed in this area (Cortvriend, 2004). Therefore, this study has begun to tentatively address the gap in the literature for a lack of application of the contract in a healthcare setting. Through the application of the contract in this setting, the research confirms that the contract can be methodologically applied across both public and private settings alike.

5. 10 Clinical Implications

There are various clinical implications, which can be explained three-fold: firstly, the finding of a psychological contract as a sense-making tool during change; secondly, how mediators, such as support by the organisation, can create a sense of autonomy for an agency to lessen the impact of stress; thirdly, how professionals can clarify and commit to action to uphold their individual and team values.

5.10.1 Sense-making and Team Formulation

The psychological contract as a sense-making tool can guide MDTs to face a lack of stability caused by change (Ndoro, 2014). Morrison and Robinson (2004, cited in Conway & Briner, 2005) have suggested holding focus groups with the agents of psychological contract within the organisation. Indeed, organisational culture is key to healthcare quality and performance in the NHS (Patterson et al., 2011).

The clinical leadership framework (BPS, 2010, p.2) states that one of the roles of a clinical psychologist is to 'lead on psychological formulation in your team' (Skinner & Toogood, 2010). Team formulation through drawing on the model of the psychological contract as a sense-making tool could enable psychologists to engage team members in collaboratively thinking about their roles to provide a sense of agency. Indeed, it has been suggested that applying a formulation in teamwork can be an effective means of actualising culture change and a more psychological perspective as a whole.

5.10.2 Consultation and Leadership

Clinical psychologists could indirectly consult with team members in order to empower them to make changes themselves. Indeed, it is widely accepted that the active involvement of staff is important for the quality improvement of organisational settings (Davies, Powell & Rushmer, 2007). This may indirectly help organisations in terms of cost efficiency and to meet their own agenda of 'doing more with less'.

Professional psychologists should adhere to the ethics of the profession at all times, but, in NHS Trusts, professional leadership may influenced by organisational culture (Wainwright, 2014). Consistent leadership within MDTs is needed to provide clear messages to staff. Distributed leadership strategies could also help the team uphold values during organisational change. Leadership has recently become a key competency of a clinical psychologist within the leadership framework (BPS, 2010) and distributed leadership could enable a sense of 'we' and reduce the hierarchical feeling of the business

culture that many professionals noticed instead of a more insular separate sense of identities. Involving employees in the change processes may encourage a more collaborative MDT.

5.10.3 Upholding Values

A practical implication of the findings that upholding values is protective may include enabling mental health professionals to have a better awareness of their personal values through an ACT-based peer support group. Indeed, Gronn (1999) identified 'shared values' as one of four necessary conditions for the development and consolidation of trust relations. An ACT intervention could also increase the tolerance of negative emotions associated with change, whilst using identified values to commit to action. This may give employees greater flexibility in coping without mentally detaching from change or physically leaving the organisation to prevent experiencing these emotions.

Values-based recruitment (VBR) of staff could be applied to assess an individual's values when selecting for NHS roles in order to align participants to the organisational values at the initial psychological contracting phase (Patterson, Zibbaras & Edwards, 2014). However, if individuals are initially recruited into the NHS with the values of patient care and compassion, their values may change due to attrition or socialisation if they are exposed to NHS Trusts or teams where these initial values do not function (Patterson et al., 2014). Therefore, an intervention that involves transparent and explicit discussion of the contents of the psychological contract prior to entry into an NHS Trust may provide employees with a clearer sense of the deal at the start of employment.

5.11 Limitations

5.11.1 Small Sample Size

Regarding the study design, although the size was adequate for a thematic analysis, there was a relatively small sample size of only 15 participants. This means that it was difficult to generalise findings to all mental health professionals. Further, the 15 mental health professionals were from a range of professions, including nursing, psychiatry, art therapy, occupational therapy and psychology. Caution should be exercised in generalising findings across all mental health professions.

5.11.2 Measurement and Analysis of the Psychological Contract

A critique of thematic analysis has been that it is more of a descriptive tool unless used with an existing theoretical framework that can ground the analytic claims (Braun & Clark, 2006). The thematic analysis applied in this study was anchored by the use of the psychological contract as a sense-making tool of change. This meant that the interpretative power of the analysis was strengthened by its link to an existing theoretical framework. However, the concept of the psychological contract is difficult to define and, for this reason, previous studies have noted difficulties in quantifying the contract (George, 2009). In the current study, a brief definition of the psychological contract was provided at the outset of the interviews with a view to ensuring that participants understood what the interviewers meant in their use of the term, and that participants had a common understanding. However, the very act of offering a definition favours one view of the psychological contract. Due to the complexity of the psychological contract as a concept (Conway & Briner, 2005), it was difficult to decipher whether the essence of the contract as a conceptual tool had been captured. This meant that the interpretative power of the findings may have been reduced.

Thematic analysis is a flexible approach and is not fixed to one particular theoretical framework (Braun & Clarke, 2006). However, due to the flexibility, it can be difficult to develop precise guidelines for data analysis. Hence, understandably, one may face challenges when deciding on areas within the data units on which to focus (Braun & Clark, 2006). In the current research, a hybrid of deductive (theory-led) and inductive (data-led) codes were used (Fereday & Muir-Cochrane, 2006). This allowed the researcher to view the data from the perspective of a theoretical lens while also allowing the analysis to capture the range of the participants' subjective views.

5.11.3 Language Bias

Regarding the use of language for deductive codes, there has also been discussion of whether the contract is defined in terms of expectations, obligations or promises (George, 2009). This study used the description 'expectations' in the initial definition of the psychological contract, which reflects the language used in the more psychoanalytic explanations of early theorists (i.e. Levinson et al., 1962). In this sense, the use of the word 'expectations' may have biased participants to see the contract more implicitly, whereas the use of the words 'promises' and 'obligations' may have generated a different understanding of the meaning of the contract.

5.11.4 Recruitment Bias

A purposive approach was taken across the three NHS Furthers, which involved a non-probability sampling method to select specific mental health professionals to represent a generic MDT structure. However, recruitment may have been subject to researcher bias as some participants were known. Further, some participants may not have wanted to volunteer for fear of expressing views as the topic of change in the NHS is controversial. Some questions may have resulted in social desirability ability bias (Fisher, 1993). Having a wider range of NHS Trusts or professionals, employing a volunteer recruitment method, may have reduced bias by allowing a greater sense of anonymity. Indeed, research has shown that the sense of anonymity increases in larger groups as the social identity model of deindividuation (Tajfel & Turner, 1979).

5.11.5 Ecological Validity

Participants were from different teams across various Trusts, which meant that there was a lack of ecological validity. Future research would be advised to consider investigating change within authentic MDT teams across Trusts to consider the impact on team values. Future research could adopt the use of a focus group design to capture the authentic essence of an MDT that has experienced change. Indeed, the present study illustrated the importance of team values as an extension of individual values and how protective values can be applied during change.

5.11.6 Lack of Causal Assumptions

The study was cross-sectional in nature, which limited the ability to make causal assumptions. Indeed, previous research of the contract has been criticised for not considering the process of change over time (Conway & Briner, 2005). The ever-evolving nature of the psychological contract, influenced by contextual and organisational changes, means that it is a dynamic concept that could benefit from a longitudinal design. Future research employing this design would directly capture the evolving nature and reduce the retrospective bias of participants remembering psychological contract change.

5.12 Future Research

Future research would be advised to further investigate the conceptual meaning of individual and team values. However, it was unclear if the moderating role of feeling supported and being able to negotiate with the organisation enabled participants to have a

sense of being able to uphold values or whether this was independent of being supported. Future research would be advised to explore the relationship between contract negotiation and the protective factor of upholding team and individual values further.

The scope of this study was not able to explore the full extent of change on the therapeutic relationship as only mental health professionals were interviewed. However, findings from this study have demonstrated the secondary finding of the impact of changes to mental health professionals' psychological contracts upon their therapeutic contracts with clients. Indeed, the findings in this study revealed the importance of the negotiation of the contract. In a therapeutic relationship, it has been argued that the process of negotiation between two different subjectivities is key to the change process (Mitchell, 1993). Future research is advised to apply the psychological contract as a sense-making tool to understand the experience of the impact of change on the contracts of both mental health professionals and users of the NHS in order to understand the reciprocal relationship. Further, this could also identity protective factors that may enable clients to continue using services effectively in spite of change.

5.13 Conclusions

'*It is ironic that in a field devoted to changing behaviour and the way people think and feel, there has been such a resistance to change*' *(Huey, 2002, p.408).*

This quote from Huey (2002, p.408) implies the irony of mental health professionals working in a profession that encourages change. The findings from this study have begun to provide an answer to this paradox and suggest that it is not change itself that is problematic but the original expectations between individuals and organisations. The psychological contract has provided a valuable sense-making tool in order to understand how contextual factors can impact upon culture change. Findings have shown that the original interpretations not being perceived to be upheld may have far-reaching impacts on both the well-being of mental health professionals and on their clients. This has resulted in experiential avoidance, privately or publically, through organisational exiting. However, it is not all doom and gloom as there are protective factors to this change process, such as having the freedom to negotiate and draw upon individual and team values. Implications for this research are important in terms of change management in the NHS and supporting both professionals and clients in their journeys of change.

5.14 Personal Reflections

I became interested in the process of change in the NHS after attending a service consultation as part of my assistant psychologist role in 2013. I was struck by the psychological impact upon colleagues who I had worked alongside. I became acutely aware of the impact of uncertainty and stress upon their working lives and found myself wondering how this would impact client care. My interest grew in 2014, when I was responsible for co-facilitating a loss and bereavement group. Through this experience, I noticed the experience of loss was very subjective and I was in awe of the resiliency shown by individuals. Therefore, I decided to research NHS staff member's experiences of change through a sense of loss process. I discovered research on the psychological contract and became intrigued by the complexity. I have found conducting the research a journey in terms of acknowledging the bleakness of experiences but also noticing the strengths of participants. Overall, the process has helped me to make sense of change and given me hope for the future work in the NHS.

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Appendix A
Table A1: Herriot & Pemberton (1997) study details

Authors	Sample Details	Study design	Findings	Implications
Herriot & Pemberton (1997)	Major organisation in UK that was recently restructured via redundancies and split into business -New contract model in place Work shop held for HR directors to explore new contract 16 employees per workshop: graduates, middle managers and clerical employees.	Qualitative design using workshops compared deal of 1975 with current deal (1995) to assess changes and future of contracts Some employees looked at archived recruitment brochures if they could not remember original deal HR employees attended conference to communicate findings from workshops. HR employees completed questionnaire about readiness of organisation to engage in process of contracting on questionnaire with 40 items (5 point).	Graduates noticed strongest contrast between old and new contracts. They mentioned ideas of challenging conformity. They were happier with time limited career. They wanted security of employability but did not see management offering much for future deal. Middle managers became nostalgic about original deal compared with current deal, noticed benefits had reduced in 'new deal. -Middle managers Upset about move from relational to transactional contracts. They were pessimistic about future of deal & wanted flexibility. Clerical employees had seen organisation as safe in 1975. They saw the next deal as 'transactional'. They wanted more flexibility for the future and more job security. HR questionnaire revealed employees were not well informed of own skills against business change in organisation but clearer on what organisation could offer.	Overall, assessment of past was predictor of how participants viewed present contract Content of deal was different for each employee group and influenced by context Negotiation required for future contracts as employees had different perception of their needs and needs of managers Shows that psychological contracts is subjective to employees and can change over time. Commitment made by HR to accept model of contracting (Informing, negotiating, monitoring, renegotiating, exit) HR agreed to put model into use in projects in organisation Contracting model as expression of values of employment relationship offered.

Appendix B
Table B1: Dick (2006) study details

Author	Sample Details	Study design	Findings	Key implications
Dick (2006)	UK police constabulary Experiencing process of transition from full time to part time work 12 participants: 5 part time officers (4 current or former colleagues of part-time officers) 3 managers of part time officers 2 HR department members	A qualitative interview design to assess different views of contract across groups Opportunistic recruitment of managers and part time officer Analysed via grounded theory analysis (inductive)	Managers and part time workers obtained their beliefs about mutual obligations from signals in the local and broader organisational contexts Institutional context of industrial tribunals, home office indicated that officers can work part time. Managers were sometimes not willing to permit part time working due to causing inequity in work groups. Part timers derived beliefs from other part timers and these were reinforced by HR department.	Overall, there is a pluralistic source of the contract by organisational policy but this is open to interpretation which can create sense of ambiguity in contract. Contract makers can provide different messages about the nature of the employment relationship which can reduce mutuality and reciprocity (Dabos & Rousseau, 2004). Suggests that contract is constantly open to negotiation and interpretation.

Appendix C
Table C1: Dick (2010) study details

Author	Sample Details	Study design	Findings	Key implications
Dick (2010)	Wider project in UK police force (2003 – 2005) Three metropolitan police forces from Northern England Eight triads of participants: composed of an officer a colleague and the manager.	Semi-structured qualitative interviews in 3 areas: 1) participant perceptions of the benefits and costs of part time working 2) participant experiences of part time working or working with part timers 3) Participant perceptions and experiences of the how the part time working is managed Total of 75 interviews and six focus groups were conducted (8 -12 participants per group). Data analysed using template technique (King, 2004) which systematically identified themes and categories	Employees saw reciprocity as a long term process suggests that employees had relational contracts as a result of professional occupation. Managers who stated that the amount of flexibility attributed to part timers depended on their ability to be trusted and do a 'good job'. Colleagues less likely to be resentful if they perceived part timers to make more effort. More part timers experienced managers as keeping their commitments, the more likely they demonstrated work flexibility Majority of employees saw part time working reduced career progression. Some part timers were also grateful about staying in their role and benefits for the organisation which was also supported by manages Transition contained relational elements in terms of employee well-being.	Demonstrates that the agreement about mutual obligations was influenced by 'taken for granted' processes and everyday interaction between employer and employees. Flexibility of manager meant that the part time staff felt supported.

Appendix D

Table D1: Richard et al (2009) study details

Author	Sample Details	Study design	Findings	Key implications
Richard, et al (2009)	Organisations in Atlanta 250 surveys distributed and 220 returned, 20 discarded (*n* = 200). MBA students in Atlanta	Surveys with measures of: affective commitment (Meyer, Allen & Smith, 1993) Organisational culture looking at impact of clan and hierarchal cultures via competing values questionnaire (Quinn et al). Control measure of negative affect (Tyler, 1994).	Clan cultures had positive impact on relational contracts Clan cultures had negative impact on transactional contracts. Hierarchal cultures had reverse effects to clan cultures on contract types Relational and transactional Psychological contract types mediated relationship between organisational culture and organisational commitment and employee earnings. Transactional contracts negatively associated with affective commitment Relational contracts positively related to affective commitment.	Organisations have role in impacting on employee views of the psychological contract. Culture has role in type of contract Suggests relationship between psychological contracts & affective commitment Organisational culture as antecedent. Supports Guest's (1998) model

Appendix E

Table E1: Thomas et al (2010) study details

Author	Sample Details	Study design	Findings	Key implications
Thomas, Fitzsimmons, Ravling, Bjorn & Barzanty (2010)	Participant from 4 countries: China, Canada, Norway & France. -	57 Interviews between 2001 2004 using semi-structured interviews Use of NViVO for coding data 4 cultural categories applied (Instrumental, exploitive, communitarian & custodial).	Cultural impact on contracts as different countries showed preferences: France (exploitive); Canada (Instrumental); Norway (Communitarian); China (Custodial). Contracts sometimes differed from cultural patterns under 3 conditions: 1.Initial expectations were often not realistic: perceptions of work influenced by previous experiences 2.Perceived breaches when original contract was relational and perceived breach was not fair: if employee has been treated unfairly 3.Individual relationships as more important than employee relationships with organisation -.	Dominant form of contract patterns based on country-level values through cognitive and motivation influences (Mclean Parks et al, 1993; Thomas, Kevin & Ravlin, 2003) Initial expectations about work are unrealistic so important for organisation to communicate realistic picture of employee-organisations, relationship. Societal values linked to cultural self-schemas – implications for cognitive mechanisms in contract. Psychological contract seen as cognitive extension of the self –enhance self-concepts. Self-schemas not linked to the contract such as 'work-domain' schemas. Mismatch between initial & long term expectations can develop independently from cultural schemas Shows importance of organisation communicating realistic picture of employee-organisational relationship

Appendix F

Table F1: Parzefall (2008) study details

Author	Sample Details	Study design	Findings	Key implications
Parzefall (2008)	Questionnaires sent to 430 employees of Organisation (199 questionnaires returned) Response rate of 46.3%. There missing responses and managers were excluded Final sample consisted of 118 employees. Sample was 79.6% female (mean age = 44) Average time in job was 8 years.	-Questionnaires contained: -**Perception of contract fulfilment** (Used 5-point scale to indicate the degree to which they believed employer had fulfilled obligations) **Perceptions of generalised reciprocity:** 7 items developed by Tetrick et al. (2004) **Perceptions of balanced reciprocity:** Tetrick et al.'s (2004) balanced reciprocity scale **Affective commitment** (7items from Allan and Meyer's (1990) affective commitment scale **Continuance commitment** (6 items using the continuance commitment scale (Allan & Meyer, 1990) 4items from the exit scale developed by Rusbult, Farrell, Rogers and Mainous, 1988)	Provides evidence of norm of reciprocity Generalised reciprocity related to contract fulfilment Balanced reciprocity negatively linked to contract fulfilment. Perceptions of generalised reciprocity mediated relationship between contract fulfilment & affective commitment, including intentions to leave organisation Supports impact of perceived contract fulfilment on affective commitment & intention to leave (positively associated with affective commitment and negatively with intention to leave)	Influence of private sector on public sector Employees no longer have balanced social exchanges Employers contractual behaviour affects employees perceptions of the form of reciprocity in exchange Permitted the investigation of the psychological contract in Finnish public sector which is undergoing change

Appendix G

Table G1: Wang & Hsieh (2014) Study Details

Author	Sample Details	Study design	Findings	Key implications
Wang & Hsieh (2014)	Survey data from 273 full-time employees 9 high tech firms in Taiwan	Investigation into role of acquiescent silence in relationship between contract breach & job satisfaction. Possible moderating role of perceived ethical climate (PEC). **Measures:** **PEC (perceived ethical climate):** Victor & Cullen (1988), 5 types: instrumental: interest in on well-being; caring: concern for other's well-being; independence: adhering to individual personal ethical beliefs; rules: expectation to comply with company polices; law: expectation to comply with law and professionals standards **Perceived contract breach**: measured by 5 items adapted (Robinson & Morrison, 2000) on 5 point Likert scale **Acquiescent silence measured** by 5 items adapted (Van Dyne, Ang & Botero, 2003). Job satisfaction: 5 items Brayfield & Roth's (1951) scale	Acquiescent silence as partial mediator of the relationship between contract breach & job satisfaction. Organisations judged as ethical by extent they comply with 5 types of PEC. PEC acts as lens by which employees see jobs Low PEC is low was not buffer Moderation of PEC on relationship between contract breach and silence	PEC provides sense of safety & provide sense making. Importance of having ethical climate to reduce negatives of breach.

Appendix H
Table H1: McGrath et al (2015) study details

Author	Sample Details	Study design	Findings	Key implications
McGrath, Millward & Banks (2015)	30 volunteers (Colleagues, co-workers) from various UK organisations. (Average age of 26 years).	30 Semi structured interviews around relationship with organisation, emotions and promise experiences. Use of critical incident technique to ensure continuity of specific of events. Interviews analysed via thematic analysis using steps by Braun and Clark (2006) Interviews divided into those who had transactional vs relational contracts	Majority of participants had socio-emotional relationships with organisation (only 7 had transactional). Employees used contract as sense making tool to make sense of perceived promises and emotions. Some employees were protective of their organisation such as internalising the blame	Psychological contract to make sense of emotions. Positive emotion was linked to socio-emotional relationships. Transactional linked to more negative emotions. Those with relational contracts blamed themselves more for events. Those with transactional, attributed blame towards the organisation.

Appendix I

Table I1: Robins et al (2012) study details

Author	Sample Details	Study design	Findings	Key implications
Robbins et al (2012)	Meta-analysis of studies about psychological contract, inequity breach and mental health. Literature search revealed 279 studies for inclusion Participants from the US	**3 research questions:** **1**. Does the link between health & unfairness differ with the type of fairness? 2) Can psychological contract breach predict the variance in health above distributive, procedural & interactional justices? 3) Does the relationship with unfairness & health differ across gender, nationality & age? **4 measures of unfairness:** distributive justice; procedural injustice; interactional injustice psychological contract breach **Codings for predictor & criterion variables**: physical health, unhealthy behaviours, mental health problems, burnout, perceived stress, negative emotional state, absences. Majority were self-reported measures of stress & burnout	The average perceptions of unfairness were significantly correlated with signs of employee health (people who experienced unfairness had worse mental health) Strain related indicators of health showed links with perceptions of unfairness Unfairness was least predictive of health when interactional justice was applied Procedural injustice was more predictive of health problems than breach or interactional injustice Distributive injustice more associated with mental health problems Psychological contract breach more predictive of burnout than distributive or interactive injustice	Employees may experience health problems when they experience workplace unfairness Stronger relationship between unfairness and health for strain related indicators of health than physiological or behavioural related indicators Psychological contract breach contributes to prediction of health related outcomes, further than perceptions of unfairness Perceptions of unfairness can be stressors which result in employees experiencing strain if overlooked

Appendix J
Table J1: Cassar & Buttigieg (2015) study details

Author	Sample Details	Study design	Findings	Key implications
Cassar & Buttigieg (2015)	420 full time technical employees & shop floor employees Automobile parts company located in Malta.	Psychometrically valid scales of breach, justice and well-being (anxiety & depression). **Hypotheses:** **1**) breach will mediate relationship between procedural injustice & emotion 2) Breach will mediate relationship between interactional injustice & emotion 3) Breach will mediate relationship of interaction between 2 justices & emotion **Measures: Psychological contract breach:** 4 item measure of exchange imbalance **Emotional well-being**: 2 scales (anxiety-comfort) and (depression-enthusiasm) (Warr, 1990); **Procedural injustice** (Niehoff & Moorman, 1993); 4 item; **Interactional injustice** (Tyler & Schuller, 1990); 4 items **Analysis:** confirmatory & exploratory factor analysis	Exploratory analysis revealed that psychological contract breach and both injustices (procedural & interactional) are distinct There were cross loadings on 2 emotional dimensions Results supported hypotheses 1 & 2 (breach partially mediates relationship between injustice & well-being) Hypothesis 3 was not supported (procedural & interactional justices did not interact) Both forms of justice (procedural & interactional) & breach predicted well-being. Breach was stronger predictor on well-being than justice. Irrespective of injustice level, mediating effect of breach did not change In absence of breach, both procedural and interactional justices are important	Perceived fairness reduces likelihood of breach. Participants reported higher levels of interactional or procedural justice may have a stronger relational contract. Interactional justice had stronger impact on breach and emotional well-being. Interactional justice (way people are treated) influences sense of decision making processes. When people value relationships, they are more likely to feel sense of worth because of trust (Colquitt & Rodell, 2011)

Appendix K

Table K1: Schalk & Freese (2000) study details

Author	Sample Details	Study design	Findings	Key implications
Schalk & Freese (2000)	Longitudinal study 4 health care organisations in the Netherlands (155 employees) 3 organisations provided care for people with mental and physical health problems. 1 organisation provided health care to elderly people. (2 of the health care organisations were involved in a merger and restructuring)	Employees completed questionnaires at 3 time points (6 months apart). Response rate 60% (245 employees for all 3 time points). Complete questionnaire data for 155 employees **Measurements**; assessment of relationship with organisation; employer & employee obligations; affective and continuance commitment Questions about changes and experiences of change process. Questionnaires administered before implementation of change process, 1 month after and 7 months afterwards (1996 – 1998). 29 in-depth interviews with employees, on change of patterns in the psychological contract using a process (balancing, revision & abandonment) Data analysed to test linear structural equation models called Analysis of Moment Structures (AMOS).	Models suggested positive attitudes towards change at specific points in time influenced the perception of employer obligations. Employer and employee attitudes influenced affective commitment & intention to turnover. -'change' was constructed differently by employees and consequences of related to these constructions (some employees did not experience change). Some experienced positive and negative changes. Employees appeared to react to changes which were salient to them and had the strongest reactions due to the saliency 13 of the employees reported changes in perception of organisational obligations. 16 did not report any change but 3 had withdrawn with one leaving, one reducing working hours and one looking for other jobs.	Organisational changes resulted in changes to the psychological contract. Limits were defined by employees as work having negative effects on health, reduced satisfaction from work, feeling hurt by the organisation and if quality of client care was affected Some employees felt that if this line was crossed, they would abandon the contract. Employees would react to change when it became salient. Change had different impacts and could be interpreted as either positive or negative. – Employees experienced satisfaction with change, related to the psychological contract affective commitment and intention to turnover. Patterns of balancing, revision and abandonment

