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The relationship between Perceived Organisational Threat and Compassion for Others: Implications for the NHS

Abstract

The National Health Service (NHS) is known to be a challenging place to work, with financial and performance targets placing increasing pressure on the organisation. This study aimed to investigate whether these pressures and threats might be detrimental to the quality of care and the compassion that the NHS strives to deliver. Quantitative data were collected via self-report questionnaires from healthcare professionals across three NHS Trusts in England in order to measure: Self-compassion; Compassion for Others; Perceived Organisational Threat; and Perceived Organisational Compassion. Qualitative data was also collected to explore the threats considered most pertinent to healthcare professionals at present. The key findings suggest that increases in Perceived Organisational Threat may reduce an individual's ability to give compassion to others, however Self-compassion and Perceived Organisational Compassion were better predictors of Compassion for Others. This highlights the need to consider compassion at a systemic level, providing interventions and training not only to cultivate self-compassion in healthcare professionals, but also to encourage compassion across the NHS more generally. In promoting self-compassion and increasing the level of compassion that employees feel they receive at work, healthcare professionals may be better able to maintain or improve their level of compassion for service-users and colleagues.

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Key practitioner message:

- Increases in Perceived Organisational Threat were found to be related to a decrease in healthcare professionals' level of Compassion for Others.
- However, Self-compassion and Perceived Organisational Compassion were significantly better predictors of level of compassion for others than was Perceived Organisational Threat; increases in Self-compassion and Perceived Organisational Compassion related to an increase in Compassion for Others.
- Healthcare service development and staff interventions may benefit from greater focus on cultivating and promoting self-compassion, and on systemic interventions promoting compassion across all levels of an organisation.
- Future research should examine the feasibility and effectiveness of compassion-focussed interventions amongst professionals in healthcare organisations, and would benefit from further investigation into the impact this may have for service-users.

Introduction

The quality of health care services is often the focus of political interest and clinical interventions, and improving the quality of services is now a key requirement for the National Health Service (The Kings Fund, 2016). In recent years, the failure of a healthcare system to meet adequate levels of quality and safety resulted in the publication of the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013), which highlights the importance of putting the service-user first, by “ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture”. Indeed, ‘compassion’ is stated as one of the six values enshrined in the NHS constitution, and underpinning all that the NHS does (eg. NHS Commissioning Board & Department of Health, 2012).

To be able to work within a ‘common culture’ involving care, compassion and commitment, compassionate and caring individuals must work alongside likeminded colleagues, but perhaps would also benefit from working within compassionate and caring services and environments more generally. This is in contrast to the current representation of the NHS within the media (Triggle, 2017a, 2017b; Unison, 2015, 2017). For example, government-driven threats to the NHS as an organisation exist in the form of privatisation and the need to compete with other providers for business (Unison, 2015), amongst others. Within the organisation additional challenges exist for individual NHS Trusts, such as the threat of financial penalties if targets are breached (NHS Commissioning Board, 2013) which can leave healthcare professionals with excessive workloads, time pressures and inadequate staffing levels (National Institute for Occupational Safety and Health- NIOSH, 2008). Alongside these top-down pressures, healthcare professionals often also face extreme suffering in service-users and interpersonal conflicts amongst colleagues and managers (NIOSH, 2008). It is perhaps unsurprising then that 27% of health service staff exceed the threshold for ‘minor psychiatric disorders’ such as anxiety and depression on the General Health Questionnaire (Goldberg & Hillier, 1979), compared to just 18% for the British workforce more generally (Wall et al., 1997). In turn, the impact of these stresses and

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pressures on healthcare professionals may also impact on the quality of the relationships and the care that service-users receive. That is, stress and burnout are thought to negatively impact on attention, concentration, decision-making skills and the professional's ability to establish relationships with service-users (Shapiro, Brown & Biegel 2007). Given the prevalence of stress and burnout within NHS staff and healthcare professionals more generally, and the impact this may have on service-users, it is important to consider ways to conceptualize and improve this situation.

Compassionate Mind

One way to conceptualise and understand this stress is through the work of Paul Gilbert (2009), using the Compassion-Focussed Therapy (CFT) model. Gilbert's (2009) theory suggests that humans, in common with other animals, possess three key emotion-regulation systems. The first system, the 'threat and self-protection system' (herein referred to as the 'Threat system') reacts quickly to threat by giving bursts of feelings such as anger, anxiety or disgust in order to protect the self. The second system, the 'incentive and resource-seeking system' (herein referred to as the 'Drive system') drives us to seek out resources in order to survive, giving feelings of motivation, excitement and pleasure. Finally, the 'soothing and contentment system' (hereafter referred to as the 'Affiliative system') brings about feelings of peacefulness and contentment when we are neither threatened nor striving to achieve, and gives us feelings of well-being associated with connectedness to others. Despite having these emotion regulation systems in common with other animals, humans are unique in that our brains have evolved to also allow complex thinking, imagination, learning and language (Gilbert, 2009). The CFT model therefore distinguishes between the 'old brain' (the three emotion regulation systems) and the 'new brain', which involves more unique skills allowing humans to reflect on the three systems and thus on our emotions and behaviours (Gilbert, 2009). In line with this model, it could be suggested that feelings of distress and burnout in healthcare professionals result from over-activation of both the Drive system and the Threat system, and under-activation of the Affiliative system. This distress may be increased if professionals relate to their experiences (via the new brain) in a critical or harsh way. For example, a nurse may find her Threat system being activated when the shift is under-staffed so she is unable to dedicate as much time as she would like to each service-user and works most of the shift feeling hungry and tired. Now consider how critical or threat-based thinking via the new brain may leave her questioning whether she is at fault for not spending enough