Appendix L

Table L1: Freese, Schalk & Croon (2011)

Author	Sample Details	Study design	Findings	Key implications
Freese, Schalk & Croon (2011)	450 health care workers from Netherlands -3 health care Organisations; 2 (mental or physical health) and 1 (older adults)	3 wave longitudinal design over 1 year: 1st at pre change; 2nd one month after change and 3rd at 7 months **-3 hypotheses:** 1)Organisational change decreases fulfilment of perceived organisational obligations 2) Organisational change decreases fulfilment of perceived employee obligations 3) Organisational change increase number of psychological contract violations 4) Non fulfilment of perceived organisational obligations in related to decreased level of perceived employee obligations 5) psychologic contract violation related to lower affective commitment 6) psychologic contract violation related intention to turnover 7)Organisational change negatively affect affective commitment 8) Organisational change negatively affect intention to turnover **Measurements**; Tilburg contract questionnaire (Freese et al, 2008) composed of 6 parts; 1) demographics 2) perceived organisation obligations (measured by 5 scales: job content, career development, social atmosphere, organisational policies & rewards); 3)violation of contract; 4) employee obligations; 5) organisational commitment & intention to turnover; and 6) Organisational change; -41 interviews conducted - **Analysis via** 6 regression analyses of perceived organisation obligations and 4 regression analyses of affective commitment, continuance & employee obligations; 1 regression of intention to quit	Organisational change results in more psychological contract violations Employees consider non fulfilment of organisational obligations as unacceptable more often during change Organisational policies and rewards were least likely to kept Career development and social atmosphere not affected No direct impact of Organisational change on affect commitment but impact on increased intention to turnover No difference of affective commitment of employees who experience change in last 6 months and those who did not Stronger effect of psychological contract breach for affective commitment than continuance commitment	Confirms that psychological contract is multi-dimensional construct as organisational change had different effects on different contents of contract Evidence of exchange relationship between perceived employee and violation or fulfilment of organisational obligations Limitations as Dutch word for promise has strong meanings too difficult to get implicit meaning in contract

Appendix M

Table M1: Bergin & Ronnestad (2005) study details

Author	Sample Details	Study design	Findings	Key implications
Bergin & Rønnestad (2005)	8 employees recruited from a Swedish psychiatric sector from one county in Sweden 3 physicians; 4 psychologists; 1 social worker and 1 psychotherapist. All physicians were specialists in psychiatry & participants represented different levels within the organisation from therapists to heads of the organisation. 2 participants were members of a management team & 6 were from 2 psychiatric centres.	Participants were selected via theoretical sampling (Glaser & Strauss, 1967). Participants described their work situation & roles Data were analysed to consider segments which related to multiple obligations and altogether 494 segments were discovered and then data was coded into 110 codes. Following this, codes were put into categories until five final categories emerged which included; external demands, internal obligations, conflicts, coping strategies, and professional authority.	External demands of changes in health and society such as demands from policeman's and county authorities and from managers within the organisation. Demands included expectations staff worked efficiently with more patients. External demands from other organisations within society such as social services (Bergin & Ronnestad, 2005). Internal obligations which were based on individual and group values (Bergin & Ronnestad, 2005). Obligations related to participant profession, theoretical framework and decision to work in public sector (Bergin & Ronnestad, 2005). Conflicts included changes within the organisation & were related to changes with the professional identity. Professional authority related to employees feeling less in control of their work situations -Coping strategies including escaping the situation such as taking sick leave and reducing working hours	Changes of beliefs and values is challenging for mental health professionals such as psychiatry as staff need to stay professional for the patients The organisational changes had been influenced by external demands but internal obligations were founded on individual and group values. The obligations were rooted in the professionals within the study One important part of relationship with patients is to be trustworthy and to be honest Changes on a large scale could result in a new organisational culture Staff had experienced 2 types of change; 1)economic and organisation aspects and 2) a change in working methods

Appendix N

Table N1: Rodwell & Gulyas (2015) Study details

Author	Sample Details	Study design	Findings	Key implications
Rodwell & Gulyas (2015)	113 allied health professionals Australian health care organisation	Surveys were distributed across locations for 113 allied health professionals aged 35 to 59 years **Measures:** Organisational commitment (Allan & Meyer, 1990) Psychological distress (Kessler et al, 2002) General well-being (Goldberg, 1972) Contract breach (Robinson & Morrison, 2000) Organisational justice (Colquitt, 200); 4 types (procedural, distributive, interpersonal & informational) Negative & Positive affect schedule (Watson et al, 1988) **Analysis via**: multiple regression & confirmatory factor analysis to assess discrimination between breach & type of justice	Contract breach negatively impacted organisational commitment and well-being which was related to employee emotions. Impact of breach occurred through effects on employee emotions and cognitive assessment of reasons for breach Different effects of organisational justice dimensions as distributive justice was found to improve organisational commitment Interpersonal justice was related to well-being and procedural justice was negatively related to well-being	When organisation breaks their promises, the employees commitment and well-being decreases The effects of distributive justice occurred when employee saw inequity between their inputs compared to other employee inputs/outputs The main effects of breach on allied health professionals was through emotions. Employees excused breach if they believed that there were fair processes to break a promise & out of organisation's control Main effects of procedural justice and interaction with breach reflect amount of input that the employee has regarding decisions compared to other professionals as even if breach occurs, if an allied health professional is able to provide input then the negative impact may be reduced (Positive effect of interpersonal justice on well-being indicated that higher interpersonal justice may increase the negative impact of breach on well-being Suggests closer relationships & respect from the organisation may increase the impact of breach as employees may take a broken promise more personally

Appendix O

Table O1: Cortvriend (2004) Study details

Author	**Sample Details**	**Study design**	**Findings**	**Key implications**
Cortvriend (2004)	31 participants 5 focus groups (4-8 participants)	8main questions Merger and de-merger of PCT in Northern England	Impact of management and leadership style during PCT merger – auto-cratic style associated with more negative attitudes Differences in experience of change, attitudes and behaviour as measured by the psychological contract Culture impacted on participants and coping difficulties Communication described as low People perceived incongruence and perceived expectations as unmet and resulted in exit	Constant cycle of change in NHS New insights into experiences of NHS Management style was important and consequences of managing different cultures Both factors affected experiences of major organisational change for participants Psychological contract appeared to change over time – exit as response to violation To create new conceptual model of change which takes into consideration the perceptions of change and complexities and idiosyncrasies in the NHS

Appendix P

Table P1: Fielden & Whiting (2007)

Author	Sample Details	Study design	Findings	Key implications
Fielden & Whiting (2007)	67 professional staff in NHS Participants e from a community mental health and specialist rehabilitation trust in South of England	Both quantitative and qualitative methods to investigate perceptions & expectations Survey had pre-determined and open questions, adapted from Working in theatres diagnostic tool with questions from the CIPD survey such as key areas in psychological contract (trust between employer & employee Questions as NHS as model employer -.	Health of the psychological contract dependent upon job satisfaction, intention to leave, organisation commitment, and trust between employees and respective managers. Respondents reported that satisfaction with their jobs (68% had scores over five or more on a 7 point scale). Job satisfaction positively correlated with trust in the organisation as well as pay, benefits and employer obligations. 67% of respondents reported working with clients was one of the most satisfying work aspects. Least satisfying element was workload and from people feeling their role or profession was not acknowledged. Employees did not have intention to leave (61%). negative correlation between trust and intuit to leave. Agenda for Change as intention to quit (8 respondents) 28% reported positive levels of commitment and this was correlated with lower levels of intention to leave.	NHS should meet employee needs and wants and exception. Important for an organisation to aim to address as many employee benefits as possible as these need to be met to meet employee expectation Employees were not satisfied by all aspect which shows that the organisation may not be living up to high expectations of employees. Unclear what had in fact been promised and what employees perceived they should have and not shared mutually by the employer The importance is in the strategy at a local level by managers but promises at the national level may not be met locally which may result in perceptions of contract violation

Appendix Q

Initial University Ethics approval form

UNIVERSITY OF HERTFORDSHIRE HEALTH & HUMAN SCIENCES

ETHICS APPROVAL NOTIFICATION

TO **XXXXXX**

CC **XXXXXX & XXXXX**

FROM **XX XXXXXX XXXXXX, Health and Human Sciences ECDA Vice Chairman**

DATE **30/06/2015**

Protocol number: LMS/PG/UH/00419

Title of study: Understanding Mental Health Professionals' Experience of Organisational Change in the NHS

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 01/07/2015

To: 30/06/2016

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix R

Amended University Ethics Approval form

UNIVERSITY OF HERTFORDSHIRE HEALTH AND HUMAN SCIENCES

ETHICS APPROVAL NOTIFICATION

TO XXXXX

CC XXXX and XXXXX

FROM XXXX XXXXX XXXX (central) Ethics Committee Chairman on behalf of the Health and Human Sciences ECDA Chairman.

DATE 30/09/2015

Protocol number: aLMS/PG/UH/00419(1)

Title of study: Understanding Mental Health Professionals' Experience of Organisational Change in the NHS

Your application to extend and modify the existing protocol as detailed below has been accepted and approved by the ECDA for your School.

Modification: Individual interviews with NHS staff will be conducted
Interviews will also be held at University of Hertfordshire premises (LRC)

This approval is valid:

From: 30/09/2015

To: 31/07/2016

Please note:

Any conditions relating to the original protocol approval remain and must be complied with.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1 or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit a further EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

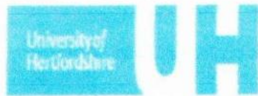
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix S:

University Ethics Risk Assessment Form



SCHOOL OF LIFE AND MEDICAL SCIENCES RISK ASSESSMENT

Ref No:	
Date:	
Review Date:	

For assistance in completing this form, please see the Guidance Notes at the end

ACTIVITY INFORMATION	
Name of Assessor/ Contact details	Name: [redacted] Email: [redacted] Ext no: [redacted]
Title of Activity	Understanding Clinical Psychologists' Experience of Organisational Change in the NHS (Focus groups)
Location of Activity	NHS Trust premises
Description of Activity Please attach a copy of the protocol, procedure, SOP etc applicable	The activity will involve two focus groups: • One with 6 Clinical Psychologists • One with the respective Line Managers (6 maximum) SOP of the focus group include: • Introduction to the group, setting ground rules, explaining confidentiality • Introducing the topic of psychological contracts* and the impact of changes in organisation • Discussing the topic from schedule of questions • Closing the discussion and debriefing participants *The topic and list of questions are explained in the main ethics form
Personnel Involved	6 Clinical Psychologists and their respective Line Managers

TYPES OF HAZARD LIKELY TO BE ENCOUNTERED		
☐ Animal Allergens ☐ Biological Agents (see COSHH) ☐ Chemical Compounds (see CoSHH) ☐ Compressed/liquefied gases ☐ Computers ☐ Electricity ☐ Falling Objects ☐ Farm Machinery ☐ Fire	☐ Hand Tools ☐ Ionising Radiation ☐ Office Equipment ☐ Laboratory Equipment ☐ Ladders ☐ Manual Handling ☐ Non-ionising Radiation ☐ Hot or cold extremes ☐ Repetitive Handling ☐ Severe Weather	☐ Sharps ☒ Slips/trips/falls ☒ Stress ☐ Travel ☐ Vacuum systems ☐ Pressure systems ☐ Vehicles ☒ Aggressive response, physical or verbal* ☐ Workshop

Appendix S:

University Ethics Risk Assessment Form

SCHOOL OF LIFE AND MEDICAL SCIENCES
RISK ASSESSMENT

☐ Glassware Handling		Machinery
The above is not an exhaustive list – all other hazards should be listed here. *Possible emotional reactions during or after focus group as a result of topics discussed.		

HAZARD ASSESSMENT						
Severity of Consequences	Score	Risk Classification				
No or minor injury/ health disorder Minor Damage or Loss Insignificant Environmental Impact Group 1 Biological agents	1	Trivial (1)	Trivial (2)	Trivial (3)	Trivial (4)	Tolerable (5)
Injury or Health Disorder – resulting in absence up to 3 days Moderate Damage or Loss Moderate Environmental Impact Group 2 Biological agents	2	Trivial (2)	Trivial (4)	Tolerable (6)	Tolerable (8)	Moderate (10)
Injury or Health Disorder – resulting in absence over 3 days Substantial Damage or Loss Serious Environmental Impact Group 3 Biological agents	3	Trivial (3)	Tolerable (6)	Moderate (9)	Moderate (12)	Substantial (15)
Long Term Injury or Sickness – resulting in permanent incapacity Extensive Damage or Loss Major Long Term Environmental Impact	4	Trivial (4)	Tolerable (8)	Moderate (12)	Substantial (16)	Intolerable (20)
Death Serious Structural Damage Environmental Catastrophe Group 4 Biological agents	5	Tolerable (5)	Moderate (10)	Substantial (15)	Intolerable (20)	Intolerable (25)
Note on Risk Classification:	Likelihood	1	2	3	4	5

2

Please think before printing the attached guidance notes – do you really need them?
RA 2015

Appendix S:
University Ethics Risk Assessment Form

SCHOOL OF LIFE AND MEDICAL SCIENCES
RISK ASSESSMENT

1-4 Trivial 5-7 Tolerable 8-12 Moderate 13-16 Substantial >20 Intolerable		Almost Impossible	Unlikely – possible exposure every 1-3 years	Harm is possible	Harm is likely to occur	Harm will occur or is very likely to occur.

RISK CONTROL MEASURES
Are the local code of practice and/or local rules adequate to control the risks identified? Yes/No Please list: -Participants will be informed of the potential risks involved in taking part in focus groups via information sheet. -Participants will have a chance to ask principle investigator and supervisor any questions they are unsure about before the focus groups. -Participants can withdraw from the focus group at any point and their data can also be withdrawn -Participants will be debriefed as a group after the focus group and will have the chance to speak to the principal investigator or supervisor individually after the group -Participants will be given the contact number of supervisor and principal investigator and relevant support websites after the group Please list all additional measures required. n/a
Local Code of Practice and Local Rules applicable [redacted] health & safety code of practice. Additional Measures: n/a

ASSESSMENT OF RESIDUAL RISK			
Hazard	Likelihood Score	Severity Score	Risk Classification
No/or minor injury	1	1 (trivial)	Almost impossible

3

Please think before printing the attached guidance notes – do you really need them?
RA 2015

Appendix S:
University Ethics Risk Assessment Form

SCHOOL OF LIFE AND MEDICAL SCIENCES RISK ASSESSMENT

EFFECT OF RISK CLASSIFICATION	
Risk Classification	Action
Trivial	No further action required. Activity can begin.
Tolerable	No additional controls required. Current controls must be maintained and monitored.
Moderate	Reduce risks if cost effective. Implement new controls over an agreed period.
Substantial	Activity cannot begin without major risk reduction.
Intolerable	Activity must not begin.

HEALTH SURVEILLANCE ISSUES	
Persons at Special Risk	n/a
Health Surveillance Measures (including symptoms and signs of exposure)	n/a
Exclusions	n/a

SIGNATURES				
	Staff/PhD student/MSc student/Undergraduate	Name (Print)	Signature	Date
Assessor	[redacted]	[redacted]	[redacted]	[redacted]
Supervisor (if Assessor is a student)	[redacted]	[redacted]	[redacted]	[redacted]
Local Health and Safety Advisor / Laboratory Manager	[redacted]	[redacted]	[redacted]	[redacted]

4

Please think before printing the attached guidance notes – do you really need them?
RA 2015

Appendix T

University Permission to use Library space

Student Name: XXXXXX
Student SRN: 13088950

Sept 2015

Re: Letter to Ethics Committee

This is to confirm that you have permission to conduct interviews in the College Lane Learning Resources Centre for the purpose of collecting data to complete a research project/dissertation. A letter to the Ethics Committee is attached.

Permission is given on the condition that:

- Ethics approval to conduct the interview is granted.
- There is no disruption to other students or staff using the LRC at the same time. Users must not in any way violate the privacy of other users or deliberately disrupt their work (University Policy and Regulations SA12 9.1.4 refers).
- The interview/s are conducted in either a study room booked in the usual way via https://www.studyrooms.herts.ac.uk or the LRC Lobby booked via XXX@herts.ac.uk
- The area booked is used appropriately and sensibly, and left tidy once the process has been completed.

Yours sincerely

Learning & Teaching Space Manager

Direct Line XXXX XXXXX

Email: XXXXX@herts.ac.uk

Appendix U

Generic Email to NHS Trust R & D

Dear R & D Manager,

I am a Trainee Clinical Psychologist based at Hertfordshire University. Please see attached form for recruitment of Mental Health Professionals from XXXX for a research study on their experience of change within the NHS. Please note that this would involve trust wide recruitment as I have not identified a particular team or site in which to conduct the research at the present. I am hoping to recruit a wide range of mental health professionals such as both psychological, occupational and medical in order to provide a representative sample of mental health professionals within the NHS.

I have also attached the following documentation:

-University of Hertfordshire Ethics approval
-Study Protocol
-Consent form
-Information sheet

I shall await to hear from you in terms of recruitment protocol.

Best wishes,

XXXXXXX
3rd Year Trainee Clinical Psychologist

Appendix V

Study Protocol Information for NHS Trusts

Purpose of Study

The aim of the study is to investigate the experience of organisational changes by Mental Health professionals in the NHS and the impact of this change on participants' perception of the psychological contract with organisation.

Rationale

The NHS is changing at both local and national levels (Cortvriend, 2004). The release of the Francis Report (2013) implies that quality of patient care is decreasing (Everest, Fitzgerald & Tate, 2014). This suggests that work related stress could be damaging to both staff and patients (West, Dawson, Admasachew & Topakas, 2011). Indeed, service redesigns can place staff at risk of stress and disengagement (Beck, 2014). The majority of research on organisational change has been carried out in corporate settings, with a dearth of research on the psychological impact of change on NHS staff (Cortvriend, 2004). Mental Health Professionals in the NHS have experienced organisational changes, but there is a lack of research on the psychological impact of change in the NHS.

The Psychological Contract

One way of accessing staff attitudes about change and the impact of this is to look at staff member's understanding of their contract with the employing organisation. The term 'psychological contract' refers to mutual expectations between the person and organisation, based on reciprocation and related to mental health outcomes (Levinson, Price, Munden, Mandl, & Solley, 1962). Levinson (1965) believed that people are motivated to fulfil their psychological needs through work, and organisations gave people the opportunity and tools.

Rousseau (1989) defined contract as "the promises that employees believe were made to them by their employer probably prior to them entering the organisation" (George, 2009, p.3). Contracts are both transactional and relational (Rousseau, 1990). Transactions include economics such as hours, pay and work flexibility (George, 2009). Relational aspects focus on the 'whole person' (George, 2009), and include trust in return for competent management and belonging (Maguire, 2002).

Rousseau (1990) saw the organisation as the principal contract holder and agents as representative such as Line Managers. Indeed, new employees can learn about mutual promises and obligations through observing the behaviour of through agents such as Line Managers (Conway & Briner, 2005). Employees can divide the contents across different agents, such as transactions with Human Resources and relational aspects with supervisors (Conway & Briner, 2005).

Content and processes of the contract

Reciprocation allows employees to achieve gains from the organisation, which is strongly linked to well-being (Conway & Briner, 2005). The contract involves mutuality of understandings of obligations which is facilitated by interactions between managers and employees (Dabos & Rousseau; Conway & Guest, 2002). Research has found that both reciprocity and mutuality were beneficial for both employees and organisation (Rousseau & Dabos, 1994).

Appendix V

Study Protocol Information for NHS Trusts

Professional workers undergo processes of both organisational and professional socialisation when starting their careers (George, 2009). Early in socialisation, the contract may be more transactional (George, 2009). However, it has been found that established professionals across a range of industries viewed contracts of newcomers to be relational (Kelly-Patterson & George, 2001).

Involvement of Participants

The research will involve Mental Health Professionals in a local NHS Trust (Hertfordshire Partnership Foundation Trust). The study will explore participants' views of their Psychological Contract in the NHS since they started employment in the organisation. As the contract is a multi-dimensional construct and can be viewed differently (Conway & Briner, 2005) it will also involve comparing the views of staff members.

The main focus of the research is to explore Mental Health Professionals' views of the content of the contract such as mutuality of understandings and reciprocity (exchanges). Secondly in terms of the process of the contract, the research will explore participants' perceptions of changes to the contract due to organisational changes and the impact of this such as change to identity with the NHS or team.

Summary of Main Aims

- To understand Mental Health Professionals' perceptions of the psychological contract;
- To understand Mental Health Professionals' perceptions of changes in the NHS;
- To understand Mental Health Professionals' perceptions of impact of change on the contract
- To compare Mental Health Professionals' perceptions of change on the contract with their team colleagues.
- To compare changes to Mental Health professionals' identity within the NHS compared with their team identity

Design

The research will use a qualitative design. Participants will include Mental Health Professionals from Multi-disciplinary teams (MDT) within a local NHS Trust which has recently experienced organisational restructuring.

Sample Size

There will be approximately 8-10 Mental Health Professionals as this number has been advocated as an adequate sample for a thematic analysis (Kuzel, 1992). This will require a purposive sample.

Two other NHS Trusts will also be approached to take part in the research study and it is estimated that approximately 3 NHS Trust will participate altogether. 8- 10 participants will be recruited from each NHS Trust.

Participants

Participants will be Mental Health Professionals from the following groups:

- Community Mental Health Nurses
- Community Support Workers
- Psychologists

- Psychiatrists
- Psychotherapists
- Family Therapists
- Occupational Therapists
- Art Therapists
- Music Therapists
- Counsellors
- Social Workers

Inclusion criteria
Mental Health professionals working as a member of a multi-disciplinary team, within a Mental Health Trust that has experienced organisational change within the past four years. Agency staff are eligible to take part if they have worked at the NHS Trust for at least one year.

Exclusion criteria
A NHS trust which has not experienced organisational change within the past four years.
Mental Health Professionals who have worked at the organisation for less than a year.
Mental Health Professionals who have line management responsibilities for some/all members of a multidisciplinary team, will be excluded from participating due to potential confounding impact of the supervisor being present in the interviews along with some of their team members.

Stage1: Identifying teams & introducing research study
Mental Health Professionals from teams within the Trust will be approached who have been identified via the Psychological Service Lead. The main investigator (XXXXX XXXXXX) will contact team leaders and then arrange to visit these teams. The main investigator will provide information about the study to team members such as time commitment and eligibility to participate.

Stage 2: Recruiting participants
Team members who are eligible and would like to take part, will then approach their line manager. They will notify their line manager of their interest. They will then need to gain verbal consent from their line manager to participate in interviews during work time. Once their line manager has provided verbal consent, they will then complete the participant list for to provide the following information: Their role and preferable time and location to take part in interviews

Stage 3: Obtaining consent from participants
Line managers will then email the participant list (password protected) to the main investigator. The main investigator will then request contact details from the line manager for the participants. The participants will then be emailed or posted an information sheet and consent form. They will need to sign and return to researcher, either on password protected file or post.

Once a suitable time and date has been arranged for team members, they will then be contacted directly by the main investigator to confirm a date, time and location. If they have any queries in the meantime, they will be able to contact the main investigator either by phone or email.

Stage 4: Conducting Interviews

Participants will consent will participate in an interview. The interviews will follow a standard format (Ritchie, Lewis, McNaughton Nicholls & Ormston, 2003) of 4 stages; 1)Individual introductions, 2) Opening topic, 3) discussion and 4) ending discussion. A schedule of questions will be expanded from the four research aims. These questions will be piloted beforehand with Mental Health Professionals, who are colleagues of the researcher.

The interviews will be audio recorded by the main investigator. Any information discussed will remain confidential. The personal identifiable information in the recordings will be anonymised in transcription. The original recordings will be kept securely (where) and only the main investigator will have access to the password. The data will be reported in anonymised form

Number of Interviews

There will be 8-10 interviews per NHS Trust. Three NHS Trusts will also be contacted altogether to take part in interviews. This means that each NHS Trust will take part in 8- 10 semi-structured interviews. There will be 24-30 interviews conducted in total across NHS Trusts.

Location of Interviews/interviews

The interviews/interviews will take part in rooms booked at the NHS premise which will depend on a location that can be booked for people and is convenient for all those taking part. The interviews will take place in an available rooms at the NHS Trust where discussions will not be overheard by other staff. The people present will include the main investigator and participants. The interviews will take place at NHS Trust Premises. There will also be an option for staff to take part in interviews at University of Hertfordshire Premises. The University has been contacted about this and the University Library has provided consent for interviews to be conducted in bookable rooms.

Duration of Interviews

The interviews will be conducted during working hours, preferably at a time that is least disruptive to working hours that is agreed by line managers. The groups/interviews will be one hour maximum, with 10 minutes either side for introductions, debrief and an opportunity for participants to ask any questions.

Stage 5: Analysis of Interviews/Interviews

The transcriptions from interviews will be analysed using a thematic analysis recommended by Braun and Clark (2006). The thematic analysis will follow six stages: familiarisation with data; initial coding; searching for themes; reviewing themes; defining and naming themes and producing the report. This analysis will produce themes which will be used to make sense the transcriptions from the interviews.

Stage 6: Report of findings

The study will then be written up as part of the main investigator's clinical psychology doctoral thesis. Once the thesis is finalised, it will be accessible to the public. Findings will also be submitted to a peer review journal article for publication. The names of the participating NHS Trusts will be anonymised. Participants will also have a chance to see a summary of the report. The main investigator will contact participants when the report is completed and they will be emailed or posted a copy of this report. They will also be able to contact the main investigator to ask any questions about the report. This report will anonymous and confidential and no personal identifiable information will be included.

Benefits of taking part

Participants will also have the chance to attend a free CPD workshop which will take place at on the NHS Trust premises. The workshop will be conducted by XX XXXXX XXXXXX (Clinical Psychologist) and the field supervisor, XX XXXXXXXX XXXXX (Occupational Psychologist). Participants will be given a choice of workshops topics that are relevant to their professional skills area. The workshop will contain strategies to aid professional development in the relevant chosen areas. The facilitators will aim to organise workshops so that professionals are able to attend a workshop with fellow professionals that is suitable to their skill area (i.e. occupational therapists attending the same workshop). However, this may not be possible in all cases but there may be some overlap in topics that participants are interested in such as 'leadership'.

Ethical concerns
British Psychological Code of Human Research Ethics (2014) ethics will be adhered to, this will concern the following:

- Participants will give informed consent to take part in the interviews and will be given an information sheet
- All personal identifiable information will remain confidential inside and outside of the NHS Trust in line with the 6 key principles of the Caldicott Report (1997)
- Data will be stored for up to 5 years
- Participants' data will stored separately in a password protected, encrypted file but will be matched to a unique code so that their data can be matched and withdrawn if they wish.
- The data will be stored securely in line with the Data Protection Act (1998).
- Access to data will be restricted to researchers involved by password protecting the data files
- Participants can withdraw at any point and up to 6 months after the study.
- All participants will be debriefed and given contact details of the supervisor/investigator and online counselling websites.

Risks/burden:
The potential risks to participants include if the interviews raise any potentially emotional distressing material around topics of organisational change. If any do arise in the course of the study, participants will be able to speak to the project lead, Dr XXXXXXX XXXX or XXXX XXXXXX about their concerns. Contact details for this will be included on information sheets. Participants will also be directed to counselling/mental health websites, details of which are included on the information sheet.

Conflict of Interest:

There are no conflicts of interest either by researchers involved. Data from the study will be disseminated as part of the Clinical Doctorate Thesis. Participants will also have the chance to see findings if they wish in a summary report. This report will anonymous and confidential and no personal identifiable information will be included.

Appendix W

Participant Information sheet

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

PARTICIPANT INFORMATION SHEET

Title of study
Understanding Mental Health Professionals' Experience of Organisational Change in the NHS

Introduction
You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulations governing the conduct of studies involving human participants can be accessed via this link:

http://sitem.herts.ac.uk/secreg/upr/RE01.htm

Thank you for reading this.

What is the purpose of this study?

The purpose of the study is to investigate the experience of Mental Health Professionals of organisational changes since they started working. The study will also compare these views with the views of fellow Mental Health Professional team members.

Do I have to take part?
It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not affect your job or any role you may have in relation to the university. You will have the opportunity to withdraw up to 6 months after taking part.

Are there any age or other restrictions that may prevent me from participating?

To be eligible for the study you need to be a Mental Health Professional working as a member of a multidisciplinary team who has worked in the Trust for at least 1 year. You should not have line management responsibilities for other members of your team.

How long will my part in the study take?

If you decide to take part, you will be invited to take part in an individual semi-structured interview. The interview will be held in a suitable room on Trust premises or in a room at the library of the University of Hertfordshire.

The interview will involve questions exploring:

- Your perception of working in the organisation
- Your perceptions of the impact of change within the organisation

The interviews will be recorded for transcription purposes but all information will remain confidential and personal identifying information will be made anonymous.

What will happen to me if I take part?
You will be contacted by the main investigator to agree the time and place for the interview to take place. You will have a chance to ask any questions about the study.

If you would like to part, you will be asked to sign a consent form. This will detail your rights to withdraw at any time as well as confidentially and anonymity of information.
You will have the right to withdraw from the study at any point and up to 6 months later if you so wish.

What are the possible disadvantages, risks or side effects of taking part?
The interviews may bring up distressing psychological issues for you around organisational change; however this is unlikely. Participants can leave the interviews any point. They will do this by verbally announcing their wish to leave.

Participants will be given a full debriefing after the interview and will also be able to speak to the main investigator individually. They will also be given contact details of the principal supervisor and field supervisor if they wish to discuss any issues afterwards

Participants may also seek support from the following resources should they wish to:

'Sane Line' (www.sane.org.uk/what_we_do/support/helpline)

'Mind' (www.mind.org.uk)

'7 Cups of Tea', free listening service (www.7cupsoftea.com)

What are the possible benefits of taking part?
All participants who take part in the study and their Multi-disciplinary Team (MDT) colleagues will be able to attend a free continued professional development workshop that will be offered by the principal supervisor and/or field supervisor who is an occupational psychologist.

How will my taking part in this study be kept confidential?
The interviews will take part in a closed room at the NHS Trust or at the University of Hertfordshire Library. The other people present will include the main investigator. Any information discussed will remain confidential and any personal identifying information will be anonymised in transcription.

Transcripts containing personal identifiable information (PII) will be protected at all times. This means that participant names will not be stored on any database and they will be assigned a unique numeric code instead. Any information discussed within the interviews will remain confidential and will not be shared with work colleagues within the Trust or with anyone else.

Appendix W

Participant Information sheet

You will be assigned the unique numerical data code when you take part in the interview. If you wish to withdraw, you will be able to contact the main investigator/supervisor and quote this code to have your data removed, up to 6 months after participating in the research.

What will happen to the data collected within this study?
The data will be stored securely in line with the Data Protection Act (1998). Access will be restricted to researchers involved by password protecting the data files.
You will have a chance to see a report with findings once these have been written up approximately 6 months after the interview has taken place. The study will also be submitted to a journal for publication. Data will be stored for up to 5 years.

Who has reviewed this study?
This study has been reviewed by:
The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority

The UH protocol number is: aLMS/PG/UH/00419(1)

Who can I contact if I have any questions?
If you would like further information or would like to discuss any details personally, please get in touch with me, in writing, by phone or by email:

Main Investigator:XXXX, email: XXX@herts.ac.uk, phone:
Principal Supervisor:XXXX; XXXX @herts.ac.uk;
Field Supervisor: Dr XXX XXX@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix X
Participant Consent form

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

………
Of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..………………………………………………………………………………………………………
Thereby freely agree to take part in the study entitled 'Understanding Mental Health Professionals'' Experience of Organisational Change in the NHS'

………

1. I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, and any plans for follow-up studies that might involve further approaches to participants. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2. I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason for up to 6 months after participating.

3. In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place.

4. I have been given information about the risks of my suffering harm or adverse effects. I have been told about the aftercare and support that will be offered to me in the event of this happening, and I have been assured that all such aftercare or support would be provided at no cost to myself.

5. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

6. I understand that my participation in this study may reveal findings that could indicate that I might require medical advice. In that event, I will be informed and advised to consult my GP. If, during the study, evidence comes to light that I may have a pre-existing medical condition that may put others at risk, I understand that the University will refer me to the appropriate authorities and that I will not be allowed to take any further part in the study.

7. I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

8. I have been told that I may at some time in the future be contacted again in connection with this or another study.

Appendix X
Participant Consent form

For further information, please contact:

Main investigator:XXXXX, email; XXXXherts.ac.uk, mobile: XXXXXX or XXXXX, email XXXX@herts.ac.uk;

Signature of participant…………………………………..…Date………………………….

Signature of (principal)
investigator……………………………………………………Date…………………………

Name of (principal) investigator *XXXXX XXXXXXX*

……………………………………………………………………………………………..

Please sign and return completed consent forms by post in the SAEs provided to the address below:

XXXXXX, Trainee Clinical Psychologist

University of Hertfordshire

XXXXX & XXXXX XXXXX Research

XXXXX & XXXXX Building

XXXXXX XXXX Campus

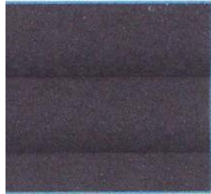
XXXXXXXX, XXXX XXX

Alternatively, these can be sent on a password protected file by email:

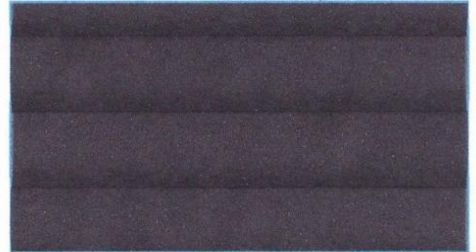
XXXXX @herts.ac.uk

Appendix Y

Initial Ethics Approval from Trust 1



R&D Department



17th July 2015

Permission for research

I am writing to inform you that permission has been granted on behalf of for the following research project, on the basis described in the application form, protocol and supporting documentation.

Study details:

Study Title	Understanding Mental Health Professionals' Experience of Organisational Change in the NHS
Chief Investigator	
Sponsor name	University of Hertfordshire
study number	
University of Hertfordshire REC ref.	LMS/PG/UH/00419

NHS organisations and locations:

Organisation giving permission	Date of permission	Sites to which permission applies
	17/07/15	All sites within this organisation subject to local management approval

Appendix Y

Initial Ethics Approval from Trust 1

The documents reviewed were:

Document	Version	Date
REC Approval letter	University of Hertfordshire REC	30/06/15
Study protocol "Overview of study"	Version 4	16/07/15
Consent form	Version 4	16/07/15
Participant Information Sheet	Version 4	16/07/15
Participant list for focus groups	Version 3	16/07/15
Interview Schedule for focus groups	Version 4	16/07/15
Researcher CVs		Various
Email correspondence	Psychological Services Lead)	Various

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), the Data Protection Act (1998) and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the REC or university ethics committee and which have been authorized by the MHRA (if applicable).

The following local conditions will apply:

1. Sponsorship of Study

The research Sponsor will be the organisation named above; the management and design of the study is not the responsibility of the Trust or Trusts giving permission.

2. Confidentiality

You are required to ensure that all information regarding participants remains secure and ***strictly confidential*** at all times. You must ensure that you understand and comply with requirements of the Data Protection Act (1998) and the NHS Confidentiality Code of Practice. Furthermore, you should be aware that under the Data Protection Act (1998), unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

3. Researcher Authorisation

Only those researchers holding a letter of access or honorary research contract, as appropriate, from may have direct contact with the participants of this study or to their patient files, unless they already have a substantive honorary contract with the Trust.

4. Urgent Safety Actions

The research sponsor, the Chief investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. This office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. This office should be notified within

Appendix Y

Initial Ethics Approval from Trust 1

	the same time frame of notifying the REC and any other regulatory bodies.
5. Serious Adverse Events	Should an SAE occur during the course of the project, this office must be notified immediately. This is in addition to your legal duty to report such events to the Sponsor.
6. Amendments	All amendments (including changes to the local research team) need to be submitted in accordance with guidelines in IRAS. This office should be informed at the same time as the REC or university ethics committee is notified in order to avoid any unnecessary delays.
7. Indemnity	You must check with the Sponsor that the indemnity arrangements, as confirmed in the Sponsor's Declaration and described in the application forms, are in place before any participants are recruited.
8. Study Progression	You will inform us of any significant developments that occur as the study progresses. You will complete and return any report forms that we send you and provide up to date information on the number of participants recruited when asked.
9. Audit of Study	You may also be subject to a random audit of research which will involve a site visit, a requirement to view study documents and a request to interview researchers.
10. Study Completion	You will notify the Chief Investigator and this office when the study has completed recruiting participants and when the study has finally finished at your site. You will complete and return the final report that we send you and inform us of any publications relating to the study.
11. Presentation of Findings	[redacted] expects that the findings of this study will be presented to members of the appropriate service line. You should contact the service line research lead upon completion of the study to arrange a suitable venue and time.

Finally, I wish you every success with the study.

With kind regards

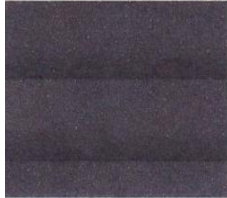
[redacted]

Manager, Research and Development Department

[redacted]

Appendix Z

Amended Ethics Approval from Trust 1



R&D Department

2nd October 2015

Dear

Permission for research

I am writing to inform you that confirmation of your amendment (Amendment 1) has been approved on behalf of Trust, for the following research project, on the basis described in the supporting documentation you have provided.

Study details:

Study Title	Understanding Mental Health Professionals' Experience of Organisational Change in the NHS
Chief Investigator	
Sponsor name	University of Hertfordshire
study number	
University of Hertfordshire REC ref.	LMS/PG/UH/00419

NHS organisations and locations:

Organisation giving permission	Date of permission	Sites to which permission applies
	2/10/15	All sites within this organisation subject to local management approval

Appendix Z

Amended Ethics Approval from Trust 1

The documents reviewed were:

Document	Version	Date
Letter from [redacted]	Outlining Amendment	17/09/15
Amended Documents	Single document detailing all proposed amendments	-
Study protocol "Overview of study"	Version 5	01/10/15
Consent form	Version 5	01/10/15
Participant Information Sheet	Version 5	01/10/15
Letter from [redacted]	Permission to conduct interviews at University of Hertfordshire	02/10/15

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), the Data Protection Act (1998) and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the REC or university ethics committee and which have been authorized by the MHRA (if applicable).

The following local conditions will apply:

1. Sponsorship of Study — The research Sponsor will be the organisation named above; the management and design of the study is not the responsibility of the Trust or Trusts giving permission.

2. Confidentiality — You are required to ensure that all information regarding participants remains ***secure*** and ***strictly confidential*** at all times. You must ensure that you understand and comply with requirements of the Data Protection Act (1998) and the NHS Confidentiality Code of Practice. Furthermore, you should be aware that under the Data Protection Act (1998), unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

3. Researcher Authorisation — Only those researchers holding a letter of access or honorary research contract, as appropriate, from [redacted] Trust may have direct contact with the participants of this study or to their patient files, unless they already have a substantive honorary contract with the Trust.

4. Urgent Safety Actions — The research sponsor, the Chief investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. This office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. This office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

Appendix Z

Amended Ethics Approval from Trust 1

5. Serious Adverse Events	Should an SAE occur during the course of the project, this office must be notified immediately. This is in addition to your legal duty to report such events to the Sponsor.
6. Amendments	All amendments (including changes to the local research team) need to be submitted in accordance with guidelines in IRAS. This office should be informed at the same time as the REC or university ethics committee is notified in order to avoid any unnecessary delays.
7. Indemnity	You must check with the Sponsor that the indemnity arrangements, as confirmed in the Sponsor's Declaration and described in the application forms, are in place before any participants are recruited.
8. Study Progression	You will inform us of any significant developments that occur as the study progresses. You will complete and return any report forms that we send you and provide up to date information on the number of participants recruited when asked.
9. Audit of Study	You may also be subject to a random audit of research which will involve a site visit, a requirement to view study documents and a request to interview researchers.
10. Study Completion	You will notify the Chief Investigator and this office when the study has completed recruiting participants and when the study has finally finished at your site. You will complete and return the final report that we send you and inform us of any publications relating to the study.
11. Presentation of Findings	████ expects that the findings of this study will be presented to members of the appropriate service line. You should contact the service line research lead upon completion of the study to arrange a suitable venue and time.

Finally, I wish you every success with the study.

With kind regards

Manager, Research and Development Department

Appendix A1

Ethics email confirmation from Trust 2

NHS Trust

on behalf of

Thu 22/10/2015 14:10

Inbox

To:

Cc:

You replied on 22/10/2015 16:34.

Dear

The advice from the research office is that if it is only staff you are interviewing, it is not necessary for the research office to put trust permission in place for you to proceed.

For our records, can you please respond to this email confirming that it is only staff you will interview.

We do appreciate having your University of Hertfordshire ethics approval and protocol on file, so we can record your study activity.

Regards

Research Team Administrator

Information for researchers:
NIHR Clinical Research Network:

Appendix B1

Trust 3 NHS REC Approval

Thank you for your call. As discussed, please find our generic email below which will help you to establish if your study is research:

Before we can advise if you will need to make an application for NHS Permission for your study, we need to confirm that the project is indeed research.

The Health Research Authority (HRA) provides online decision tools to assist you in determining whether your project is classified as research on http://www.hra-decisiontools.org.uk/research/ and "Defining Research" leaflet (http://www.hra.nhs.uk/documents/2013/09/defining-research.pdf) which provides more detailed information to help you decide if a project is research, or whether it is some other activity such as Audit, Service Evaluation or Public Health Surveillance.

Provided that the information you have entered is correct the outcome delivered by the decision tools may be taken as an authoritative decision. You do not need to seek further confirmation. Please note that projects other than research (which do not require NHS permission) must instead be approved by the relevant trust Clinical Governance representative.

If after using the decision tools, you disagree with the outcome or are unsure of whether you have answered the questions appropriately, further clarification can be obtained by contacting the Queries Line (hra.queries@nhs.net). If you are requesting further advice your email should include the following information:

* Project title
* IRAS Project ID (if available)
* An A4 summary outlining your proposed project (one side only: 1,000 words max)
* A PDF or screenshot of the results page of the decision tool(s)
* An explanation of which questions you have difficulty in answering and why and/or
* An explanation of why you disagree with the outcome of the decision tool(s)

Please note: responsibility for determining if an activity is research (and whether the research requires review, including ethics approval within the Research Governance Framework) sits ultimately with the sponsor and investigator.

Please let me know the outcome so that I can advise you further.

Please do not hesitate to contact me if you have any query.

Kind Regards,

Noclor Research Support Service

Appendix B1

Trust 3 NHS REC Approval

MRC Medical Research Council

NHS Health Research Authority

Do I need NHS REC approval?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Understanding Clinical Psychologists' Experience of Organisational Change in the NHS

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England.** However, **you may need other approvals.**

You have answered ***'YES'*** to: Is your study research?

You answered ***'NO'*** to all of these questions:

Question Set 1

Appendix C1

Trust 3 Email Ethics approval to recruit staff

From: Noclor Contact
Sent: 28 September 2015 16:54
To:
Subject: RE: Noclor R&D

Dear

Thank you for your email.

Projects are registered with noclor if they utilise NHS patients, staff, records, facilities or other resources of NHS.

As we deem your study does not use any NHS resources (and its evident from HRA decision tool), you will not need to register with us, nor gain a favourable opinion from the National Research Ethics Service, nor seek our permission for commencement of this project.

You will need to contact the Clinical Governance team about your proposed study. I believe is part of the Clinical Governance team and should be able to advise you. Her email is

I wish you every success with your research. Do feel free to get in contact if you have any other queries.

Kind Regards,

Noclor Research Support Service

Assistant Research Facilitator

From:
Sent: 28 September 2015 16:49
To: Noclor Contact
Subject: RE: Noclor R&D

Dear

Thank you for sending this. I have received the same response from HRA decision tool that the study is not research, please see attachment.

Please can you advise on the procedure for recruitment.

Best wishes,

From:
Sent: 28 September 2015 15:59
To:
Subject: Noclor R&D

Appendix D1

Generic email to Line Managers regarding recruitment

Dear…

I am a 3rd year Clinical Psychology Trainee based at Hertfordshire University. I have been passed your contact details by XXX XXXXX as I am hoping to conduct my Doctoral dissertation on exploring Mental Health Professionals' views of change in the NHS. The project has gained ethical approval from the University of Hertfordshire and from the Trust's R & D department. Two other NHS Trusts are taking part in the study and all details will remain anonymous and confidential.

I was wondering if it would be possible to visit one of your team meetings to discuss the research project with staff. The project would involve staff taking part in interviews and discussing their experience of change in the NHS. The staff should have been employed by XXXX for at least 6 months to one year and have experienced the impact of change in the Trust. They can be from different mental health professions (psychologists, psychiatrists, CMHT nurses, etc). The interview will take part on XXXX premises so staff would not have to travel. Further, the principal supervisor and field supervisor who is an Occupational Psychologist will run a CPD workshop for all staff to attend.

If you would be happy for your staff to take part, I can send you further information in the form of information sheets, consent forms, overview and interview schedule. In the meantime, please let me know when it would be suitable to meet staff to discuss this.

Thanks for your help with this.

Best wishes,

3rd year Trainee Clinical Psychologist
Mobile: XXXXX XXXXXX

Appendix E1
Generic recruitment email to Mental Health Professionals

Dear Mental Health Professional,

You are being invited to take part in an interview on your experience of change in the NHS at XXXX. The interviews are being run as part of my Clinical Doctoral Thesis project at Hertfordshire University. The interviews will involve discussing the impact of change on working in the NHS. Interviews will be one hour in duration with 10 minutes either side for introduction and debrief. The interviews will take part on XXXX premises or at the University Library facilities.

In order to take part, you should be a Mental Health Professional who has worked at XXXX for at least one year. If you would like to take part during work time, you will need to obtain verbal consent from your Line Manager. Interviews will be audio recorded for transcription purposes. All information will remain anonymous and confidential and no personal identifiable information will be included.

Two other NHS Trusts have been approached to take part and no names of NHS Trusts will be mentioned in the write up of findings. A summary report will be provided for your information and findings will be discussed in my Doctoral thesis.

Refreshments will be provided. If this is something that you feel that you would you like to do, then please read the attachment for further information and how to take part. Please email: XXXXX or phone: XXXXXXXXXXX for further information.

Thanks for your help with this.

Best wishes,

XXXXXX
3rd Year Trainee Clinical Psychologist

Appendix F1

Overview of study for Mental Health Professionals

Overview of Study

Title: Understanding Mental Health Professionals' Experience of Organisational Change in the NHS

Purpose of Study

The aim of the study is to investigate the experience of organisational changes by Mental Health professionals in the NHS and the impact of this change on participants' perception of the psychological contract with organisation.

Rationale

The NHS is changing at both local and national levels (Cortvriend, 2004). The release of the Francis Report (2013) implies that quality of patient care is decreasing (Everest, Fitzgerald & Tate, 2014). This suggests that work related stress could be damaging to both staff and patients (West, Dawson, Admasachew & Topakas, 2011). Indeed, service redesigns can place staff at risk of stress and disengagement (Beck, 2014). The majority of research on organisational change has been carried out in corporate settings, with a dearth of research on the psychological impact of change on NHS staff (Cortvriend, 2004). Mental Health Professionals in the NHS have experienced organisational changes, but there is a lack of research on the psychological impact of change in the NHS.

Mental Health Professionals include:

- Community Mental Health Nurses
- Community Support Workers
- Psychologists
- Psychiatrists
- Psychotherapists
- Family Therapists
- Occupational Therapists
- Art Therapists
- Music Therapists
- Counsellors
- Social Workers

What is your involvement?

- The study will explore mental health professionals' views of their Psychological Contract in the NHS since they started employment and changes that have taken place

- The research will involve Mental Health Professionals in XXXX taking part in individual interviews which will audio recorded (all recordings will be anonymous and confidential)

Appendix F1

Overview of study for Mental Health Professionals

- The interviews will be one hour in duration, with 10 minutes for intro and debrief

Are you eligible to take part?

- You should have worked as a Mental Health professional was a member of a multi-disciplinary team within XXXX for at least one year

Benefits of taking part

Participants will also have the chance to attend a free CPD workshop which will take place at a XXXX premise. The workshop will be conducted by XXXXXX XXXX(Clinical Psychologist) and the field supervisor, XXXXX XXXX (Occupational Psychologist). Participants will be given a choice of workshops topics that are relevant to their professional skills area. The workshop will contain strategies to aid professional development in the relevant chosen areas. The facilitators will aim to organise workshops so that professionals are able to attend a workshop with fellow professionals that is suitable to their skill area (i.e. occupational therapists attending the same workshop). However, this may not be possible in all cases but there may be some overlap in topics that participants are interested in such as 'leadership'.

What should I do if I want to take part?

- If you would like to take part during work time, then please notify your line manager.

- You will then be contacted by the main investigator, XXXX (3rd year Trainee Clinical Psychologist)

- The main investigator will then email you an information sheet and consent form (Please sign and return).

- Once a suitable time and date has been arranged, you will be contacted directly by the main investigator, XXXX. If you have any queries in the meantime, please contact XXXX (XXXX@herts.ac.uk) or mobile: XXXXXXXX.