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time with each service-user, or what she might have done ‘wrong’ during the shift. In contrast, Gilbert (2009) describes how nurturing the Affiliative system can help one to develop a more compassionate motivation, helping the three emotion regulation systems to operate in more balanced, healthy and productive ways. For example, the Drive system can attend to action in the service of compassion, to prevent or resolve the sources of suffering; the Threat system can attend to situations that may jeopardise compassion; and the Affiliative system promotes soothing, encourages connection with others and emphasises the importance of maintaining positive relationships. Thus, cultivating a compassionate motivation, based on a clear understanding of how this tricky brain works, can allow humans to think and behave in ways which are more likely to create happiness for the self and others (Gilbert, 2009).

Compassion can be broadly described as a non-judgemental sensitivity to the suffering of self and others, with a commitment to prevent and alleviate that suffering (Dalai Lama, 1995). Gilbert (2009) proposes that compassion involves the flow of compassion to the self, to others, and also involves allowing compassion to flow from others to oneself. He has also identified a number of attributes and skills thought to be necessary in cultivating this flow of compassion. The six key attributes include: ‘motivation’ to care for well-being, ‘empathy’ and ‘sympathy’, ‘distress tolerance’ rather than controlling or avoiding emotions, ‘sensitivity’ to distress, and a ‘non-judgemental’ stance (Gilbert, 2009). The compassionate skills with which to build on the six attributes include: imagery to bring about feelings and sensations of warmth and kindness; learning to direct attention in a compassionate and mindful way; thinking and reasoning in a helpful and honest way, without rumination; and behaving compassionately to the self and to others (Gilbert, 2009). Kristen Neff (2003a) has expanded on the concept of self-compassion and describes three necessary components: self-kindness- being warm and understanding towards ourselves; common humanity- recognizing that suffering and personal inadequacy is part of the human experience; and mindfulness- taking a balanced, non-judgemental approach to our emotions so that they are neither suppressed nor exaggerated.

The present study

This paper comprises three studies investigating the perception of workplace threats and stressors amongst NHS employees, and how this relates to the flow of compassion (to self, to other and from other). In Study One, the link between how threatening the individual perceives their organisation/workplace to be, and how able they are to feel compassion for

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others at work, is quantified and explored. In Study Two, this analysis is further explored, and additional factors (including demographic characteristics, level of self-compassion, and perceived level of organisational compassion) are included to test for their moderating effect. That is, these additional factors are investigated to see whether they impact on the relationship between Perceived Organisational Threat and Compassion for Others, to explore possible areas for intervention. Finally, Study Three reports on a qualitative analysis of the factors that trouble NHS employees about working in their organisation to explore the issues considered most important by the individuals themselves, again providing opportunity for intervention. Data for all three studies was collected simultaneously, within one online survey, which was distributed across three NHS Trusts in England.

Study One

Introduction

The Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) highlights the importance of putting the service-user first, by “ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture”. However, with the combination of government-driven threats to the NHS as an organisation, individual challenges within NHS Trusts, and extreme suffering within service-users and the wider system, it is apparent that a ‘common culture’ of care, compassion and commitment may not always be achievable or sustainable. Stress and burnout on account of these threats and pressures are thought to negatively impact on attention, concentration, decision-making skills and the professional’s ability to establish relationships with service-users (Shapiro et al., 2007). What is currently less clear, is whether the healthcare professional’s perception and experience of such threats impacts upon their ability to feel compassion for others and to work compassionately with others, including those individuals accessing services.

As compassion is thought to involve a complex interplay of motivational and emotional systems, over- or under-stimulation of one of these systems could be detrimental to an individual’s capacity for compassion. That is, according to Gilbert’s (2009) theory, the flow of compassion requires a range of skills and attributes, which draw on higher-level cognitive

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components such as attention and reasoning. It could be suggested that such skills might be difficult to access whilst one's Threat system is activated, as one's body may have shifted into a 'survival mode'. Returning to the previous example of the nurse – if she continued to work shifts that were under-staffed she may find her stress symptoms gradually worsening; she may become more emotionally exhausted, and her attention and concentration may decline (Shapiro et al., 2007). This would likely leave her with less emotional reserve and thus less capacity to tolerate the suffering of service-users and colleagues – one of the skills identified by Gilbert (2009) as important for compassion. Despite this theoretical relationship, as yet this link between perceived threat and compassion for others has, to the best of the authors' knowledge, not been investigated.