Appendix G1

Letter to Participants to take part in study

XXXXXXX, Trainee Clinical Psychologist

University of Hertfordshire
XXXXX & XXXXX XXXXXX XXXXXX Institute
XXXX XXXX, XXXXX XXXXXX Building
XXXXXXX XXX XXXXXX XXXXXXX
XXXX XXX

XXXXXXXX

(Insert Participant address)

October 2015

Dear XXXXX,

Re: Consent to take part in Interview on 'Mental Health Professionals experience of change in the NHS'

I understand that you would like to give consent to take part in an interview on 'Mental Health Professionals experience of change in the NHS'. Please see enclosed information sheet and consent form. Please read through and sign and return the consent in the SAE which is enclosed.

I will be in touch shortly to confirm a time and date for the interview. Please note that this will take place on XXXX premises or at the library at the University of Hertfordshire.

Yours sincerely,

XXXXXXX

Encs (3)

Appendix H1

Confidentiality Agreement for Transcription

Transcription Agreement

Doctorate in Clinical Psychology

University of Hertfordshire

Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

X (‘the discloser’)

And

***Transcription service* (‘the recipient’)**

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:……………………………………

Name:…………………………………...

Date:………………………………

Appendix I1

Table I1.1: Structural Codes

Interview Topic	Question number	Structural Code Name	Structural Code Definition
Psychological contract content	Q 1.2	Obligations	**Brief**: obligations within psychological contract of employer/organisation towards participant **Full:** obligations from implicit and explicit promises.(only accompanied by belief that a promise has been made) by employer/organisation towards participant **When:** mention of obligations within psychological contract **When not:** Mentions expectations or promises (not obligations) within psychological contract
Psychological contract content	Q.1.2	Expectations	**Brief**: expectations of participant towards organisation/employer **Full**: what the participant expects to receive from their employer **When:** mention of what participant expects to receive in terms of content of contract **When not:** Mentions obligations or promises (not expectations) within psychological contract
Psychological contract content	Q.1.2	Societal Expectations	**Brief:** Participant mentions societal expectations on psychological contract **Full**: Influence of society on psychological contract expectations (financial, political, social) **When**: mentions wider influences on contract outside organisation **When not**: No mention of wider influences of contract outside organisation
Psychological contract content	Q 1.2	Promises	**Brief:** Promises within psychological contract of employer/organisation towards participant **Full**: a type of expectation that once it is made, employees believe that it will be kept. (Commitment to do something) **When**: Mention promises of contract by organisation within psychological contract **When not**: Mention of obligations/expectations (not promises) within psychological contract
Specific concrete Exchanges within psychological contract content	Q 1.3	Transactions Relational	**Brief:** transactional exchanges within the psychological contract **Full:** concrete exchanges such as work for pay **When:** mention of specific concrete exchanges **When not**: emotional aspects of psychological contract
Specific interpersonal exchanges within psychological contract content	Q 1.3	Relational contract	**Brief: relational** contract exchanges within psychological contract **Full:** support/sense of belonging from organisation/employer towards participant **When:** mention emotional aspects within the psychological contact **When not**: mention concrete exchanges within psychological contract

Appendix I1

Table I1.1: Structural Codes

Interview Topic	**Question**	**Structural Code**	**Structural Code Definition**
Psychological Contract holder	Q 1.3	Contract holder	**Brief:** Holder of contract **Full**: Organisation/NHS/team/trust is perceived by employer to hold contract **When:** mention of the psychological contract holder **When not**: if there is no identified holder of the psychological contract
Specific exchanges within psychological contract content	Q 1.3	Explicit exchanges	**Brief:** explicit exchanges within psychological contract **Full:** Description explicit exchanges within psychological contract **When**: mention of explicit exchanges **When not**: implicit social exchanges within psychological contract
Specific exchanges within psychological contract content	Q.1.3	Implicit exchanges	**Brief:** implicit social exchanges within psychological contract **Full:** Description of implicit social exchanges within psychological contract **When**: mention of implicit exchanges **When not:** explicit exchanges within psychological contract
Understanding of psychological contract content	Q 1.4; Q.2.; Q.3.1; Q.4	Mutuality	**Brief:** mutuality of contract content between employer & participant **Full:** how employee & employer see contract the same **When**: mention of employer views **When not**: not mutual understanding of psychological contract between participant and employer
Understanding of psychological contract content	Q.1.4; Q.2.; Q.3.1; Q.4	Non mutuality	**Brief:** different views of psychological contract between employer & participant **Full**: similar views between how employee & employer of psychological contract **When**: mention of different employer and participant views towards psychological contract **When not:** mutual understanding of psychological contract between participant and employer
Specific concrete exchanges changed in psychological contract	Q .2; Q.4	Transactional exchanges change	**Brief:** transaction exchanges changed towards individuals/team **Full:** If participant views transaction changed towards individuals/team **When:** Describes how contract has not changed towards individual/team **When not**: mentions non transactional contract change towards individuals/ team
Specific interpersonal exchanges changed in psychological contract	Q. 2; Q.4	Relational exchanges change	**Brief:** Relational contract changed towards individuals/team **Full:** If participant views relational contract changed towards individuals/team **When:** Describes how relational contract has not changed towards individual and/or team **When not**: mentions transactional contract change towards individuals/ tea

Appendix I1

Table I1.1: Structural Codes

Interview Topic	Question	Structural Code	Structural Code Definition
Unfairness social exchanges within contract	Q 2.2; Q.4.2	Balanced reciprocity	**Brief:** balance between social exchanges from organisation towards participant/team dependent on timing and/or outcome **Full:** Social exchanges determined by fixed timing or particular exchange **When:** Describes unfair contract towards individuals and/or team **When not**: mentioned lack of reciprocity towards individuals/team
Fairness of social exchanges within psychological contract	Q. 2.2; Q.4.2	Generalised reciprocity	**Brief:** participant/team mentions fair exchanges **Full:** an exchange of which the correspondence and timing of the profit is less important, and there is altruistic motivation towards participants/team **When**: Describes exchanges that happen freely towards participants/team **When not**: Exchange are balanced towards participants/team
Organisation not fulfilling psychological contract	Q. 2.3; Q.4.3	Contract breach by organisation	**Brief:** breach of contract by organisation **Full:** Organisation has not fulfilled their side of the contract **When:** Mention of organisation not living up to the contract **When not**: if mention that contract is fulfilled by organisation
Organisation not fulfilling psychological contract and breaking trust	Q.2. 3; 4.3	Violation of contract by organisation	**Brief:** violation of contract & breaking of trust **Full**: Employer has not fulfilled their side of the contract towards participant/team **When:** Mention of employer not living up to the contract & there are strong emotions **When not**: if no mention of strong emotions/lack of trust
Participants not fulfilling psychological contract	Q. 2.3; Q.4.3	Contract breach by participants	**Brief:** Breach of contract by participant/team **Full**: Participant/team have not fulfilled their side of the contract **When:** Mention of participant/team not living up to the contract **When not**: Contract is fulfilled by participant/team
Organisation fulfilling psychological contract	Q.2.3; Q.4.3	Contract fulfilment	**Brief:** Contract is fulfilled by organisation **Full**: Participant/team have contract fulfilled by organisation **When:** Mention of when organisation is living up to the contract **When not**: Contract is not fulfilled by organisation
Change of organisation's aims	Q.2.4; Q.4.4	Organisational Purpose	**Brief:** Participant/team mentions purpose change of organisation **Full:** Description of organisation purpose change ,i.e from relational to transactional **When:** Describes mention of organisation changing purpose in addition to contract change **When not**: does not mention organisational purpose change but solely contract change

Appendix I1

Table I1.1: Structural Codes

Interview Topic	Question number	Structural Code name	Structural Code Definition
Change of Organisational climate/culture	Q.2.4; Q.4.4	Organisational climate/culture	**Brief:** Participant/team mentions change of organisational culture **Full:** Description change towards private sector or business orientated culture **When:** Describes move towards business culture in addition to contract changes **When not**: Does not mention change of organisational culture
HRM policies/practices	Q.2.4; Q.4.4.	HRM policies/practice	**Brief:** participant mentions influence of HRM policies/practice **Full:** Description of influences of HRM policies/practices on contract **When:** Describes change in HRM policies/practice have affected contract **When not**: does not mention change of HRM policies/practice on contract
Process of psychological contract change	Q.2.4; Q.4.4	Tipping point	**Brief:** Event when participant/team became emotional **Full**: Particular event that made participant/team feel emotional around change **When**: Participant/team can recall tipping point **Whe**n not: Participant/team is unable to remember tipping point
Impact of psychological contract change	Q.2.5; Q.3.2; Q.4.5	Organisational Citizenship behaviour	**Brief:** Participant/team still doing more than expected within psychological contract **Full**: Participant/team goes out of way to do more than psychological t contract **When**: Participant/team mentions going beyond psychological contract **When not**: Participant/team does not mention going beyond psychological contract
Impact of psychological contract change	Q.2.5.; Q.3.2.Q.4.5	Anti-citizenship behaviours	**Brief:** Participant/team explains why they do less in in organisation **Full**: Participant/team engages less in social exchanges/output with organisation **When:** Participant/team mentions not doing particular exchanges **When not**: Participant/team mentions still going out of their way for organisation
Justification for organisational changes	Q.2.5; Q.4.5	Justification of changes	**Brief**: Participant/team explains why organisation/NHS changed **Full**: Participant/team explains why organisation made changes **When**: participant/team mentions justification of changes **When not**: participant/team does not mention justifications
Discussion of psychological contract change by participant	Q.3	Renegotiation of psychological contract	**Brief**: Participant is able to renegotiate contract changes **Full**: Participant able to say what changes they are not able to accept **When**: participant mentions renegotiating contract **When not**: if participant does not mention renegotiation of contract

Appendix I1

Table I1.1: Structural Codes

Interview Topic	Question number	Structural Code name	Structural Code Definition
Discussion of psychological contract change by participant	Q.3.	Non negotiation of psychological contract	**Brief**: Participant is not able to negotiate contract changes **Full**: Participant able to say what changes they are not able to accept **When**: participant mentions renegotiating contract **When not**: if participant does not mention renegotiation of contract
Change of identification towards organisation/NHS/team/profe ssion	Q.3.3; Q.5.; Q.5.1; Q.5.2; Q.5.3; Q.5.4	Identity increase	**Brief:** Decrease to organisational/team/professional/NHS identities **Full:** Describes decrease with identity to organisation/team/profession/NHS **When:** participant discusses change to identity **When not**: if participant does not mention decrease to identity with organisation/team/profession/NHS
Change of identification towards organisation/NHS/team/profe ssion	Q.3.3.5.; Q.5.1; Q.5.2; Q.5.3; Q.5.4	Identity decrease	**Brief:** Decrease to organisational/team/professional/NHS identities **Full:** Describes decrease with identity to organisation/team/profession/NHS **When:** participant discusses change to identity **When not**: if participant does not mention decrease to identity with organisation/team/profession/NHS
Impact of psychological contract change on commitment to job	Q.3.2.	Organisational Commitment	**Brief**: Participant is committed to organisation **Full**: Participant remains committed in terms of work **When**: participant mentions feelings of identity and commitment to organisation **When not**: if participant does not mention being committed
Impact of psychological contract change on job satisfaction	Q.3.2	Job satisfaction	**Brief**: Participant mentions loyalty with organisation/contract holder **Full**: Participant mentions feelings of loyalty towards organisation **When**: participant mentions loyalty with organisation/contract holder **When not**: if participant does not mention loyalty
Impact of psychological contract change on interpersonal relations in organisation/team	Q.3.3	Employment relations	**Brief**: Participant mentions change in employment relations **Full**: change in work relationships with colleagues being affected by change **When**: participant mentions work relationships have changed **When not**: if participant does not mention change in work relationships

Appendix I1

Table I1.1: Structural Codes

Interview Topic	Question number	Structural Code name	Structural Code Definition
Impact of psychological contract change on stress/absences/exhaustion	Q.3.3	Burnout & stress	**Brief**: Participant mentions stress, sick leave or burnout **Full**: Participant states they or colleagues took sick leave, were stressed or burnout **When**: participant mention sick leave/stress/burnout **When not**: if participant does not mention sick leave/stress/burnout
Impact of psychological contract change on participants mental health	Q.3.3	Depersonalisation	**Brief**: Mention mentally detaching from clients **Full**: Participant mentions mentally detaching or switching off emotionally from clients **When**: participant mentions mentally detaching **When not**: if participant does not mention mentally detaching
Impact of psychological contract change on participants intention to leave organisation	Q.3.3	Intent to quit	**Brief**: Participant mentions wanting to leave organisation **Full**: Participant mentions wanting to leave/retire from organisation due to change **When**: participant mentions intention to leave **When not**: if participant does not mention intention to leave
Impact of psychological contract change on participants motivation levels	Q.3.3	Motivation	**Brief**: Participant mentions change in motivation **Full**: Participant mentions motivation levels been affected **When**: participant mentions feeling more or less motivated **When not**: if participant does not mention motivation
Fairness of changes to psychological contract in terms of distribution of resources	Q.3.4	Distributive justice	**Brief**: Participant has distributive justice in terms of equal output for rewards **Full**: Participant states they think new contract is balanced **When**: participant mentions fairness of resources in new contract **When not**: if participant does not mention fairness of resources
Communication of psychological contract changes by organisation	Q. 3.4	Promises exaggerated	**Brief**: Participant mentions impact of communication **Full**: Participant/colleagues affected by communication such as promises being exaggerated **When**: participant mention promises exaggerated **When not**: if participant does not mention promises exaggerated
Treatment towards participants by organisation	Q.3.4	Procedural injustice	**Brief**: Participant thinks organisation's actions are fair in terms of new contract **Full**: Participant states they think organisation acted fairly **When**: participant mentions fairness of procedures by organisation **When not**: if participant does not mention fairness of procedures

Appendix I1

Table I1.1: Structural Codes

Interview Topic	Question number	Structural Code name	Structural Code Definition
Individual differences in perceptions of change	Q.3.4	Individual differences	**Brief**: Participant mentions individual differences in coping with change **Full**: Participant mentions individual differences in how they have reacted to change **When**: if participant mentions personality or specific factors about coping with change **When not:** Participant does not mention individual differences
Participants' perceptions of future employment with organisation	Q.3.4	Trust	**Brief**: Participant mentions change in Trust for organisation **Full**: Participant mentions change how they see future of working with organisation **When**: participant mentions trust for organisation has changed **When not**: if participant does not mention change of trust organisation

Total = 42 codes

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

Line numbers	**Initial codes, Inductive & Deductive codes**	**Text**	**Annotations**
		I would just like to give you an overview of the topic which is around your experience of change in the NHS. One way of accessing attitudes about change and the impact of this is to look at people's understanding of their contract with the employing organisation. The term 'Psychological Contract' has been defined differently over the years. It can refer to mutual expectations between the person and organisation. This can also include obligations towards the organisation and vice versa. The contract has also been defined as the promises that employees believe were made to them by their employer probably prior to them entering the organisation. Contracts involve reciprocal exchanges between yourself and the organisation. i.e., working for pay or working overtime in return for time in lieu. Contracts are both transactional and relational. Transactions include economics such as hours, pay and work flexibility. Relational aspects focus on more emotional aspects such as trust in return for competent management and belonging. Contracts can be implicit as well as explicit. For example, you may have explicit written items in your job contract such as working 5 days a week. You may also have implicit items that you have learnt vicariously colleagues such as noticing that if someone works overtime, they can claim this back, etc. The holder of the contract is usually a representative of the organisation such as your Line Manager. However you can have different contracts with both your MDT team and the organisation itself).	
1 2		**So how long have you been employed by the organisation?**	
3 4		Um, I think I started here in 2005 so that would make it 10 years	
7		**And the NHS itself?**	
8		Since 2000, January 2000 so yeah, 15 years	
9 10 11 12		**Ok, and can you describe your understanding of the deal in terms of exchanges between yourself and the employer such as any obligations, promises and expectations between yourself and the employer?**	
26 27 28 29 30 31 32 33	Flexible contract	So basically, I, I work, offer psychological knowledge to my particular field which is learning disabilities and in exchange they pay me for that um that's sort of the basic crude agreement I have um but there's also sort of additional benefits to working like for example, I, I'm paid when I take annual leave, I was paid when I had maternity leave, um I can work flexi hours so I can work longer days and shorter days and as long as I	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

34 35 36	Expectations from organisation	(sighs) but in turn, I have to meet um targets and err clear expectations set out by the organisation	
39 40 41		**Ok, um and do you think you've got different contracts with the organisation and with your team or do you think they're the same?**	
43 44 45 46 47 48 49 50	Different Contract Holders	5 second pause) um, um I think they're all the same, in the past, I would have thought it was more different, the contracts with the organisation and with the teams, it felt more separate but as we've become more of a mmm, more of an organisation identity and because the teams have reshuffled and we are now just 2 teams where we were lots of smaller teams, I would say its closer, yeah, expectations are very much similar	Similar team & organisation contracts
53 54 55 56		**Um, do you see the contract with the NHS or with the organisation or with your team? The contract holder, would you say it was the team or the organisation?**	
60 61 62 63 64 65 66 67	Implicit contract with team	But you have a, so my official contract, I think its held by the Trust and I think its very much in line now, more so than it used to be with the team, expectations but I think the, the implicit contract is with the team, their kind of explicit expectations, this is what you do, we pay your for this and that, is with the Trust but the sort of emotional contract is with the team, more implicit kind of stuff, relational	
70 71 72 73 74 75		**And, how did you come to have this view of the deal such as with explicit exchanges for example, your contracted to travel so many miles a week or in terms of implicit, so if you notice a colleague does something, then you can do the same such as having a longer lunch break or something like that?**	
80 81 82 83 84 85 86 87 88 89	Informal relationships	Ooh dear! (laughs) probably by (3 second pause) my goodness! Informal kind of conversations and relationships and over years of just being part of the team I think but err I think sometimes, when there was strong leadership within the team, just through kind of more formal routes such as business meetings or whatever people would hold, this is how things are. I don't know if that really answers your question. I think informal and relational and sort of seeing somebody do something and then realising is that possible? (laughs)	
95 96		**And do you think your colleagues and employer view this differently to yourself?**	
106 107 108 109 110	Contract is more formal	3 second pause) I, err, really honestly think over the past say probably 4 or 5 years, (3 second pause) um through for example, the, the PDP process, through um insisting that we have job plans, through um insisting we have a contract (laughs) for a written contract	Trust is becoming a business

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

111 112 113 114 115 116 117 118 119 120 121 122 123 124 125	Clearer expectations	which in the past, I think we had but we never saw, so it's through those processes, through the team, the err Trust having more of a corporate identity, um, being more visible in terms of their values, being more visible in terms of what training they want us to do, being more outspoken about the targets and I think through those processes, its become much closer um, what I think the contract with them is and what they think the contract is, I think that has become a, the process has become, I think in the past I might have thought this is what I'm supposed to do and I do my job and I sort of fumble along but since they've been much more of a corporate identity and they're much more stricter on these things, I think that kind of expectations are clearer.	model & making contract more explicit
130 131		**So since that everyone has a sort of similar about what their contract is?**	
132 133 134 135 136 137 138 139	Political influence (agenda for change) Financial Climate	I think so and I think part of the process started with 'Agenda for Change' so years ago when we were sort of assessed in terms of what exactly is it that you do, I think that started the thinking process of what is it that I am expected to do as a psychologist within this team? But then you know, I don't think that changed it but it started the thinking around well am I doing what? They think I'm doing and then	Political & social influences on contract
142 143 144		**In terms of job roles is it more about that in terms of everybody having to have a job role or Agenda for Change?**	
145 146 147 148 149 150 151	Galvanised job plans	So everybody has to have a job plan and a contract and a PDP so that makes it very clear what role, depending on the quality of your PDP but its clear, this is what you want to do and this is what we expect you to do um and agree you can do or can't do, agree this is your role and it felt like once the processes were more galvanised and used more regularly	Everyone now appears to be clearer of job roles
156 157 158 159		**Ok, um so thinking about that, after the Agenda for Change, do you think that um now you and your colleagues have the same sort of implicit understanding as well?**	
160 161 162 163 164 165 166 167 168	Banding process	Let me just, so Agenda for Change started the process of people thinking about what exactly because you were, it was silly like for example you were scored on whether you said um 'I handle' ,and this is a bad example, I can't remember the exact details but 'I handle um equipment that requires um say for example extreme concentration or some concentration' and you almost ended up being under a different banding because you said its extreme concentration was, so	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

169 170 171 172 173 174 175 176 177 178 179 180	Corporate image	there were a lot of conversations are we seeing extreme complex cases or just complex cases or cases or? You know when did you do what and, so there were, that started conversations around but how do we score ourselves? What is it that we say we do? And what do we say that the organisation expects us to do? But that didn't really, brought in the changes, the change that started the thinking process, I think the change has really happened 5 years ago and I say 5 years ago, it feels like 5 years ago but it may be more or less when we really started to have like a corporate image for some reason	
189 190 191 192		**And some changes have occurred in the organisation over the years, do you think this has changed the deal between you and the employer? Or do you think things are the same as when you?**	
196 197 198	Deal changer	Yeah, definitely, it changed the deal between the organisation and the employee which is me, yeah, definitely, the change has changed	
200 201 202 203		**Um what do you think has changed in terms of the deal? Um, for example, do you feel you have to work longer hours or you have more or less support?**	
204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223	Inconsistent expectations Unrealistic expectations	(5 second pause) (sighs) Let me just think, yes, um, what has changed? I think because we are clearer about (clears throat) for example the expectations, the organisation is clearer, we expect you to work in the community because they aren't any rooms available (laughs) um but we err don't want you to travel too much because if you travel too much you lose some of your travel claims after a certain amount of mileage. So they are clear about their expectations but I think their expectations are inconsistent so we want you to be working, we want you to do all your XXXXX notes and we want you to do all your um err, meet all your targets of seeing so many people within so many hours and so many and we want you to do all these mandatory trainings and we expect you to do all this in 37.5 hours, so their expectations are clear but I think where its changed is that um those expectations aren't realistic and there is no mechanism, I think, there is mechanism, you can have kind of you know a kind of, XXXXX surveys and stuff	Organisation is not being considerate of impact of changes
254 255 256		**And do you think your colleagues and your employer view this differently to yourself? Like would they say the same things?**	
257 258		No (laughs) I think my colleagues would say the same thing but I don't know about the organisation	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

280 281		**And do you think this has changed over the last 2 years?**	
282		No, its been like that for a while	
283 284		**So nothing in the last 2 years, is it more of a gradual process?**	
285 286 287		Yeah, it's exactly what I said but it's just um more intense. It just err, yeah, no, its just like it was now for a few years, one or two years, yeah	
289 290 291 292 293 294 295		**And can you think of a specific exchange that has changed between you and the organisation, something maybe you did for the organisation but you can't do anymore and something maybe they did for you but they can't do anymore, or they don't do anymore? Such as um, you no longer work overtime or you no longer do that bit extra?**	
297 298 299 300 301 302 303	Not able to do CPD	Um, it's' difficult to go on training, on CPD, that has changed, it has been easier to say 'can I please have CPD?' Now they say no because you are not going to meet your targets um you can't go, 3 psychologists off to the same CPD, unfortunately we all have to do the CPD um so that's def., def., definitely different and that has changed so sort of um yeah	
306 307 308		**Yeah, and is there anything else in terms of work that you feel that you can't do anymore or don't have enough time to or?**	
309		That's changed in the last 2 years?	
310		**Yeah, or don't feel motivated to do?**	
311 312 313 314 315 316 317 318	Service development & clients demands	(Sighs) um, that I can't do anymore or don't feel motivated to do? I mean I think service development is becoming and its difficult so you have to do service development because sort of within my role, that's an expectation although it feels like, there's also a clear expectation to see service users which of course I think is right that, that should be what my role should be, say that again, what things that I can't do anymore?	
393 394		**Ok, um and are there any times when you feel you haven't lived up to the contract at all?**	
396 397 398 399 400 401 402 403 404 405	Impossible contract	Oh yeah, all the time, so you are constantly in that place where you think, I'm not meeting my targets, I'm not um doing all my reports, I'm not putting the (3 second pause) the right stuff in there, right folders. I'm not printing off the last risk assessment, I'm not err yeah, travelling a little enough, I'm not seeing enough people in the community, travelling too much (laughs) constantly feel, all the time , 90% of the time, that you are not living up to the contract because its the impossible	
407 408		**Hmm, so you were talking before about some of the changes may be made things not sort of realistic,**	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

409 410		**and it sounds like its, sometimes its really difficult to live up to that**	
411 412		Oh, its, its not just difficult, its impossible, its absolutely impossible	
413 414 415 416 417		**Um, and can you describe what sort of triggered this change? Like what happened before and then maybe during and after, so the process of things changing within the organisation so you felt like you couldn't live up to all parts of the contract?**	
419 420 421 423 424 425 426 427 428 429 430 431 432	Clearer expectations	To me it felt like it changed when we became more of a err, corporate, when we started having more of a corporate image so I think its because they were more, they were clearer in their expectations of us, so you sort of were aware, I think perhaps in the past, you avoided what you didn't do, you sort of thought oh well, I'll get to that and you know I'll just take 3 days or 4 days and just do my admin and catch up. Now you can't cos if you do that you won't have the right amount of client contact so (sighs) I think when the organisation was clearer about their expectations (3 second pause), you were sort of more aware of the fact that you can't live up to them (laughs)	
554 555		**And do you still feel the need to go beyond what's explicit in your work contract now**?	
556		For example?	
557 558 559 560 561		**Um, so, say for example, you know you have to work a certain number of hours but you feel like actually to get everything done to my standard, I feel like I need to work more hours or do that bit extra, do you still feel motivated to do that?**	
563 564		Oh, no, not at all (laughs) I'm not motivated to do that at all	
565		**But would you still do it?**	
566 567 568 569	Grumble & Groan	But I still do it, I have no choice, I grumble and I groan and I moan and I shout at everybody at home and I say 'why do I have to do this?' and I get angry, no, I'm not motivated to do that at all but	
571		**What keeps you doing it?**	
572 573 574 575 576 577 578 579 580 581	Responsibility to clients & team	Think err to be honest, I, I do feel I have to deliver, try and deliver a good service to people I see. I feel a responsibility towards the people I see, so that keeps me doing it um and um also I think everybody else does that, everybody else works very long hours, out of hours so you don't want to let your team members down and I started off trying to be a good psychologist, I have lost, I think um that ability to be a good psychologist I think. I'm now just being a psychologist	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

582		(laughs) So, you still sort of try, you still think 'Oh I want to read this article, I want to improve myself'	
585 586 587		**And is that more for your profession that you sort of see that responsibility or more for the team in terms of?**	
588 589 590		Team, very much for the team and profession, I mean I still, I still feel psychology is a good profession and can make a difference	
622 623 624 625 626 627		**And thinking about um the specific changes, have they affected, for example, thinking about specific social exchanges, have they been renegotiated? Such as transactional parts of the contract? It sounds like this was a sort of renegotiation, was this a renegotiation with the Trust?**	
629		My hours, do you mean?	
630		**Yeah**	
631		Yeah, that was um renegotiated	
649 650		**So do you think in terms of the hours, do you think that was renegotiated fairly?**	
651		Yeah	
683 684 685		**And do you think your identity with the organisation has changed at all? Like in the last 2 years?**	
686 687 688 689		Yeah, much more businessy kind of view (laughs) not so much, its that, I don't know whether that's a good idea, good thing, but yes, it feels like its more of a business corporate	
691 692		**How would you have sort of seen your identity before that?**	
693 694 695 696 697 698	Less individual identity, freedom & choice	Health, healthcare um as a psychologist um now I'm much more like part of an organisation. Whereas, before I felt I was part of a team, as a psychologist, having much more individual identity and freedom of choice (laughs). Not necessarily good, I'm not saying that was better but that had definitely its value	
708 709 710 711 712		**And do you think the changes have impacted on your working relationship with your employer? For example, do you feel less loyalty towards the organisation before, than before, or do you feel the same amount of loyalty?**	
714 715		sighs) my loyalty change (5 second pause) I've never thought about my loyal, um	
716 717		**Or do you sort of see your loyalty more with the NHS as a whole or maybe with your team?**	
719 720 721	Loyal to team & NHS	I think it's with the NHS and with my team than the organisation. I've never thought of loyalty to the organisation other than feeling guilty because I'm not	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

723 724		doing what I'm supposed to do but I feel my loyalty is to the NHS and definitely to my team	
725 726 727 728 729		**Hmm, um and thinking about these changes, have they impacted on working relationships with colleagues or with clients at all? For example, have you noticed any interpersonal difficulties or have you noticed people taking more sick leave at work?**	
731 732 733 734 735 736	Unattainable demands	(sighs) I think people are more stressed because of unattainable or sorry unreasonable, its not necessarily unreasonable, its reasonable but its unattainable demands and this constant feeling of you're falling short and not doing things good enough. I think people are more stressed as a result of that	
747 748		**Um, have you noticed any work efficiency decrease in terms of client caseload and?**	
749 750 751 752 753 754 755 756 757 758	Less efficient	Definitely less of, less efficient because I have to figure out how to save something on XXXXX or I've now mastered XXXXX (laughs) but yes, you know since we are all doing exactly the same thing, I can never remember what it is so spend my life trying to figure out how was I supposed to do this again? (laughs) So, yes, I'm less efficient because its not my own little system that I know, have to follow the corporate system so you know	Cannot use own system due to corporate system
763 764 765		**And do you feel any less able to deal with clients emotionally? Have you experienced exhaustion or burnout at all at work?**	
766 767 768 769 770	Less available to colleagues	I'm sorry to say, I think I'm less available for people that I supervise, I think I try and so for example, trainees or you know um other people that I supervise in the organisation so I think that has in effect. Not so much in terms of clients or	
802 803		**How do you think things could be communicated better in a way?**	
804 805 806 807 808 809		I think um (3 second pause) big organisation things should go through managers like organisational changes and stuff, it does happen but in consultation, no they do have this 'XXXXX' stuff where they listen to staff and once again, I do think they try, I can't be so negative as to say they are not trying but um yeah	
812 813 814 815		**And do think sometimes it would be better not to exaggerate promises so that people are less disappointed? Have you noticed that people have been sort of?**	
816		I don't think they exaggerate promises so much	
818 819		**Um, and do you think specific contents of, do you think there are changes to specific contents of social**	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

820 821 822		**exchanges that have been handled in a fair way? So rather than the general changes, do you think particular aspects have been handled in a fair way?**	
825		Do you mean by particular aspects?	
826 827 828 829		**Um, say with hours or, maybe not work, travel for work but um other not sort of general changes, but particular aspects so you think, actually that was quite fair, the way that was handled.**	
831 832 833 834 835 836 837 838 839 840	Difficult to get it right	(5 second pause) Err, I'm trying to think of something else, particular aspects, um (5 second pause) yeah, I mean I think it was um, I'm trying to think of something in particular, in general, I don't think they are unfair, I just think sometimes it's a very big organisation with loads and loads of employees and its just really difficult to get it right and they are trying, they are trying (sighs) I' m try to think of a specific thing that I thought was managed well (3 second pause) I can't think of any specific but you know	Justify changes
843 844 845 846 847 848		**Um, so thinking about your team, do you think these changes have affected your teams' deal with the employer? So the contract your team holds? Do you think they've been affected, such as your team has to work longer hours, they feel less support from the organisation?**	
850 851 852 853 854 855 856	Out of hours service	I don't know but there was a time when nurses just used to work until, you know, normal office hours and they then were expected to provide an out of hours service so that was a big change and the issue is then so why just nurses, so what's wrong with all the other professions, why can't they provide an out of hours service?	
873 874		**So was there sort of um difficulties between the professions then in terms of that?**	
875 876 877 878 879 880 881	Renegotiation of responsibilities	Not out spoken but definitely I think felt at that stage. This is now a few years ago, its not a recent thing, that was difficult and why certain professions did certain things in certain ways, I would think that was normal with any organisational change for people to sort of renegotiate roles and responsibilities and opportunities and in a way that, that's just what happened	
912 913 914 915 916 917		**And can you think of specific exchange that has changed between your colleagues um in the team and the organisation such as something the team did before but they can't do anymore because of the changes or they don't feel they want to do anymore?**	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

918 919 920 921 922 923 924		ooh, changes (10 second pause) um, its so difficult because it waxes and wanes and sometimes, it depends on the context at the particular time and the vacancies and the recruitment and um what's, you know, what's expected at that particular time from the team, so its difficult to say because its so, it changes so quickly um but things that we don't want to do anymore?	
927		**Or feel that you can't do**	
928 929 930 931 932 933 934 935 936 937 938	establish individual roles	Can't do it anymore, I think struggling to work as a team rather than as individuals so we worked very much as individuals and there was a big, a lot of things happened and it was quite difficult to establish roles and stuff and the teams changed and then we sort of gelled a little bit more in terms of working as a team but now with added pressures, you just go off and do your own thing just to, to meet that target, you just need to see somebody within, that kind of team cohesion and coordination seems to go by the wayside sometimes	
1066 1067		**What was it about the NHS that you could identify with?**	
1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078	Value free health care (Identity with NHS)	(sighs) I very much identify with the value that healthcare should be free at the point of delivery, I come from a context where it isn't, wasn't free at the point of delivery, necessarily and when it was, it was such a bad quality that. So I, and I've seen the desire, what can I say? The disaster and the heart ache caused by health care that is unavailable to big parts of the population so I really identify and strongly with that value that it should be a good service at the point of delivery	
1080 1081		**Um and did you identify your team prior to the change?**	
1082		Err, yeah, I think I did	
1083		**And has that changed at all?**	
1084 1085 1086 1087 1088	Identify less with profession	Err, no, I think its always been kind of, I did identity more with the psychology team at some stage and then more, identified more with the MDT um I feel, I identify much less with psychology team at the moment than I would	
1090 1091		**So it's more the MDT? What do you think might have triggered that change in terms of identity?**	
1093 1094 1095 1096 1097		Just the way we work, so sort more kind of um collaborative working and err and then I think when there's lots of pressures and you just start to pick up people, you do identify then more with psychology (laughs)	
1107		**Um, and why do you think this is the case?**	

Appendix J1

Table J1.1: Example of coded interview transcript for Participant 13

1107 1108 1109 1110 1111 1112 1113 1114 1115	NHS valued	3 second pause) Perhaps my identity has changed because I think I, I felt more that the NHS as an organisation was valued. I feel less that they are valued as an organisation now, although I think the government says they are valued. I don't think, people will really actually pay more taxes in order to, to have a better NHS, I don't think it's really valued um, as far as money goes and resources goes and the question was? Why has it changed?	
		Thank you for taking part in this interview around change and the Psychological contract. I hope that you found the discussion helpful. Please note that if any distressing material came up for you that you, then please notify me. Please note that all transcriptions will be stored securely in Line with the Data Protection Act, 1998. If you wish to withdraw your data, you will be able to do this. If you have any questions now then please stay behind. If you do not have questions now but later, then please contact either myself or supervisors on the contact details provided	

Appendix K1

Example of diary extract

10th December 2015

Themes: How implicit contracts have become explicit and pros and cons of business model in the NHS

Organisational culture change: discussed how they could see change in NHS culture which appears to have impacted on Trust culture and eroded values of NHS such as Free Health Care for all

Breach: No specific incidents of breach but discussed making personal sacrifices for work

Buffers: Described supportive management and team to help with personal issues

NHS values: Identified strongly with NHS values such as free health care for all as came from different country without this concept

Overall Reflections: Participant gave balanced views of changes, could see positives in terms of having clearer expectations but negative in terms of becoming business model and adopting blame culture.

Summary of Themes across 15 Interviews from research diary

- Implicit contracts
- Political influence
- Major changes to contracts and NHS
- Not agreeing with change
- Coping with stress if there are resources
- Importance of doing best for clients
- Support from organisation and managers
- Importance of having work and life balance
- Range of emotions displayed
- Identity changes
- Resiliency and coping strategie

Appendix l1; Table l1.1: Deductive codes Applied to data

Deductive Codes	Brief Description
1.Implicit contracts	Implicit Psychological contract
2.Contract holders	Contract holders of psychological contract
3.Expectations	Expectations from employee & organisation of psychological contract
4.Societal Expectations	Societal influences on psychological contract
5.Organisatiaonl Purpose	Organisational purpose influence on psychological contract
6.Balanced reciprocity	Exchanges that depend on timing and certain rewards
7.Organisational culture	Culture within organisation (e.g. Business culture)
8.Trust	Trust in organisation to keep promises and future promises
9.Promises exaggerated	Promises from organisation that are not realistic/kept
10. Procedural injustice	Unfair treatment to self or colleagues by organisation
11. Distributive injustice	Unfair distribution of resources by organisation
12. Contract breach	Organisation does not keep to original deal
13. Contract violation	Organisation does not keep to original (strong emotions)
14. No renegotiation	Contract not renegotiated
15. No mutuality	Not mutual understanding of contract from employer
16.Stress & burnout	Stress, burnout and absences caused by work situation
17. Depersonalisation	Switching off and mentally distancing self from change
18. Intention to quit	Intention to leave organisation due to change
19.Individual differences	Individual differences in coping
20.Employment Relations	Interpersonal relationships
21.Identity decrease	Identity decrease towards Trust/NHS
22. Organisational citizenship behaviours	Increase of going above & beyond psychological contract
23. Identity Increase	Identity towards Team/NHS increase
24. Renegotiation of contract	Renegotiation of psychological contract
25. Contract Fulfilment	Contract Expectations met by organisation

Appendix M1

Table M1.1 Inductive Codes Applied

Inductive Code Name	Description
1.Not fixed	Psychological contract is described as not being fixed and subject to change
2.Implicit*	Describes psychological contract as being learnt vicariously and contents assumed rather than being explicit
3.Open to interpretation	Describes psychological contract as being subjective to participants so that they put their own meanings onto this
4.Flexible contract	Describes a psychological contract that is flexible in content and interpreted as flexible by employee and manager
5.Contract holders*	Describes contract that has different holders (organisation, NHS, manager, team, etc.)
6.Employee expectations*	Expectations of what is in the psychological contract for the employee from the organisation
7.Parking/travel expectations	Specific expectations around rights to parking and travel from organisation
8.Organisational expectations	Views of what the organisation expects from them
9.Financial savings	Financial impact on organisation in terms of savings and across NHS
10.Negative national changes	Changes that have occurred nationally but have had negative impact on NHS as whole and NHS Trusts
11.Not sustainable	Views of long term future and sustainability of organisations and NHS
12.Less time	Less time for work and clients
13. Fragile services	Views that services are weaker & do not have adequate resources
14.Politiical pressures	Pressures from government and politics on NHS and NHS Trusts
15.External pressures on NHS	Pressures external to NHS and NHS Trusts, i.e. commissioners
16.Media pressures	Pressures from the media such as bad publicity on the NHS and NHS Trusts
17.Corporate model	NHS transforming into a corporate business model
18.Performance focused	NHS and NHS Trusts more focused on outputs than nature of clinical work
19.Survival of NHS	Changes on NHS helping NHS to survive in financial climate
20.Less reciprocity†	Participants not consulted on changes or involved in process of change

* *Overlap with deductive codes*

Appendix M1

Table M1.1 Inductive Codes Applied

Inductive Code	**Definition**
21.Clearer contract	Clearer expectations
22.Tick box culture	NHs and organisations are less flexible and more about 'ticking the boxes'
23.Nostalgia	Participants missing 'old' way of working and previous job perks
24.Damaging change	Changes that have occurred to NHS and/or NHS Trusts that have damaged services and working conditions for staff and/or clients
25.Change process	Description of pace of change process of change (fast vs gradual)
26.Team ethos affected	Team ethos is different as a result of change to NHS and/or NHs Trusts
27.Internal scrutiny	More scrutiny from inside NHS Trust from
28.Problem focused	Feel blamed and not having positives acknowledged
29.External scrutiny	Participants feeling under scrutiny from outside NHS and/or NHS Trusts, i.e. from commissioners
30.Fear climate	Participants feel fearful and uncertain about working in NHS and/or NHS Trusts
31.Less relational	Less interpersonal relationships
32.Trust broken	No longer have trust the NHS and/or NHS Trusts
33.Unrealistic promises	NHS Trust and/or NHS does not provide realistic promises and/or does not keep these
34.Unfair treatment	Experienced unfair treatment towards themselves and/or staff from NHS and/or NHS Trust
35.Exchanges not balanced	Feel that social exchanges are not balanced between them and NHS and/or NHS Trust
36.Efforts not rewarded	Work efforts are not rewarded, i.e. lack of praise
37.Lack of reciprocity	Overlap with deductive code: Participants feel that there is no reciprocity between output & reward
38.Unethical treatment of staff	Participants feel they and/or colleagues were treated unethically
39.Personal impact	Work experiences have affected participant personally and they have shown emotions as a result

Appendix M1

Table M1.1 Inductive Codes Applied

Inductive Codes	Definition
40.Unclear communication	NHS and/or NHS Trust did not communicate information about change clearly
41.Poor management	Poor management from NHS and/or NHS Trust about change process
42.Done deal	No room for negotiation and deal has already been decided by NHS and/or NHS Trusts
43.Lack of support	Lack of support from NHS and/or NHS Trusts
44.Lack of respect	Lack of respect from NHS and/or NHS trusts verbally or by email
45.Professional expectations not met	Expectations about what they expect in terms of professions have not been met by NHS and or/NHS Trust
46.Unment original expectations	Original expectations from the NHS and/or NHS trust have not been met
47.Parking/travel expectations not met	Specific expectations (parking and travel have not been met)
48.Increaed pressures	Increased pressures from NHS and/or NHS Trust in terms of doing more
49.Unrealistic expectations	Unrealistic expiations from NHS and/or NHS Trust from them
50.Not enough resources	Lack of resources to implement new expectations from NHS and/or NHS Trusts
51.Lack of mutual understanding	NHS and/or NHS trust does not understand the challenges they face
52.Strong emotions from service users	Service users express strong emotions about changes to participants
53.Impact of clinical work	Negative impact of change on clinical work
54. Increased clinical pressures	Increased clinical demands from clients and/or NHS and/or NHS Trusts
55.Lack of client time	Less time with clients
56.Lack of resources for clients	Lack of resources for clients
57.Quality of care reduced	Reduce quality of care provided
58. Too many demands	Too many competing demands
59.Sickness & exhaustion	Taking absences of seeing staff take sick leave due to stress
60.Stress*	Participants describe feeling stressed due to work

**Overlap with deductive code*

Appendix M1

Table M1.1 Inductive Codes Applied

Inductive Code	Definition
61.Mental health problems	Experience mental health problems (anxiety and/or low mood) due to work
62.Depersonalisation*	Disconnect mentally as a result of stress and change at work
63.Internalise blame	Blame themselves for changes and not doing more
64.Less efficient	Less efficient at work
65.Leave jobs*	Leaving jobs early and/or retiring
66. Individual differences*	Individual differences in terms of coping with change
67. Vent anger	Venting anger and being upset about changes
68. Fear of change	Fear around change
69. Meet targets & reduce costs	Targets being met and costs reduced due to change
70. Improves service quality	Service quality improves as a result of change
71.Organisation not responsible	organisation is not responsible for the change
72.Get on with it	Getting on with work in spite of change
73.All in together	Sense of comradery in teams
74.Work life balance	Proactive about having work life balance to help
75.Interperonal team difficulties	Team interpersonal difficulties
76.Less team cohesion	Reduction in team cohesion
77. NHS & Trust loyalty reduced	Reduction in NHS and/or Trust loyalty
78. Professional identity reduced*	Reduction in professional identity
79. Gove above & Beyond	Still going beyond psychological contract and doing more
80. Identify with team values*	Identifying with team values
81.Identify with professional values*	Identifying with professional values
82.Identity with NHS values*	Identifying with NHS values
83.Identity with Trust values*	Identifying with Trust values
84.Prioritised clients	Prioritised clients in service
85.Improve quality of client care	Improved the quality of care for clients in service
86.Reached compromise	Able to reach contract compromise

**Overlap with deductive code*

Appendix M1

Table M1.1 Inductive Codes Applied

Inductive Code	Definition
87.Psychological contract still flexible	Participants described contract as still flexible
88.Kept to original contract	Trust kept to original contract
89. Understanding of employee needs	NHS and/or Trust understanding participant needs
90.Clear communication	Clear communication about change
91.Valued by Managers	Feel valued by managers
92.Valued by Trust	Feel valued by NHS Trust
93.Valued by Profession	Feel valued by profession

Appendix N1
Arrangement of initial codes for content Psychological Contract

Photo of preliminary grouping of themes, subthemes and codes

Names of grouped of preliminary themes, subthemes & initial codes

Expectations

- Contract expectations
- Expectations to overwork
- Expectations of contract

Clients as priority

- Service users come first
- Looking after self and clients
- Going out of way to support service users
- Put service user needs first
- Service user needs as priority

Not balanced

- Felt bad for leaving on time
- Unfairness of organisational expectations
- Not noticing what people do
- Managers don't understand

Balanced

- Fair distribution of time & resources
- Never worked extra hours
- Trusting employees
- Allow others to take toil

Not fixed

- Managers shake things up
- Many changes
- Supervision fluctuation

Team contract

- Team culture
- Work closely with other professionals

Contact holders

- Managers as contract holders
- Trust as employer
- Different managers

Implicit

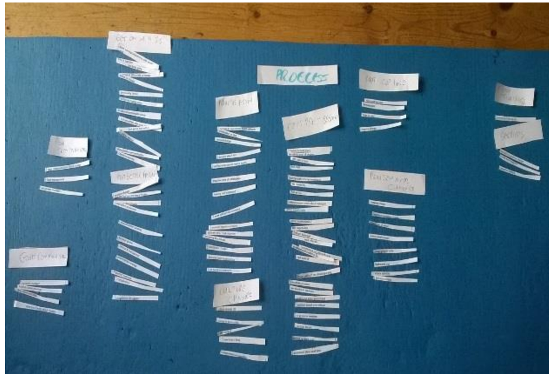
- Contract open to interpretation
- Individual basis
- Implicit contract
- Learnt contract
- Agreement rather than contract
- Being left to it
- Overtime up to staff
- Organisation not clear about expectations
- Not taking lunch break
- Local contract
- Managers interpret contract
- Not explicit in contract
- Snuggle day

Explicit

- Parking permit
- Contracted travel time
- Not meant to work overtime
- Accept travel as part of job
- Not paid for overtime
- Not able to work privately
- Evidencing work

Appendix O1
Arrangement of initial codes for process of Psychological Contract Change

Photo and names of groupings for preliminary themes, subthemes & initial codes for 'Process of Contract Change'



Poor communication

- Poor communication about change
- Poor management
- Lack power managers

Good Communication

- Dynamic manager
- Helpful communication
- Clear communication
- Open & honest about change

Get on with it

- Good working relationships with service users
- In it together
- Just keep going
- Respond differently to change
- Adapt to change
- Personality factors
- Different coping styles
- Protective personality factors
- Feel should be able to do it
- Just got to deal with it
- Doing best in circumstances
- Clients as priority

Protective Factors

- Positive change
- Contract becomes more flexible
- Protective profession
- Mutual understanding
- Receive praise
- Ethical & transparent
- Preventative strategy
- Protected contract
- Transparency
- Compliment for support

Privitisation

- Increase in non mental health referrals
- Privitisation of NHS
- National change
- Pessimism about NHS
- Overlap social care and mental health
- Negative view of privitisation
- Agency staff employed
- Work with private company
- Provided input to company
- Different NHS Trust responses
- Becoming less private
- Corporate changes
- Become more business like
- Cut back in social care

Culture Change

- Culture change
- Change in team ethos
- Team merged
- Everyone is busy
- Independent relationships

Contract Breach

- Pressure to work more
- Unrealistic goals of services
- Non contractual task
- Lack staff
- Unreciprocal exchange employees
- No reciprocity
- Lack praise
- Different expectations about waiting list
- Unmet expectations
- Not original deal
- Expect too much
- More referrals
- Compliment not acknowledged
- Workload staff in balance
- Lack control
- Lower paid staff not allowed parking
- Unrealistic promises
- Parking no longer part of the deal
- Contract breach over mileage
- No praise for overtime
- Contract breach
- Contract not lived up to
- Questioned about work time

Not Coping

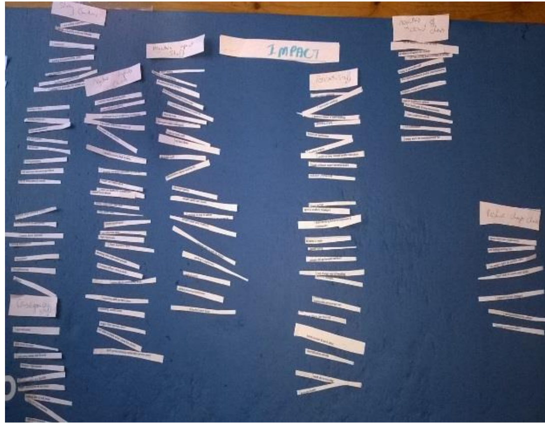
- Sick leave increase
- Leaving jobs
- Head in sand
- Anger at change

Non-sencial Change

- Creeping change
- Negative experience of change
- Reinvention of wheel
- Non-senscial change
- Change going in circles
- Backwards step
- Tick box activities
- Tick box exercise

Appendix P1
Arrangement of initial codes for process of Psychological Contract Change

Photo and labels of groupings for initial codes into preliminary themes for 'Impact of Change'



Strong Emotions

- Previous building more service user friendly
- Building less personal for users
- Feelings of loss
- Feeling shaken up
- Feel overwhelmed
- Low self-esteem
- Strong emotions
- Felt everyone was out to get them
- Resentment
- Anxiety about unknown
- Worried about change
- Thoughtlessness

Consequences

- Sick leave increase
- Not going above & beyond
- Became regimented
- Became less flexible
- Stress caused work decrease

Negative Impact on clients

- Pressure to get people into the community
- Anxiety around lack of beds
- Impact on clinical work
- Depersonalisation
- No reflection time
- High risk levels
- Working with vulnerable people
- Changes affect clinical work
- More risks in community work
- Less time with service users
- Excluding service users
- Anger from service users
- Not able to think what's best for clients
- Guilt around closing vulnerable service users

Negative Impact on Staff

- Staff leaving
- Grotty work conditions
- Disillusioned with services
- Took time to rebuild relationships
- Role blurring
- Cuts on bank staff
- No fixed base
- Belittles staff
- Expectations about waiting lists
- Job uncertainty
- People upset over travel
- Parking is nightmare
- Added stress
- Added pressure & stress
- Share less with team

Positives Staff

- More joint working
- Positive impact of joint working
- Rebanding of pay
- Impact on profession
- Meeting targets
- Useful to have mental health team close
- Make referrals easier between teams
- Exclusion criteria clearer
- Trust savings
- Agency workers employed
- Joint working between inpatient & community
- Became stronger
- People still go beyond contract
- Not change way of working
- Positive change
- Transactional contract met
- Same passion & work ethic
- Diversification of role
- Work Christmas day
- Lessons learnt

Negatives of National Change

- Lack of support from other services
- Problems of Agenda for Change
- Trust not setting good example of savings
- Hoops to jump through
- Discrepancy between professionalism and commissioning
- Negative change of profession
- Gaps in healthcare system
- Short term gains & long term chaos
- More corporate speak
- Not sustainable
- Doing work not commissioned for

Positive Changes clients

- Good client care maintained
- Not having waiting lists
- Do what's right for service users
- Open eyes to service user needs
- Support has not changed
- Caring professional nature
- Loyalty to service user

Appendix Q1

Table Q1.1: Summary of Theme 1; 'Implicit Psychological Contract', subthemes, deductive, inductive codes, initial codes and extracts

Table Q1.1: Theme 1 'Implicit Psychological Contract'

Theme 1	Sub Theme(s):	Deductive codes	Inductive codes: recoded codes	Inductive codes: Initial codes	Participant Extracts
1.Implicit Psychological Contract	**1.1 Flexible Contract**	1.**Implicit Psychological contract**	1.**Not fixed**	1.Different managers 2.manager shaking things up 3.supervision fluctuation 4.Many changes 5.contract changed 6.managers interpret contract	*"..I feel like um a lot of it is open to interpretation really depending on the manager and how much they um are interested or do get involved in the day to day processes" (Participant 4, p.1, line, 15).* *"Well they expect us to be quite clear about what we do but I don't think the organisation is always clear about what their vision is and what they expect of us"(Participant 5, p.6, line 178).*
1.Implicit Psychological Contract	**1.1 Flexible Contract**	1.**Implicit Psychological contract**	**2.Implicit psychological contract (deductive code overlap)**	7..Muddled through 8. Overtime up to staff 9. Assumed part of contract 10.local contract 11. Not in contract 12.Not taking lunch break 16.Managers respond in different ways 17.individual basis 18.Snuggle day 19.Being left to it 20.Informal relationships 21.Not explicit in the contract 22.Not explicitly discussed 23..Implicit contract with team	*"Something that's recently been offered me and that was really not by my line manager was having a mentor um which I kind of negotiated with the person and said 'yes, I would like that' but we haven't actually kind of progressed that situation."(Participant 14, p.1., line.29).* *"…this wasn't in any contract…this was sent to me by, by our supervisor, you know that I could have um one session a week as CPD and I remember thinking god that's a lot….I don't know what I'll do with that. She also said that I could have one session a week to do research and again I thought, well I don't know what I'd do with that". (Participant 15, p.1., line.15).*
1.Implicit Psychological Contract	**1.1 Flexible Contract**	1.**Implicit Psychological contract**	**3. Open to interpretation**	24.Contract learnt through colleagues 25.learnt contract 26.Contract open to Interpretation 27.Contract negotiated	"*…but the sort of emotional contract is with the team, more implicit kind of stuff, relational" (Participant 13, p.2.line, 66).*

Appendix Q1

Table Q1.1: Summary of Theme 1; 'Implicit Psychological Contract', subthemes, deductive, inductive codes, initial codes and extracts

Table Q1.1: Theme 1 'Implicit Psychological Contract'

Theme 1	Sub Theme(s)	Deductive Codes	Inductive Codes: Recoded	Inductive Codes: Initial	Participant Extracts
1.Implicit Psychological Contract	**1.1 Flexible contract**	**1.Implicit Contract**	4.**Flexible contract**	28.Flexible manager & flexible contract 29.Work longer if manager works longer 30.Flexible approach to contracts 31.Compromise on hours 32.Agreement rather than contract 33.Negotiated having a mentor 34.Flexible contract	*"…I'm allowed to make it flexible but its also flexible in terms of the organisation so… there's flexibility in both, in both ways" (Participant 8, p.1, line 14,)*
1.Implicit Psychological contract	**1.2 Different contract holders**	**2. Contract holders**	**5.Contract holders**	35.National contract 36.Trust as employer 37.Responsible to manager 38. Incentivising recruitment 39.Managers as contract holders 40.Team holds relational contract 41.Organisation holds transactional contracts	*"That's fluctuated as well sometimes…. I feel a lot more micro-managed so it's really fluctuated over the years, depending on who my manager's been really" (Participant 4, p.1, line 13)* *"There's a kind of expectation that there's always a manager above you and they are always taking responsibility above your responsibilities…" (Participant 14, p.2, line 45).* *"Erm, so people can see the employer as different, some people might see the line manager as the employer, some people might see the Trust and some people might see the NHS so….it really depends" (Participant 2, p.8, line 242)* *"I would have thought it was more different, the contracts with the organisation and with the teams, it felt more separate but as we've become more of …an organisation identity...I would say its closer, yeah, expectations are very much similar"(Participant 13, p.1, line, 44)*

Appendix Q1

Table Q1.1: Summary of Theme 1; 'Implicit Psychological Contract', subthemes, deductive, inductive codes, initial codes and extracts

Table Q1.1: Theme 1 ' Implicit Psychological Contract'

Themes	Sub Theme(s)	Deductive codes	Inductive codes: recoded	Inductive codes: initial	Participant Extracts
1.Implicit Psychological Contracts	**1.3 Expectations**	**3.Expectations**	6. **Employee expectations**	42.not paid for overtime 43.not able to work privately 44.not meant to work overtime 45.Work hours 46.Manage competing demands 47.Fulfilling job plan 48.Never worked overtime 49.Not working extra hours 50.evidencing work 51.Service users come first 52.Not implicit 53.Expectations of contract 54.Expectation to over work 55.Contract expectations	*"…well I suppose my expectation would be to…my service users always come first, so I always make sure that I meet their needs" (Participant 7, p.1, line.9).* *"..but in turn, I have to meet um targets and err clear expectations set out by the organisation."(Participant 13, p.1., line,35).* "*I don't remember really working much extra hours in my first few years but I was pretty junior then and I don't think anyone really expected…I did a few extra hours here and there but it wasn't anything major…" (Participant 15, p.1, line 31.)*
1.Implicit Psychological Contracts	**1.3 Expectations**	**3.Expectations**	7.**Parking/travel expectations**	56.parking permit 57.accept travel as part of job 58.contracted travel time	*"I think for years and years we've been very fortunate in having parking on site and all of our sites you just turn up at ten to nine and you're guaranteed a space pretty much…"(Participant 6, p.3, line 79)*
1.Implicit Psychological Contracts	**1.3 Expectations**	**3.Expectations**	**8.Organisation expectations**	59.organisation not clear about expectations 60.Similar expectations with team & organisation 61.Follow organisational values	*"...I can work flexi hours so I can work longer days and shorter days and as long as I (sighs) but in turn, I have to meet um targets and err clear expectations set out by the organisation" (Participant 13, p.1, line 33).* *"Well they expect us to be quite clear about what we do but I don't think the organisation is always clear about what their vision is and what they expect of us"(Participant 5, p.6, line 178)* *"...people were within the old contract, they were still expected to fulfil the obligations of the new contract and that was quite a challenge for me, I was thinking for those people, how did that work, how did that transaction work?" (Participant 10, p.3, line 147).*

Appendix R1
Table R1.1: Theme 2; 'Contextual Factors', subthemes, deductive, inductive, initial codes and extracts

Table R1.1 : Theme 2 Contextual Factors

Theme 2	Subtheme(s)	Deductive codes	Inductive codes: recoded	Inductive codes: initial	Participant Extracts
2.Contextual Factors	**2.1 Financial climate**	**4.Societal Expectations**	**9.Financial savings**	62.Financial restraints in NHS 63.Funding cuts 64.Financial issues in Trust 65.Service had no extra money 66.Trust not setting good example of savings 67.Financial climate 68.National Shortages 69.Trust savings	*"The thing is you know, the last, certainly the last 5 years, you know the NHS has been so squeezed with um so called efficiency savings...." (Participant 15, p3. line 92)* *"I think change within the organisation which is affected by broader change within the NHS and the financial climate, um, I think has directly affected the deal (laughs) between the organisation and employers and I don't think it's necessarily…that the deal has changed dramatically…" (Participant 11, p.2, line 90).*
2.Contextual Factors	**2.1 Financial climate**	4.**Societal Expectations**	**10. Negative National changes**	70.Hijacking agenda 71.Nationally driven strategies 72.Commissioning 73.Discrepancy between profession & commissioning 74.Doing work not commissioned for 75.NHS squeezed 76.Pressure to reduce inpatient beds 77.Problems of Agenda for change	*"…I think part of the process started with 'Agenda for Change' so years ago when we were sort of assessed in terms of what exactly is it that you do, I think that started the thinking process of what is it that I am expected to do as a psychologist within this team?" (Participant 13, p.3, line 132).*
2.Contextual Factors	**2.1 Financial climate**	4.**Societal Expectations**	**11. Not sustainable**	78.Short term gain for long term chaos 79.Not sustainable	*"…people preferred it fudged in mental health by and large but I understand the need to do so but it must be resisted because it's a short term gain for longer term chaos…" (Participant 1, p.18, line, 568).* "*I see it as the NHS and the Trust and it does give me concern for the long term….you know you just think how sustainable is this for all of us? … it does worry me as I say for the future"(Participant 3, p.4, line.110)*

Appendix R1
Table R1.1: Theme 2; 'Contextual Factors', subthemes, deductive, inductive, initial codes and extracts

Table R1.1 : Theme 2 Contextual Factors					
Theme 2	**Sub Theme (s)**	**Deductive Codes**	**Inducitive Codes: Recoded**	**Inductive Codes: Initial Codes**	**Participant Extracts**
2.Contextual Factors	**2.2 Lack of Resources**	**n/a**	**12.Less time**	80.No time to be creative 81.Increased client contact time 82.Less time and resources	*"… I feel personally really kind of protective now over any sort of time that I might have that I can give to things like formulating, thinking, breathing (3 seconds) it feels like it all gets taken up so quickly" (Participant 12, p. 10, line 494)* "*Um having time and space for reflection has definitely changed, like we used to be able to do a visit, come back, reflect, write up, you know discuss.." (Participant 5, p. 19, line 626)*
2.Contextual Factors	**2.2 Lack of Resources**	**n/a**	**13. Less Resources & Fragile services**	83.Negative change of profession 84.Gaps in healthcare system 85.Fragile services 86.Cut backs in social care 87.No support from external agencies 88.Mental health teams close 89.Fragmentation of external agencies	*"….it's just become even more of a given that you just are not going to have enough time and resource to do all the things that you want to do um that need doing as part of your job within the hours that are given because there is a shortage of people so therefore there's more for us to do and less time to do it in…so I think the change in the organisation has affected how our jobs look at this point compared to 2 years ago," (Participant 11, p2, line. 96)* *"…the ever growing list of paper work that you have got to fill in…for people at the expense of actually like seeing them or doing anything with them… you think well that doesn't really incentivise you to see someone for 5 minutes because on the basis of having known them for 5 minutes, you've got to do all of this stuff … and agency staff notoriously just don't tend to do all of that stuff…" (Participant 1, p.12, line 364).*

Appendix R1
Table R1.1: Theme 2; 'Contextual Factors', subthemes, deductive, inductive, initial codes and extracts

Table R1.1 : Theme 2 'Contextual Factors'

THEME 2	Subtheme (s)	Deductive codes	Inductive codes: recoded	Inductive codes: initial codes	Participant Extracts
2.Contextual Factors	**2.3 Social & Political**	**4. Societal Expectations**	**14. Political pressures**	90.Political situation 91.Pressures from government	*"…I think part of the process started with 'Agenda for Change' so years ago…I think that started the thinking process of what is it that I am expected to do as a psychologist within this team?" (Participant 13, p.3, line 132).* *"No, increasingly pessimistic, I think that the government is out to, politicians are out to destroy it and fragment and the fragmentation has already started, 5 or 6 years ago and …when the services were being cut down and you know anyone could come and tender for them, and the values are being completely eroded at last…" (Participant 10, p.21, line 1122)*
2.Contextual Factors	**2.3 Social & Political**	**4. Societal Expectations**	**15.External pressures on NHS**	92.Narrow tunnel vision nationally 93.Pressure to sort things out 94.NHS not able to be fair 95.No room for negotiation 96.External pressures 97.Pressure to cut waiting times 98.Pressure to fix mental health services 99.Pressures of NHS England & commissioners 100.Increase in non-mental health referrals	"*…because they are under a lot of pressures wherever, government or NHS England or whatever, …to meet these targets or commissioners because commissioners will just say well if you can't meet this, we will get somebody else to do the job for us…I think what has changed is that they are clearer in their expectations" (Participant 13, p. 5, line 230)* *"I think most the changes are driven by external pressures, i.e. by government and cos I have friends in lots of Trusts, I, I just see it happening everywhere…Obviously some Trusts do it slightly better than others but it's hard everywhere."(Participant 15, p.13, line 410).*
2.Contextual Factors	**2.3 Social & political**	**4. Societal Expectations**	**16.Media pressures**	101.Pressures from media 102.Bad NHS publicity 103.High public expectations	"*…so I think the media has contributed to it cos the publicity has been so bad for the NHS and I think that in itself places the organisation in a climate of fear um therefore they then drive those things" (Participant 8, p.3. line 116).*

Appendix S1

Table S1.1: Theme 3; 'Contextual Factors', subthemes, deductive, inductive, initial codes and extracts

Table S1.1: Theme 3: 'Organisational Culture Change'

Theme 3	Subtheme (s)	Deductive Codes	Inductive Codes: Recoded	Inductive Codes: Initial	Participant Extracts
3. Organisational Culture Change	**3.1Business Model**	5.**Organisational Purpose**	**17.Corporate model**	104.More corporate speak 105.Agency workers employed 106.Dual role of manager/ clin lead 107.Beaurocratic hoops 108.Private business enterprise 109.Ridiculous bureaucracy 110.NHS more business minded 111.Private business enterprise 112. Privatisation of NHS 113.Agency staff employed 114.Work with private companies 115.Cooperate changes 116.Acquired Capitalistic ethos 117.Become more business like 118.More business model 119.Galvanised job plans 120.Cooperate image 121.Change policies (Agenda for Change)	"*I've just come to a position now thinking actually these are a group of loosely affiliated private organisations bidding and tendering for each other's money…"(Participant 12, line 888, p.18)* "*err…over the past say probably 4 or 5 years, (3 second pause)…for example, the, the PDP process, through um insisting that we have job plans, through um insisting we have a contract (laughs) for a written contract which in the past, I think we had but we never saw, so it's through those processes…the Trust having more of a corporate identity, um, being more visible in terms of their values, being more visible in terms of what training they want us to do, being more outspoken about the targets and I think through those processes…" (Participant 13, p.3, line 108)*
3. Organisational Culture Change	**3.1Business Model**	5.**Organisational Purpose**	**18. Performance focused**	122.Numbers over people 123.Targets over values 124.Target driven 125.Overlap social care & mental health 126.Tick box culture 127.Less clinical role 128.Numbers over quality 129.Performance & outcomes 130.Performance focused 131.IAPT culture 132.Undermines NHS	*"I think our, our team has become much more focused on (3 second pause) input and output than it was a couple of years ago"(Participant 12, p.2, line. 194).* "*…so much more about the paperwork and ticking boxes and actually doing what looks good. You know they want us to do this new um new thing where …it's going to be more, …paperwork, it really does…they're asking us to fill in these new assessments which I feel like are not going to help with the actual clinical work, it's more that we fit in and look like we're playing ball." (Participant 4, p.30, line, 624).*

Appendix S1
Table S1.1: Theme 3; 'Contextual Factors', subthemes, deductive, inductive, initial codes and extracts

Table S1.1: Theme 3 'Organisational Culture Change'

Theme 3	Subtheme(s)	Deductive Codes	Inducitve Codes: Recoded	Inductive Codes: Initial Codes	Participant Extracts
3.Organisational Changes	**3.1 Busines model**	**5. Organisational Purpose**	19**. Survival of NHS**	133.Different NHS Trust responses 134.See clients & do service development 135.More accountable 136.Survival as business model 137.More leaderships 138.Became ahead of the game 139.Transformed NHS 140.More streamlined 141.Need to be savvy to survive 142.Raised standards 143.Developed clear pathways	
3.Organisational Changes	**3.1 Business model**	**6.Balanced reciprocity**	**20.Less reciprocity (overlap with Deductive code)**	144.Less direct employee participation 145.Commissioners don't understand 146.Cannot play implicit game 147. Not supported in decisions	*"…Implicit contracts are exactly that, they are implicit and, and that means people don't have to live up to them…maybe, we, we're becoming more a kind of cruel society…I certainly feel that the NHS is…acquiring a capitalistic ethos in the sense that its much more…ruthless than it used to be…commissioners just aren't that understanding about services, that don't work properly, therefore managers aren't that understanding about workers who don't perform, etc.…I don't think you can get away from playing an implicit game, you know…" (Participant 15, p.7, line, 208).*
3.Organisational Changes	**3.1 Business Model**	n/a	**21. Clearer contract expectations**	148.Contract is more formalised 149.Clearer expectations	*"…we became more of a err, corporate…so I think its because they were more, they were clearer in their expectations of us.." (Participant 13, p.9, line. 423)*

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Table S1.1: Theme 3; 'Contextual Factors', subthemes, deductive, inductive, initial codes and extracts

Table S1.1: Theme 3 'Organisational Culture Change'

Theme 3	Subtheme(s)	Deductive Codes	Inductive Codes: recoded	Inductive Codes: initial	Participant Extracts
3.Organisational Culture change	**3.2 NHS culture Erosion**	**7. Organisational Culture**	**22. Tick box culture**	150.Tick box activities/exercises 151.Trust values became explicit 152.Less flexible service 153.Put people into boxes	*"….people are always trying…put these people in boxes and people don't read these boxes and come to, you know the attention of clinicians so…, I think we've lost out on that flexibility, everybody has become, sort of, quite narrow within their…clinical situations, …and we've also lost the flexibility to work I think with external agencies." (Participant 10, p.4, line 197).*
3.Organisational Culture change	**3.2 NHS culture Erosion**	**7. Organisational Culture**	**23.Nostaliga**	154.Take less for granted 155.Nostalgia of implicit contract 156.Disillusioned with services 157.No longer job for life 158.Waxing and waning 159.Miss freedom	"*..I think over the, certainly since 'Agenda for change' came along, there's been a kind of, quite a shift in um, you could say implicit, implicit kind of expectations/um err (7.4), you know what I would expect to get from a job in a sense, I don't, I don't expect to get any research time now, I don't expect to even that much CPD time actually…"(Participant 15,p1., line.22)*
3.Organisational Culture change	**3.2 NHS culture Erosion**	**7. Organisational Culture**	**24.Damaging change**	160.Negative experience change 161.Reinvention of wheel 162.Nonsensical change 163.Change going in circles 164.Hamster wheel of stress 165.Juggling expectations 166.Change for change sake 167.Constant cycle of change 168.Driven by outcomes 169.Things feel harder 170.Chipped away 171.Damaging to organisation 172.Backwards step	*"…you're on that 'hamster wheel', and you are just feeling like, I'm just not making any headway here, I think in some ways, that decreases the loyalty because you think, I'm doing everything I can, I'm not getting anywhere, I'm not getting, you know, there's no perks here, there's no, there's no particular incentive for me to keep doing this, what's, what's the point?" (Participant, 8. p.14, line.698)*
3.Organisational Culture change	**3.2 NHS culture Erosion**	**7. Organisational Culture**	**25.Change process**	173.Creeping change 174.Changing narratives 175.Pace of change increased 175.Culture change	"*…it's a whole different landscape now. I mean when I started in the NHS it was definitely a kind of 'job for life' and err, I wouldn't say it was an easy job but…you know, the workload was ok and…the Trust was stable, they had, they had a kind of solid platform of contracts..."(Participant 15, p.4, line 101).*

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Table S1.1: Theme 3; 'Contextual Factors', subthemes, deductive, inductive, initial codes and extracts

Table S1.1: Theme 3 'Organisational Culture Change'

Theme	Subtheme(s)	Deductive	Inductive: recoded	Inductive: initial	Participant Extracts
3.Organisational Culture Change	**3.2 NHS Culture Erosion**	**7.Organisational culture/climate**	26.**Team ethos affected**	*176.*Change in team ethos 177.Team merged 178.Everyone is busy 179.Independent relationships 180.Temporary service 181.Change in leadership	*"Yeah and then the end result is the team is not functioning brilliantly and they expect a lot more agency staff so my experience of change has not been good with the NHS" (Participant 1, p.4, line.174).*
3.Organisational Culture Change	**3.3 Blame Culture**	**7.Organisational culture/climate**	**27. Internal scrutiny**	182.Less tolerant 183.Neo-liberal service 184.Accountability 185.Scrutiny for managers 186.Team started to save emails as evidence 187.People got away with more in previous climate 188.Look at individual practice	*"I think the team now feels under much, much more scrutiny um from the employer and the employer's masters so the commissioners really, yeah, um which makes it feel a bit harder" (Participant 10, p.7, line. 310)* *"It's less tolerant, used to be …if you don't do it, that's a disciplinary issue, we, you know, we'll deal with you…we've become a kind of neo-liberal ((sighs)) set of services, its all about data ((yawns))…and outcomes…so if your data is rubbish, it looks like your services are rubbish even if your services are great.." (Participant 15, p.14, line 451).*
3.Organisational Culture Change	**3.3 Blame Culture**	**7.Organisational culture/climate**	**28.Problem focused**	189.Focus on quantitative not qualitative 190.Heat is on 191.Blame emails 192.Not noticing positive	*"…people sort of writing you a personal email to say you know, why haven't you done these 5 risk assessments? I mean I, I don't know. I think and also because most people want to do a good job.." (Participant 13, p.21, line.1020)*
3.Organisational Culture Change	**3.3 Blame Culture**	**7.Organisational culture/climate**	**29.External scrutiny**	193.Fear of CQC 194.External scrutiny 195.NHS under scrutiny	*"Now we've got a CQC inspection and suddenly they are worried about your PDP so everybody goes off and does PDPs or now everybody has to do mandatory training …" (Participant 13, p.20, line, 973)*
3.Organisational Culture Change	**3.3 Blame Culture**	**7.Organisational culture/climate**	**30.Fear climate**	196.Fear of redundancy 197.Climate of fear 198.Organisational uncertainty	*"..it's the external pressures…I think it just makes everybody much more aware of everything, people are aware of how much work they're doing and that makes them aware of how much work other people"(Participant 8, p.16, line 805).*
3.Organisational Culture Change	**3.3 Blame Culture**	**7.Organisational culture/climate**	**31.Less relational**	199.Social interactions are more critical 200.Relational culture eroded	*"…we used to laugh a lot and we don't anymore. And we used to do a lot of socials, we don't anymore…I used to organise socials. I lost my motivation …"(Participant 5, p.20, line, 6*

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Table T1.1: Themes 4; 'Deal breakers', subthemes, deductive, inductive, initial codes and extracts

Table T1.1: Theme 4 'Deal breakers'

Theme 4	Sub Theme (s)	Sub Theme (s)	Deductive Code	Inductive Code: Recoded	Inductive Code: Initial	Participant Extracts
4.Deal Breakers	**4.1 Injustices**	**4.1.1 Trust broken**	**8.Trust**	**32.Trust broken (overlap with Deductive code)**	201.Questioned about overtime 202.Broke Trust 203.Organisation not honest 204.Community as Unknown 205.Pessism about NHS 206.No one knew what was happening 207.Organisation not honest	"*I don' think the organisation is honest anymore because they under a lot of pressures" (Participant 13, p.5, line. 229).*
4. Deal Breakers	**4.1 Injustices**	**4.1.1 Trust broken**	**9. Promises exaggerated**	**33.Unrealistic promises**	208.Painted too rosy a picture 209.Unrealistic promises 210.Promises not met	*"…I think there were a couple of private companies…we, we were lead to believe that we were um um all going to keep our jobs and then, there came the time when actually we were lead to believe that we really weren't going to keep our jobs after a lot of work had been put in which was really quite difficult to take..." (Participant 12, p.7, line 306).*
4. Deal Breakers	**4.1 Injustices**	**4.1.2 Unfair treatment**	**10. Procedural injustice**	**34.Unfair treatment**	211.Unfair treatment of colleagues 212.Unfair team process 213.Lower paid staff not allowed parking 214.unfairness of organisational expectation 215.Unfair commissioning 216.Staff responsibility 217. Situation not acknowledged 218.Not fair for team manager 219.Organisation made employees lives more difficult 220. Sick leave not allowed 221.Staff down banded 222.Colleagues favoured	"*..the NHS used to be very (6.8) kind is probably is the right word but you know, just very understanding around sickness and less so now, there's a large drive to get people not to be off sick and to really put pressure on them erm so yeah"(Participant 15, p.5, line.153* "*…just in terms of the expectations, pressure, stress, the inflexibility but yet they want you to be flexible, the sort of unfairness between what's expected of us and what they sort of expect. It's just completely different*" (*Participant 5, p.9. line 290)*

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Table T1.1: Themes 4; 'Deal breakers', subthemes, deductive, inductive, initial codes and extracts

Table T1.1: Theme 4 'Deal breakers'

Theme	Sub theme (s)	Sub theme (s)	Deductive Codes	Inductive codes: Recoded	Inductive Codes: Initial Codes	Participant Extracts
4.Deal breakers	4.1 Injustices	4.1.2 Unfair Treatment	11. Distributive injustice	35.Exchanges not balanced	223.Increase in referrals but no training 224.No day off 225.Nurses worked longer hours 226.Lack of control 227.felt bad for leaving on time 228.Employees expected to accept 229.No consideration of team 230.Not support that was wanted 231.Working harder becomes expectation 232.uccess Snot acknowledged 233.Hard work not acknowledged	*"I came to….to do a project, originally I'm not doing that project anymore , it was a very hard project, there was a lot at stake, I had to make a lot of personal sacrifices ….to do it you know all sort of sacrifices, time, visits far from my home, erm financially and but mostly there was pressure and stress and hard work and hours and erm and we did a very good job and I think everyone knows that and I thought, implicit in that was, was that I would be offered a position because of that and erm in the end, I wasn't and I did feel quite pissed off about that if I'm honest erm and err felt like one half of the organisation had kind of remembered that another half hadn't…." (Participant 15, p.6, line.169).*
4.Deal Breakers	4.1 Injustics	4.1.2 Unfair Treatment	12. Contract Breach	36.Not rewarded for efforts	234.No praise for overtime 235.Lack of praise 236.Not rewarded for hard work 237.Worked hard & did good job 238.Not able to take sick leave 239.Not allowed external training 240.CPD in own time 241.Staff in double binds 242.Time in lieu not feasible 243.Extra out of own time 244.Longer hours 245.Compliment not acknowledged	"*I think it really sparks off some sense of basic injustice…this is not the world being fair to these people and its, its disquieting and erm uncomfortable to kind of feel that the kind of rules you want to be there aren't really in play which I suppose is the kind of rule that if you work hard and you do a good job, then good things will come to you…they worked hard and did a good job and they just felt treated like shit at the end and dropped so maybe they shouldn't have worked quite...." (Participant 1, p.7, line.224)*
4.Deal Breakers	4.1 Injustices	4.1.2 Unfair Treatment	6.Balanced reciprocity	37.Lack of Reciprocity	246.Unreciprocal exchanges 247.No reciprocity	" *I think but in a way, the bad bit is that somehow now it feels as if research and CPD which is valued is not given time for.." (Participant 13, p.5, line.346)*

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Table T1.1: Themes 4; 'Deal breakers', subthemes, deductive, inductive, initial codes and extracts

Table T1.1: Theme 4 'Deal breakers'

Theme	Sub Theme(s)	Sub Theme (s)	Deductive Codes	Inductive codes: Recoded	Inductive codes: initial	Participant Extracts
4.Deal Breakers	4.1 Injustices	4.1.2 Unfair Treatment	13.Contract Violation	38.Unethical Treatment of staff	248.Injustice of work ethics 249.Ageism 250.Appalling treatment 251.Treated like child 252.Belittles staff	*"… it wasn't like an adult-adult conversation, it was very much me as the child and them telling me what's doing and I acted like a child as a result of that.." (Participant 5,p.13, line.395).*
4.Deal Breakers	4.1 Injustices	4.1.2 Unfair Treatment	13.Contract Violation	39. Personal impact	253.Impact on personal life 254.Anger at lack of parking & writing notes in own time	*"…then I feel angry about the fact that you know I'm going to sit at home writing notes for however many hours in the evening because I spent 20 minutes trying to find a parking space and then having to work, walk to the office." (Participant 11, p.6, line. 258)*
4.Deal Breakers	4.1 Injustices	4.1.3 Poor communication & management	n/a	40.Unclear communication	255.Word of mouth communication 256.No one knew what was happening 257.Make less promises 258.Poor communication of change 259.Poor communication 260.Organisational myths 261.Implicit communication 262.Organisation defensive about sick leave	"*I think, I think its mixed actually, I think there were so many changes, so quickly that messages couldn't be communicated as um freely, and as clearly as we'd want to be so I think lots of big messages did but then I think the myriad tiny little exchanges weren't communicated, yeah" (Participant 12, p.11, line. 507).*

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Table T1.1: Themes 4; 'Deal breakers', subthemes, deductive, inductive, initial codes and extracts

Table T1.1: Theme 4 'Deal breakers'

Theme	Sub Theme(s)	Sub Theme (s)	Deductive Codes	Inductive codes: Recoded	Initial Codes	Participant Extracts
4.Deal Breakers	4.1 Injustices	4.1.3 Poor communication & management	n/a	41.Poor management	263.Processes slipped 264.No manager appointed 265.Managers don't understand 266.Manager's don't understand clinical work 267.Not noticing what people do 268.No manager 269.Poor management 270.Lack of power managers 271.Not credible & visible manager 272.Systems make it worse 273.Poor relations with senior staff 274.Ineffective recruitment 275.Negative organisational talk 276.Ridiculous training 277.No team manager	*"…I haven't felt involved, think when managers have made decisions and just pushed it down to the clinicians, without involving the clinicians"(Participant 14, p.9, line 272).* "*You know I think as a middle manager before, I would have been able to manage situations more autonomously and probably with as good an impact, a good outcome as probably the more formal way we manage things now and less so there's less autonomy for a manager to manage situations.."(Participant 3, line, 209).*
4.Deal Breakers	4.1 Injustics	4.1.3 Poor communication & management	14.No Renegotiation	42. Done Deal	278.Done deal 279.Organisation not flexible 280.'Au fait compli' 281.Not consulted 282.Inflexible manager & contract 283.Manager not flexible	*Some did, the more vocal ones did but I don't think they felt listened to. I think they felt it was a fait accompli and whatever their view was, some…" (Participant 6, p.14, line 467)*
4.Deal Breakers	4.1 Injustices	4.1.3 Poor communication & management	m/a	43.Lack of support	284.Decisions not related to managers 285.Need more support 286.Need for training 287.No support external agencies 288.Need more team support 289.Organisation should do more 290.Less support for team	"*..I remember asking to the person who was heading it up the consultation…saying what do we do about erm about telling our clients because they are going to be losing us and we are moving and…how do we stop our sort of stress cos I said the morale is low at the moment...I remember them saying, 'Oh, you mustn't let them know that you are stressed!' (Participant 2 p.10, line.298)*

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Table T1.1: Theme 4 'Deal breakers'						
Themes	**Sub theme (s)**	**Sub theme (s)**	**Deductive Does**	**Inductive Codes: recoded**	Inductive Codes: Initial codes	Participant Extracts
4.Deal Breakers	**4.1 Injustices**	**4.1.3 Poor communication & management**	**n/a**	**44. Lack of respect**	291. Impersonal emails 292.Badgerd by emails 293.Trust values not in line 294. Told off 295.Shouted at	*"...I see an awful lot more emails that are badgering me about…and are aimed at me as well about whether I've done risk assessments, whether I've seen people within X number of days…, that social exchange has become much more critical…" (Participant 11., p.7, line.336).*
4. Deal Breakers	**4.1 Injustices**	**4.1.3 Poor communication & management**	**n/a**	**45.Professional expectations not met**	296.Lack respect for profession 297.Job uncertainty 298.Cuts on bank staff 299.Re-banding of pay	*"…but at the end of the day you know the number of vacancies we have is also a pressure but not being able to support staff properly can cause the staff to go so do you support the staff or do you have managers jumping up and down so…" (Participant 3, p.3, line.96)*
4. Deal Breakers	**4.2 Expectations not met**	**4.2.1 Not original deal**	**n/a**	**46.Original expectations Not met**	300.Conference not paid for 301.Deal changer 302.Less job perks 303.No longer have own office 304.Unmet expectations 305.Not able to do CPD 306.Not original deal 307.Contract not lived up 308.No conducive environment 309.No fixed base 310.Should be able to use laptops 311.Less luxuries 312.No IT support 313.Out of hours service 314.Less individual work 315.Difficult to establish roles 316.Reduce work bases 317.Different expectations about waiting list 318.Inconsistent expectations	*"…I was working to the contract, working to what is expected of me, above and beyond and all I ask for is a bit of flexibility which is allowed in the contract and they basically said no" (Participant 5, p.8, line 251).* *"…if I don't have a clinical space I can't work and if it's not appropriate, safe and contained and then I can't do my work and actually it felt like to save a quick buck they decided to move the team out to be moved to a place where there wasn't a clinical space and so I wasn't able to work …" (Participant 4, p.6, line 189)* "*Um, yeah I think the flexibility has gone um that use to be around um in terms of being able to sort of make decisions that you think are right, I think that's reduced hugely err and I think the um focus on numbers has become more important than um the flexibility to be able to make choices um…"(Participant 12, p.13, line.640)*

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Table T1.1: Themes 4; 'Deal breakers', subthemes, deductive, inductive, initial codes and extracts

Table T1.1: Theme 4 'Deal breakers'						
Themes	**Sub Theme(s)**	**Sub Theme(s)**	**Deductive Codes**	**Inductive: Recoded**	Inductive codes: Initial	Participant Extracts
4. Deal Breakers	**4.2 Expectations not met**	**4.2.1Not original deal**	**12. Contract breach**	**47.Parking/travel expectations not met**	319.Parking no longer part of deal 320.Contract breach over mileage 321.No enough parking	*"…they then had to worry about parking, um some of the lower paid staff um weren't entitled to permits and had to park in car parks and obviously the more senior staff were getting permits. I think that was a break of contract. People felt although the Trust would say well it was never guaranteed that they would get parking, I think people felt that was a bit, yeah they took that quite hard…" (Participant,6, p.3, line, 89)*
4.Deal Breakers	**4.2 Expectations not met**	**4.2.2 Do more for less**	**n/a**	**48.Increased pressure**	322.Pressures & expectation 323.Pressure to work more 324.Risk redundancy 325.Expect too much	"*…so you are constantly in that place where you think, I'm not meeting my targets, I'm not um doing all my reports, I'm not putting the (3 second pause) the right stuff in there, right folders. I'm not printing off the last risk assessment…I'm not seeing enough people in the community, travelling too much (laughs) constantly feel.90% of the time, that you are not living up to the contract because it's the impossible" (Participant 13, p.8 line 396).*
4.Deal Breakers	**4.2Expecationas not met**	**4.2.2. Do more for less**	**n/a**	**49.Unrealistic expectations**	326.Defeated by whole system 327.Too many pressures 328.Impossible contract 329.High risk levels 330.Unrealistic caseload 331.Unrealistic expectations 332.Unrealistic service goals	*"I think is going wrong with the NHS, its kind of, kind of continual ridiculous demands that you, just can't be met and erm, and erm and then err, a, I guess, I just had a sense of being defeated by her and by the whole system and I, I decided to leave…"(Participant 15, p.7, line.231)*

Appendix T1
Table T1.1: Themes 4; 'Deal breakers', subthemes, deductive, inductive, initial codes and extracts

Table T1.1: Theme 4 'Deal breakers'

Theme	Sub Theme(s)	Sub Theme (s)	Deductive	Inductive: recoded	Inductive codes: initial	Participant Extracts
4.Deal Breakers	**4.2 Expectations not met**	**4.2.2 Do more for less**	**n/a**	**50.Not enough resources**	333.Building not good for staff 334.Doing more for less 335.Lack of time & resources 336.Non contract task 337.Lack of staff 338.Role blurring 339.More referrals 340.Work load and staff in balance 341.Grotty work conditions 342.New setting is too clinical 343.Wasted time	*"…doctors still work within their patches err partly because we've got you know between all the doctors and XX in XXXX, we've got about 600 people on our caseload so you know you couldn't cover the whole of XXXX and XXXX, covering 300 patients, its just not possible so subsequently, consequently we still work within place name and place name, is my patch, place name or place name, or whatever, so local authorities, XXXX boundaries.."(Participant, 10.p.9, line.420).* *"..their expectations are, putting people in a double binds because you can't do both, travel in the community but not incur travel costs…"(Participant 13, p9, line.440).*
4.Deal Breakers	**4.2 Expectations not met**	**4.2.2 Do more for less**	**15. No mutuality**	**51.Lack of mutual understanding**	344.Hard to have shared understanding 345.Social care pressures 346.Ineffective commissioning 347.Personal sacrifices	*"…I think why it was so unexpected was not the response of that person that I knew for quite a while which, it wasn't the response I would have got from that person prior to the changes in the NHS over the last five or six years cos I knew that person for a long number of years and as I say, it's wow, it's…" (Participant 3, p.6, line 173).* *"I don't think that, I'm sure there are other ways of communicating but or you just get an email to say, now you have to do this mandatory training, two emails on…this is your 28 day um targets um, next email is this is how many clients you are seeing and you think well ok, the person sending this email, are they actuall1y thinking about how I'm going to fit all of this in…" (Participant 13, p.16, line, 789).*

Appendix T1

Table T1.1: Themes 4; 'Deal breakers', subthemes, deductive, inductive, initial codes and extracts

Table T1.1: Them 4 'Deal breakers'						
Theme	**Sub Theme(s)**	**Sub Theme(s)**	**Deductive**	**Inductive: recoded**	**Inductive: initial**	***Participant Extracts***
4.Deal Breaker	**4.3 Impact on service users**	**4.3.1 Uncontained**	**n/a**	**52.Strong emotions from service users**	348.Service users are angry 349.Service users don't feel safe 350.Disgruntled patients	*"I think that's a change, yeah… they just don't have the capacity to do it anymore so …I, sort of have the fortune/misfortune of meeting lots of disgruntled patients, service users ((sighs)) (Participant 15, p.10, line.344)* *"It's sort of the impact it has on the service users and you end up having to cope with a lot of anger in sessions…I was forced to finish with people…you know they needed more support but I had to finish with them because there was no clinical place to work with…People just stop coming" (Participant 4, p.7, line 232)*
4.Deal breakers	**4.3 Impact On service users**	**4.3.1 Uncontained**	**n/a**	**53.Impact on clinical work**	351.Working with vulnerable people 352.Impact of clinical work 353.Guilt around closing vulnerable service users 354.Anxiety about number of clients seen 355.Not able to think what's best for clients 356.Too upset to see clients 357.Patient expectations not met 358. Impact on therapeutic relationship	*"…I think for some service users who are really vulnerable you know they stop coming…it's not contained enough, they don't feel safe um the fact that I'm the same therapist doesn't you know isn't enough for them" (Participant 4, p.14, line 461)* *"…I couldn't take on like really complex people or, I did cry once in front of my clients as well which I never do cos.. I was already on edge, that tipped me over, just the hearing that, would have been fine but, cos I was already up here it sort of tipped me over the edge emotionally" (Participant 5, p. 16, line 516).*

Appendix T1
Table T1.1: Themes 4; 'Deal breakers', subthemes, deductive, inductive, initial codes and extracts

Table T1.1:Theme 4 'Deal Breaker'

Theme	Sub Theme (s)	Sub Theme(s)	Deductive Codes	Inductive: recoded	Inductive: Initial	Participant Extracts
4.Deal Breakers	**4.3 Impact on Service users**	**4.3.2 Quality care reduced**	**n/a**	**54.Increased clinical pressures**	359.Pressure to get people back into community 360.Pressure for client contact 361.High risk forensic situations 362.Higher risk in the system 363.More risk in community work 364.Organisation more important	*"I don't, I think they like it if you work a bit extra and I think they like it if you add pressure to you because then you feel guilty because you're not meeting the needs of your service users" (Participant 5, p.3, line 79)*
4.Deal Breakers	**4.3 Impact on Service users**	**4.3.2 Quality Care reduced**	**n/a**	**55.Lack client time**	365.No reflection time 366.Less time with service users 367.Less client time 368.No time to check risk assessments	*"I think probably it does compromise my clinical work …you know when, if a patient calls up, I'm not there and they have to wait usually 3 or 4 days before I'm back in the office to call them" (Participant 14, p.5. line 160).*
4.Deal Breakers	**4.3 Impact on Service users**	**4.3.2 Quality Car reduced**	**n/a**	**56.Lack of resources for clients**	369.Building less personal for service users 370.Building less accessible for service users 371.Fewer inpatient beds 372.Anxiety around lack of beds	*"…I think next five years, I think it will change very differently, again looking at more closures of beds, I think that will continue, that's where the pressure is, much more complex people in their own home because of the Winterbourne Programme, much more complex people coming back…" (Participant, 6, p.26, line.888)*
4.Deal Breakers	**4.3 Impact on service users**	**4.3.2 Quality Care reduced**	**n/a**	**57.Quality of care reduced**	373.Excluding service users 374.Compromises clinical work 375.Caseloads not manageable 376.Not meeting risk targets 377.Quality of risk assessments reduced 378.Decision between admission & staying community 379.Clinical work diluted 380.Change affects clinical work 381.Waiting time increase	*"…it's simple, they pay tax, the NHS is there, the NHS should help them but sometimes, the NHS chooses not to help certain people with certain problems"(Participant 15, p.11, line 353).* *"I would say it's become some of the decisions made by the Trust are maybe not around service users are much more about promotion of the Trust and expansion and taking on other Trusts, and I think that could be seen as a break of contract because our mission is to be the provider of XXXXX and mental health services um, within XXX" (Participant 6, p.4, line 130)*

Appendix U1
Table U1.1: Theme 5 'Strong Emotions', subthemes, deductive codes, inductive codes, initial codes and extracts

Table: U1.1 Theme 5 'Strong Emotions'						
Themes	**Subtheme (s)**	**Subtheme (s)**	**Deductive Codes**	**Inductive Codes: Recoded**	**Inductive Codes: Initial Coding**	**Participant Extract**
5.Strong Emotions	**5.1Stress & Burnout**	**5.1.1.Reduced well-being**	**16. Stress & Burnout**	**58.Too many demands**	382.Unattainable demands 383.Resources depleted 384.Start therapy on back foot 385.Pressure to fit it all in	*"…at the time my work sort of, I think cos I was quite stressed and feeling quite low, I couldn't put much, like to write a report would take me all day to see somebody, I had to cancel a few visits because I was too upset to see them, sometimes I had to cancel visits" (Participant 5, p.16, line 494).*
5.Strong Emotions	**5.1Stress & Burnout**	**5.1.1.Reduced well-being**	**16. Stress & Burnout**	**59.Sickness &exhaustion**	386.Exhaustion 387.Colleague ill health 388.Presenteeism 389.Sick leave increase 390.Taking a lot of sick leave 391.Culture of staff stress & absences 392.Colleagues burnout	*"…the rest of the team are dropping like flies, yeah I, I am sure that, I am sure that the rate of illness and the rate of stress are correlated" (Participant 12, p.9, line 443).* *"…. I tell you what I see a lot of is what's now called, what do they call it? 'preseneteeism' which is a different, which is sort of similar to absenteeism so its people who come to work but they are not productive ." (Participant 15, p.12, line.362)*
5.Strong Emotions	**5.1 Stress & Burnout**	**5.1.1. Reduced well-being**	**16.Stress & Burnout**	**60.Stress**	393.Stress due to bid 394.Stressed with work 395.Added Stress & pressure 396.Sleepless nights due to colleagues 397.Stressed team 398.Stresses & colleagues	*"..I've certainly felt, felt the stress of it at times erm for sure and fed up and you just get fed up with how much of your time is spent trying to work out who it is you are meant to be referring and what form and whether that has change or has that person or who is it now who is the last person…" (Participant 1, p.10, line.396)*
5.Strong Emotions	**5.1Stress & Burnout**	**5.1.1 Reduced well-being**	**16.Stress & Burnout**	**61. Mental Health**	399.Panic attacks due to work stress 400.Anxiety about unknown 401.Anxiety fuelled social interactions	*"Yeah and how, what processes to take and stuff and then it caused a lot of stress. I was having panic attacks at work because I felt like they were trying to get me." (Participant 5, p.9, line.258)*

Appendix U1
Table U1.1: Theme 5 'Strong Emotions', subthemes, deductive codes, inductive codes, initial codes and extracts

Table U1.1: Theme 5: 'Strong Emotions'

Theme	Subtheme (s)	Subtheme (s)	Deductive	Inductive: recoded	Inductive: initial	Participant Extracts
5.Strong Emotions	**5.2 Get on with it**	**5.1.2 Leave/detach emotionally**	**17. Depersonalisa tion**	**62. Mentally Detach**	402.Depersonalisation 403.Lose heart 404.Gave up 405.Less connected with Trust 406.Not seeing team much 407.Disconnected from team 408.Head in sand 409.Divorce self from change 410.Shut it out 411.Less available to colleagues 412.Share less with team 413.People more distant	"*…in fact people have divorced themselves from it. they are not working on any emotional level at all and I can't bear, but you know something, that's not how you work, that's not how I work anyway so I find it really, really frustrating" (Participant 2, p. 11, line 359)* *"…that's why I just divorce myself from that and just get on with what I can do, what I can do is I can help people and get them better and I'm good at that" (Participant 9, p. 19, line. 933).*
5.Strong Emotions	**5.1.Stres & Burnout**	**5.1.2 Leave/detach emotionally**		**63. Internalise blame**	414.Fear of being open and honest 415.Self-blame	"*…but in the past managers can be a bit fearful of telling their staff about change because of reactions but I think it's better to just get it out there and just deal with their reactions." (Participant, 7, p.27,line. 929).*
5.Strong Emotions	**5.1.Stres & Burnout**	**5.1.2 Leave/detach emotionally**		**64.Less Efficient**	416.Less productive 417.Efficiency decrease 418.Not doing enough 419.Anger caused work decrease 420.Positive practice sharing reduced 421.Became regimented 422.Staff members became less flexible 423.No going above & beyond 424.Pace self	"*…my manager did comment, um and other people around me would comment, just be like, not you're leaving again but sort of like you know, you're leaving on time and I'm like yes cos I'm sticking to my working pattern um so it did become quite, yeah I did become quite regimented, yeah." (Participant 5, p.13, line 414).*

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Table U1.1: Theme 5 'Strong Emotions', subthemes, deductive codes, inductive codes, initial codes and extracts

Table U1.1: Theme 5 'Strong Emotions'						
Themes	**Sub Theme(s)**	**Sub Theme(s)**	**Deductive**	**Inductive**	**Inductive**	**Participant Extracts**
5. Strong Emotions	**5.1 Stress & Burnout**	**5.1.2 Mentally detach/leave**	**18. Intention to quit**	**65.Leave jobs**	425.Became less efficient 426.Not motivated 427.Leaving jobs 428.Staff leaving organisation 429.Early retirement	*"I decided to leave…to leave that job erm but…I think what, what got to me there was the fact that I just, I, I, I put so much work in and so much time and effort and it, it just never seemed to be good enough and I just realised I can't actually win this game, this can't be won um and probably I became extremely unproductive after that actually…" (Participant 15, p.8, line 239)* *"…the team has completely changed which is why I left but I didn't want to leave cos I love the job. I had to leave because of the team and because of the way that I was treated and the way that it's going" (Participant 5, p.9, line 285).* *"Well I have noticed that there are more people who suddenly seem…to have firmed up their retirement dates that could be coincidence but I don't think it is…" (Participant 1, p.14, line. 448).*
5. Strong Emotions	**5.1 Stress & Burnout**	**5.1.3 Individual differences**	**19. Individual Differences**	**66. Individual differences (deductive code overlap)**	430.Personality factor 431.Different coping styles 432.Respond differently to change 433.Protective personality factors 434.Personal issues 435.Less individuality, freedom & choice 436. Individual work ethics	"*Everybody went into their own particular chosen methods for dealing with stress so some people became a lot more vocal, some people became a lot more angry, some people became a lot more withdrawn…"(Participant 12, p.12, line 766).* *"I think it comes down to individual practitioners…work ethic really, I think there are some people who always go above and beyond…"(Parrticipant14, p.14, line.445).*

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Theme	**Subtheme(s)**	**Subtheme(s)**	**Deductive**	**Inductive: recoded**	**Inductive: Initial**	**Participant Extracts**
5.Strong Emotions	**5.2 Get on with it**	**5.2.1Complain**	**13. Contract Violation**	**67. Vent anger**	437.Grumble & Groan 438.Upset & Angry 439.Anger at organisation 440.Anger at change 441.Anger at organisation not team 442.Fed up and angry Burdened 443.Feeling shaken up 444.Felt pissed off 445.People upset over travel 446.Resentment 447.More complaints 448.Question everything	"*…so people leave and then some people just get angry all the time, you know, and they're angry at the system, angry at this, angry at that. I don't know, you avoid going to meetings or you're just angry um and it's hard to express that I suppose in a positive way" (Participant 4, p.4, line 117).* "*…I think I felt just more frustrated during that time and more angry about little, silly…where the pressure has been or the amount I've got to do has started to feel a bit overwhelming..." (Participant 11, p.12, line. 577)* *"But I still do it, I have no choice, I grumble and I groan and I moan and I shout at everybody at home and I say 'why do I have to do this?' and I get angry, no, I'm not motivated to do that at all but."(Participant 13, p.12., line. 566).*
5.Strong Emotions	**5.2 Get on with it**	**5.2.1 Complain**	**n/a**	**68. Fear of change**	449.Feeling disillusioned 450.Low self-esteem 451.Scary moment 452.Cried in front of clients 453.People out to get them 454.Feeling undervalued 455. Felt powerless 456.Feelings of loss 457.Fearful & vulnerable 458.Felt despondent 459.Overwhelming job 460.Feel overwhelmed	*"…I was quite fearful because you know erm, you know, when you, you're in a position where you think you understand the rules and then the rules don't work that way anymore, it makes you feel quite vulnerable as you're not quite sure how to play the game anymore…"(Participant 15, p.8, line.254).*

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Table U1.1: Theme 5 'Strong Emotions', subthemes, deductive codes, inductive codes, initial codes and extracts

Table U1.1: Theme 5 'Strong Emotions'						
Themes	**Subtheme(s)**	**Subtheme(s)**	**Deductive**	**Inductive: recoded**	**Inductive: Initial**	**Participant Extracts**
5.Strong Emotions	**5.2 Get on with it**	**5.2.2 Justify**	**n/a**	**69. Reduce costs & meet targets**	461.Trust saved money 462.Staff costing reduced 463.Meeting targets	*"…I think they are aware of it but…I don't think they can do anything about, that's just where they are, there isn't the money and…you know nobody is going to say you don't have to see anybody in 28 days" (Participant 13, p.6, line 173)* *"I am just an employee like everyone else and I might have done a great job but you know if there's no money, there's no money and some big decision has to be made and that's that" (Participant 15, p.10, line 324).*
5.Strong Emotions	**5.2 Get on with it**	**5.2.2 Justify**	**n/a**	**70. Improves Quality of service**	464.Make referrals easier between teams 465.Not change way of working 466.Exclusion criteria clear 467.Lessons learnt 468.Transactional contract met 469.Positives 470.Make lives better in community 471.More likely to stay in job 472.Look at wider picture 473.Positive team change 474.Positive CQC report 475.Improve quality of care 476.Flexibility good for service 477.More independence in community work	*"…we work hard, urm , we've had that for a couple of years and then this year because we got this good CQC report, they've given us 25 pounds each but I just feel a bit weird about that, I have to say cos, so our team here will go out for a meal…" (Participant 9, p.16, line.808)* *"…we're part of the fast track bid to change the model of working so we are getting extra funds to help that so that should be a positive thing." (Participant 6, p.26, line. 882).* *"…maybe positives in the longer run but the NHS starts to sort itself out um and I think targets and things like that as much… they do also make sure that for some people who aren't pulling their weight, then it does highlight that and it makes them have to start doing more..." (Participant 11, p.8, line.398).*

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Table U1.1: Theme 5 'Strong Emotions', subthemes, deductive codes, inductive codes, initial codes and extracts

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Themes	**Subtheme(s)**	**Subtheme(s)**	**Deductive**	**Inductive: recoded**	**Initial Codes: recoded**	**Participant Extracts**
5.Strong Emotions	**5.2 Get On With It**	**5.2.2Justify**	n/a	**71. Organisation Not responsible**	478.Organisation has no power 479.Trust not able to keep to values 480.Difficult to get it right	"*...but with the team it just doesn't feel like it comes from them again it feels like its a wider, more Trust and more NHS and then beyond that to whoever the hell it is who is responsible for commissioning"(Participant 1, p.10, line 314)*
5.Strong Emotions	**5.2 Get On With It**	**5.2.3 Pragmatism**	**n/a**	**72. Get on with it**.	481.Acceptance of service limits 482.Trudge on 483.Be Pragmatic 484.Just keep going 485.Adapt to change 486.Feel should be able to do it 487.Just got to it 488.Pressure as motivator 489.Created opportunities 490.Have to become efficient 491.Doing best in circumstances 492.Remind self of positive impact of work	*"...there was a period of celebration particularly, it felt like a period of trudging on and getting going through, yeah it didn't feel particularly happy at the time" (Participant 12, p.17, line 800)* *"...I'm sort of pragmatic in a sense that I (pause), you know just got on with it and tried to do it as best I could and erm, made the most out of it..."(Participant 15, p.9, line 275)* *"...but its more about the practical ways in which you do that and acceptance...I can't always do things exactly how I want, how I'd like to do them in an ideal world and that that's ok erm and that doesn't mean that that family won't get a good service" (Participant 8, p.10, line 466).*
5.Strong Emotions	**5.2 Get On With It**	**5.2.3 Pragmatism**	**n/a**	**73.All in it Together**	493.Joint work between 494.Professionals 495.More joint working 496.All in it together 497.More cohesive between teams 498.Different professionals working together 499.More MDT nurse work	*"...I think there's something about in a team, when you're really motivated and you're really working hard and you're trying to meet these targets and meet these expectations and, it does bring you closer together, there's very much as sense of like we are all in this together and we are a close team ..."(Participant 8, p.14, line.681).*

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Table U1.1: Theme 5 'Strong Emotions', subthemes, deductive codes, inductive codes, initial codes and extracts

Table U1.1: Theme 5 'Strong Emotions'

Theme	Subtheme (s)	Subtheme(s)	Deductive	Inductive: Recoded	Inductive: Initial	Participant Extracts
5.Strong Emotions	**5.2 Get on with it**	**5.2.3 Pragmatism**	**n/a**	**74. Work life Balance**	500.Sense of perspective 501.Stay healthy 502.Good work life balance 503.Develop self-awareness 504.Step back 505.Look at bigger picture	*"…the other thing that I find is to err keep your own err your own sense of perspectives having, so work life balance … making sure you keep physically err fit and healthy err making sure you have got a GP…" (Participant, 10, p.11, line. 549).*
5.Strong Emotions	**5.3 Loss of Belonging**	**5.3.1 Team fragmented**	**20.Employment Relations**	**75. Interpersonal Difficulties in team**	506.Team used to be sociable 507.Interpersonal difficulties 508.Break down relationships 509.Less positive talk 510. Different personalities 511.Incestuous team 512.Team split 513.Love job but not team	*"How well you function as a team if you don't have a manager…stronger personalities within the team will take over …. And so I think the team, people become more independent and then they don't attend meetings. I think that's one of the big things people do don't they…stop attending the team meetings cos they don't feel like they've got a say so…*" (*Participant 4, p.16. line, 496)*
5.Strong Emotions	**5.3 Loss of Belonging**	**5.3.1 Team fragmented**	**20.Employment relations**	**76.Team less cohesive**	514.Team less cohesive 515.Not feeling part of team 516.Everyone is busy 517.Insular team 518.Team uncertainty 519.Less team fluidity 520.Sloppy team processes 521.Lost team respect 522.MDT work fractured 523.Impact on team 524.Poor team functioning 525.Team's going to crumble 526.Tipping point for team 527.Not attending meetings 528.Less collaborative role 529.Team gone downhill	"*…not being based with our teams, so we all live in one big open plan office now so we've lost that sort of sense of belonging and you don't feel you're part of a team, you're just part of a big call centre…"(Participant 6, p.5, line 145)* *"…as a Psychologist um now I'm much more like part of an organisation. Whereas, before I felt I was part of a team, as a psychologist, having much more individual identity and freedom of choice (laughs). Not necessarily good, I'm not saying that was better but that had definitely its value" (Participant 13, p.14, line 693).*

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Table U1.1: Theme 5 'Strong Emotions', subthemes, deductive codes, inductive codes, initial codes and extracts

Table U1.1: Theme 5 'Strong Emotions'

Themes	Subtheme(s)	Subtheme(s)	Deductive	Inductive: recoded	Inductive: initial	Participant Extracts
5.Strong Emotions	**5.3 Loss Of Belonging**	**5.3.2 Incongruent values**	**21. Identity Deceased**	**77. NHS & Trust Loyalty reduced**	530.Reduced loyalty 531.Less Loyalty to NHS 532.Not advert for Trust 533.Identified with old NHS model 534.Less organisational loyalty 535.Attitude changed 536.Pessism about NHS	*"I think if you come to work and you get a chance to do a good job and you see people benefiting from what you do, you are willing to put in some hours. I think if you, if its all rubbish and…you can't see the benefits and your manager is always giving you a hard time, then you're, you're going to lose heart, you know" (Participant 15, p.16, line 513)* *"…but I think I probably identify a little less cos I feel like the NHS cos it doesn't exist, doesn't have any loyalty to me, erm so it's hard to be loyal back" (Participant 15, p.18, line 579).*
5.Strong Emotions	**5.3 Loss Of Belonging**	**5.3.2 Incongruent values**	**n/a**	**78. Professional & Trust identity discrepancy**	537.Professional identity discrepancy 538. Professional identity only	*"Yeah, it was to help with their finances and I think it went against a lot of people's professional sort of identity really. We're here to care for people not to try to make money out of people" (Participant 6, p.9, line 295).* *"I can identify but I don't, its not what I want, because I think theirs is just language, you know, its words, I don't think its real actually, I don't think you can just put words and then close teams and take away money and say you can't do things to support people, it doesn't work like that, its got to be real but my own internal identity in terms of being an XX has strengthened" (Participant 2, p. 14, line 435).*

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Table V1.1 Theme 6 'Deal Buffers', subthemes, deductive codes, inductive codes, initial codes and extracts

Table V1.1: Theme 6 'Deal buffers'						
Theme 6	**Sub Theme (s)**	**Sub Theme (s)**	**Deductive Code**	**Inductive Code: Recoded**	**Inductive Codes: Initial**	**Extracts**
6.Deal Buffers	**6.1Uphold values**	**6.1.1 Do more**	**22.Organisational citizenship behaviours**	**79. Go above & Beyond**	539.Going above & beyond 540.Going beyond contract becomes norm 541.Multi-task 542.Motivated to do good job 543.Took time to rebuild relationships 544.Create new systems 545.Team going above & beyond 546.Always make up time 547.Perception of people doing more 548.Do more to meet expectations 549.Work s into ground 550.People should fit in hours 551.Culture of doing more 552.Prioritise work over organisation 553.Do what you can 554.Want to make things better 555.Engage external drivers 556.Stayed on top of admin 557.Focus to change narrative 558.Ticked boxes 559.Same passion & work ethic 560.Love client time 561.Prioritise clinical tasks **Discarded initial code:** -Took holiday (specific to one participant)	*"I think and also because most people want to do a good job, I think most people are in this business, definitely not for the money err but they want to do a good job and I think that sort of motivates them and there…"(Participant* *The team leader said to me once that she lies awake at night sometimes thinking of the unallocated clients…" (Participant 1, p.16, line 519)* *"Well patients are always the priority, the safe ward is always the priority but you know…that is quite a situation which when nationally there are shortages of staff" (Participant 3, p.3, line 91)* *"…all the CAMHS clinicians I know are working…themselves into the ground and services are on their knees and I'm trying really hard here but what's the, you know, where's the benefit?"(Participant 8, p.15, line 732).* "*Um, wanting to do the best for the clients because feeling that if we, if we didn't then the clients would be in a much worse position, yeah, yeah I think that's, that's a big thing" (Participant 12, p.15, line 739)*

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Table V1.1: Theme 6 'Deal Buffers'						
Themes	**Subtheme(s)**	**Sub theme(s)**	**Deductive Codes**	**Inductive Codes**	**Initial Codes**	**Participant Extracts**
6.Deal buffers	**6.1Uphold values**	**6.1.2 Increase Identity**	**23.Identity increase**	**80. Identify with Team values**	562.Value & support 563.Pride in colleagues 564.Loyal to team 565.Loyal to team & NHS 566.Aligned to team 567.Separate team contract from organisation 568.Responsbilty to clients/ team 569.Work closely with other 570.Support team mental health 571.Help each other 572.Importance of team values 573.Team innovation 574.Team as breath of fresh air 575.Awareness of self & others 576.Recognise pressure 577.Learning together 578.Flexible & responsive 579.Joint working 580.Mutual support 581.Share compliment 582.Team feels contained 583.Enjoyed Team work 584.Team spirit 585.Good team functioning 586.Team more coherent 587.Sacrifice for team 588.Positive team change 589.Team won nursing award 590.Team pride 591.Belong to team 592.Supportive team	"*…the new service, so everybody um feels very emotionally connected to the service…I think probably because of that, because of the emotional buy-in into the team really" (Participant 12, p.1, line 45)* "*…think it's with the NHS and with my team than the organisation. I've never thought of loyalty to the organisation other than feeling guilty because I'm not doing what I'm supposed to do but I feel my loyalty is to the NHS and definitely to my team*" (*Participant 13, p.15, line 719)* *"…so I think the first, the team feeling increases my loyalty to my team and to the Trust and there's very much a…" (Participant 8, p.14, line 689).* "*…think it's with the NHS and with my team than the organisation. I've never thought of loyalty to the organisation other than feeling guilty because I'm not doing what I'm supposed to do but I feel my loyalty is to the NHS and definitely to my team*"(*Participant 13, p.15, line.719)*

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Theme	**Subtheme(s)**	**Subtheme(s)**	**Deductive codes**	**Inductive Codes**	**Initial Codes**	**Participant Extracts**
6.Deal buffers	**6.1Uphold values**	**6.1.2 Increase identity**	**23.Identity increase**	**81. Identify with Professional values**	593.Professional responsibilities 594.Pride in profession 595.Fulfil professional obligations 596.Stand up for the profession 597.Locate themselves in profession 598.Profession as support	"*I can identify but I don't, its not what I want, because I think theirs is just language, you know, its words, I don't think its real actually, I don't think you can just put words and then close teams and take away money and say you can't do things to support people, it doesn't work like that, its got to be real but my own internal identity in terms of being an XX has strengthened" (Participant 2, p.14, line. 436).*
6.Deal Buffers	**6.1Uphold values**	**6.1.2 Increase identity**	**23.Identity increase**	**82.Idenftify with NHS values**	599.Value free health for all 600.Done time in NHS 601.Belief in Free Health care to all 602.Passionate about NHS	*"….its easy to then and I think there is a bit of a culture within the NHS, that we can be a bit martyrs some of the time and people think 'oh, I'm so hard done by'…we do this job for a reason and its our choice.. I could work in the private sector but…I believe in public service so you just roll with the punches …" (Participant 8, p.16, line 765)* "*I very much identify with the value that healthcare should be free at the point of delivery, I come from a context where it isn't, wasn't free at the point of delivery, necessarily and when it was, it was such a bad quality that" (Participant 13 p.22,line 1068).*
6.Deal Buffers	**6.1Uphold values**	**6.1.2 Increase identity**	**23.Identity increase**	**83.Idenftify with Trust values**	603.Identify with Trust values 604.Promote organisation	*"…so I did still attend AGMs, I still like tweeted during outside of the work hours, um I still promoted XXX as an organisation…" (Participant5, p.13, line.425).*

Appendix V1
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Table V1.1: Theme 6 'Deal Buffers'						
Themes	**Subtheme (s)**	**Subtheme (s)**	**Deductive**	**Inductive: recoded**	**Inductive: initial**	**Participant Extracts**
6. Deal Buffers	**6.1 Uphold values**	**6.1.3 Prioritise clients**	**n/a**	**84. Prioritise Clients**	605.Looking after self & clients 606.About service users experience 607.Clients as priority 608.Put service users first 609.Put service users at heart of working life 610.Loyal to service users 611.Put service user needs first 612.Going out of way to support service users 613.Extra hours for service users 614.service user needs as priority service users come first 615.Stayed in job for clients 616.Service user involvement 617.Do what's right for service users 618.Caring professional nature 619.Loyalty to service users	*"Um, wanting to do the best for the clients because feeling that if we, if we didn't then the clients would be in a much worse position, yeah, yeah I think that's, that's a big thing" (Participant 12, p.15, line 739)* *"…all the CAMHS clinicians I know are working…themselves into the ground and services are on their knees and I'm trying really hard here but what's the, you know, where's the benefit?"(Participant 8, p.15, line 732).* *"The team leader said to me once that she lies awake at night sometimes thinking of the unallocated clients…" (Participant 1, p.16, line 519)* *"Well patients are always the priority, the safe ward is always the priority but you know…that is quite a situation which when nationally there are shortages of staff" (Participant 3, p.3, line 91)*
6. Deal Buffers	**6.1 Uphold values**	**6.1.3 Prioritise clients**	n/a	**85.Improve service quality**	620.Good working relationships with service users 621.Good client care maintained 622.Not having waiting lists 623.eyes opened to service user need 624.Improvement from bottom	"*..it opens your eyes a little bit in regards to what the service user may need because …somebody will say right they need a psychologist, and then you think, when you're all together you can talk about the case and you think actually no they might need a bit of speech and language therapy first .. we do case discussions, I think they're really useful...so we're kind of all under one umbrella really so I think that's been really positive…" (Participant 7, p.14, line.46*

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Table V1.1 Theme 6 'Deal Buffers', subthemes, deductive codes, inductive codes, initial codes and extracts

Table V1.1: Theme 6 'Deal Buffers'

Themes	Sub Themes	Sub Themes	Deductive	Inductive: recoded	Inductive: initial	Participant Extracts
6. Deal buffers	**6.2 Support & Communication**	**6.2.1 Negotiation**	**24. Renegotiation**	**86.Reached Contract compromise**	625.Allow others to take toil 626.Make choices 627.Financial incentives 628.Reneogiation of responsibilities 629.Work longer hours if manager works longer hours 630.People should fit in hours 631.Compromise on hours 632.Work life balance	*"I would think that was normal with any organisational change for people to sort of renegotiate roles and responsibilities and opportunities and in a way that, that's just what happened."(Participant 13, p.18, line 879)* *"I've got a good balance um…I mean, it, its, I feel really proud of myself getting to this point and I just want to be able to live up to the expectations now of the role,"(Participant 14, p.7, line.210).*
6.Deal buffers	**6.2 Support & Communication**	**6.2.1 Negotiation**	**24. Renegotiation**	**87.Psychology contract Still flexible**	633.Contract has become more flexible 634.Balance between business & clinical work 635.Flexible manager 636.Flexible approach to contracts 637.Flexible manager & contract 638.Flexible hours continued	*"…we've had a manager who was very flexible and was like you know the policy says this but actually I'm happy for you to do this because it doesn't affect, you know, there's some things in a policy that can have some flexibility," (Participant 5, p.2, line.45).*
6.Deal Buffers	**6.2 Support & Communication**	**6.2.1 Negotiation**	**24. Renegotiation**	**88.Kept to Original contract**	639.Not acted outside role 640.Never worked extra hours 641.Ethical & transparent 642.Trusting employees	"*I think you've got to make choices I mean I personally choose to work 4 days a week erm so I make less money but I do that to handle my work life balance and my stress, etc. I think, I think you that you know, you've got choices to be made erm I think it may have tipped a little too far into pressurising staff but erm but its not, its not you know, I think we were, we had, we had it a bit too easy previously." (Participant 15, p.13, line.402).*

Appendix V1
Table V1.1 Theme 6 'Deal Buffers', subthemes, deductive codes, inductive codes, initial codes and extracts

Table V1.1: Theme 6 'Deal Buffers'						
Themes	**Sub Theme(s)**	**Sub Theme(s)**	**Deductive Codes**	**Inductive codes: recoded**	**Initial codes**	**Participant Extracts**
6.Deal Buffers	**6.2 Support & Communication**	**6.2.2 Clear Communication**	**25. Contract Fulfilment**	**89.Understnd Employee needs**	643.Dynamic manager 644.Managing change 645.Mutual understanding 646.Shared local understanding 647.Local understanding 648.Concerned with welfare 649.Met needs of team	*"I suppose although people felt it was a done deal, the opportunities were there for people to raise their concern…I don't, I think it had to happen but I think they tried to take people's views into account as much as possible" (Participant 6, p.15, line 504).*
6.Deal Buffers	**6.2 Support & Communication**	**6.2.2 Clear Communication**	**25.Contract fulfilment**	**90.Clear Communication**	650.Adequate communication 651.Appreciate being told information 652.2 way communication process 653.Opportuntity to raise concerns 654.Keep people in the loop 655.Helpful Communication 656.Managers voice concerns 657.Clear communication 658.Open expectations 659.Open & Honest 660.Internal communication 661. Make voices heard 662.Invited to drop in sessions 663.Whistleblowing	*"I think its, it's a bit, it's a mixed picture….there's quite a lot sort formal support erm I think the Trust, certainly in the last couple of years has been very erm aware that if their staff are happy, they'll do better.. I think there's quite a lot more, communication, you know, internal communications erm, that sort of thing which, which helps and makes you feel better about the organisation you work for…"(Participant 15, p.13, line.420).* *"…its come down the communication really, making sure communication is really effective and that everyone's in the loop all the time…you can't get that right all the time um but I think that is significant in managing change, being able to communicate where you're at and where you're going" (Participant 14, p.11, line. 349)*
6.deal Buffers	**6.2 Support & Communication**	**6.2.2 Clear Communication**	**25. Contract Fulfilment**	**21.Clear Expectations**	664.Clearer boundaries 665.Trust consistent with values 666.Clearer expectations 667.Balanced staff treatment	*"...but the bigger err changes that I think is positive like the organisation being more of a corporate image and sort of more kind of open with what their expectations are although they are not realistic. I think that is good in the sense that it is clear" (Participant 13, p.12, line.375)*

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Themes	Subtheme(s)	Subtheme(s)	Deductive Code	Inductive codes: Recoded	Inductive codes: initial	Participant Extracts
6.Deal Buffers	**6.2 Support & communication**	**6.2.3 Feel valued**	**25.Contract Fulfilment**	**91.Valued by managers**	668.Praise from manager 669.Support with safeguarding 670.Competent manager 671.Manager bears brunt 672.Ok if manager respects you 673.Good supervision 674.Supportive manager 675.Fantastic manager 676.Assume manager can solve things 677.Visibility of managers	**"***"…she was a very sort of relaxed like you need to look after your health and wellbeing otherwise you can't look after the clients. She, you know, she recognised when you were working over and would like tell you either to ensure that you take the time back or not to do it kind of thing but said it in a really nice way" (Participant 5, line 27, p.1).* "*Um, my manager did acknowledge it and the compliment so yeah he was very good, he did say you know you've done some really good work with them and it's been really effective…"(Participant 7, p.12, line.406)*
6.Deal Buffers	**6.2 Support & communication**	**6.2.3 Feel valued**	**25.Contract Fulfilment**	**92.Valued by Trust**	678.Compliments 679.Acknowledge hard work 680.Trust was accredited 681.Hard work acknowledged 682.Team away events 683.nvest in staff 684.Receive praise 685.Contained clinical work 686.Team rewarded	*"…definitely, good supervision and support um I've, I have got a really good supervisor who I can just go and go 'blahhh!' to which um just helps being able to go and vent stuff and get some perspective and talk things through and um yeah, I think that, that, that's really important" (Participant 14, line 327, p. 10).* *"…but now its more evened out which I think is good so now everybody is expected to see lots of people and people who I think but in a way…" (Participant 13, p.11, line.353)*
6. Deal Buffers	**6.2 Support & communication**	**6.2.3 Feel valued**	**25.Contract Fulfilment**	**93.Valued by profession**	687.Protective profession 688.Valued as professional **Discarded initial codes:** -Support from friends & family -Support from peer group	*"…so professions supporting each other in working with cases.. so the way that we erm professionally…support each other.." (Participant 11, p.10, line.465)*