Aims

It can be theorised that healthcare professionals experiencing occupational stress, or whose levels of Perceived Organisational Threat is high (for example, when there is job insecurity or long working hours), may find it more difficult to access the attributes or higher level cognitive components required for compassion. This is an important consideration given the current drive for 'compassionate care' in the NHS (eg. NHS Commissioning Board & Department of Health, 2012). However, this link is yet to be investigated and thus the aim of Study One is to explore this potential relationship.

Hypothesis 1: Perceived Organisational Threat experienced by healthcare professionals will be negatively correlated with their level of Compassion for Others at work.

Method

Design

A cross-sectional design was employed. Participants completed one survey, which allowed for the collection of both quantitative and qualitative self-report data via questionnaires, and enabled data collection for all three studies presented within this paper. Within Study One, only quantitative data was analysed; the dependent variable was Compassion for Others; the predictor variable was Perceived Organisational Threat.

Procedure

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Ethical approval was obtained via a local University ethics committee. Employees were invited from three NHS Trusts in England to take part in an anonymous online survey between August 2014 and January 2015. Trusts 1 and 3 were Mental Health Trusts, whilst Trust 2 was an Acute Trust. At the point of recruitment, only Trust 3 was already integrating the CFT model into service delivery and planning, staff training, and research and development.

Advertisements for the survey were circulated online via the Trusts' intranet pages and their staff newsletters. The advertisement briefly outlined the aims of the study, the broad focus of the anonymous survey questions, and that it should take approximately 30 minutes to complete. Potential participants voluntarily self-selected by following the link within the advert, re-directing them to the online survey hosted by Survey Monkey (www.surveymonkey.com). Upon following the link potential participants were presented with an information sheet, a description of the inclusion criteria, and a consent form. Following completion of the questionnaires participants were presented with a debriefing page.

Participants

The inclusion criteria specified that participants were: an NHS employee; working in a clinical profession and/or their job role involved clinical contact with service-users/patients. A total of 314 participants met the inclusion criteria, consented to participate, and completed at least one questionnaire. Of the 314 participants included, 276 (87.90%) completed all questionnaires within the survey. Demographic data are presented in Table 1.

Power Analysis

Data collection for Study One and Study Two occurred simultaneously using a single survey. As Study Two required a greater number of variables and a greater number of statistical analysis procedures, the power analysis calculation was computed with those figures in mind. Please see Study Two for details.

Measures

Demographics

Participants were asked to disclose their age, gender, the NHS trust within which they were employed, their job role/job title, and for how many years they had worked within the NHS.

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Perceived Organisational Threat

In the present study the aim was not to measure whether stress symptoms were present but instead was to measure the level of perceived threat, which involves the stressors and challenges faced by individuals working within that organisation. Consequently, A Shortened Stress Evaluation Tool (ASSET; Cartwright & Cooper, 2002) was chosen, which is a measure developed to assess risk of stress within a workforce with respect to a range of known workplace stressors. It contains three main scales as well as collecting biographical information. Specifically, the ‘Perceptions of your job’ scale of ASSET was used to measure ‘Perceived Organisational Threat’ as a predictor variable. The ‘Perceptions of your job’ scale contains 37 items covering the following categories of workplace stressors: work relationships, the nature of the job, overload, control, job security, resources and communication, work-life balance and pay and benefits. Each item is preceded by “I am troubled that...” and participants respond via a six-point likert scale, ranging from ‘1 (strongly disagree)’ to ‘6 (strongly agree)’. For example, the first item reads “I am troubled that... I work longer hours than I choose or want to”. ‘Perceived Organisational Threat’ was measured by summing the 37 individual item scores, giving a minimum possible score of 37 and a maximum of 222, where higher scores indicate greater Perceived Organisational Threat. Although not included within the Perceived Organisational Threat predictor variable, participants also completed the remaining two scales of ASSET- ‘Attitudes towards your organisation’ and ‘Your health’. The ‘Attitudes towards your organisation’ scale contains nine items, such as “I feel valued and trusted by the organisation” which participants respond to via a six-point likert scale ranging from ‘1 (strongly disagree)’ to ‘6 (strongly agree)’. The ‘Your health’ scale contains a list of 17 physical symptoms associated with stress, such as “headaches”, and asks participants to rate how often they experience each, ranging from ‘1 (never)’ to ‘4 (often)’. Faragher, Cooper and Cartwright (2004) report adequate internal consistency and strong convergent validity. ASSET was normed on a large sample of public and private sector workers in the UK ($N = 25,352$) and the available norms for each subscale can be found in Table 2.

Compassion for Others

The Compassion Scale (CS; Pommier, 2011), although a measure of compassion for others, was developed around Neff’s (2003a) conceptualisation of self-compassion. It is a 24-item questionnaire giving an overall measure of Compassion for Others, as well as scores on three

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positive subscales (Kindness, Common humanity and Mindfulness) and three negative subscales (Indifference, Separation and Disengagement). Participants respond to each item using a five-point likert scale describing how often they ‘behave in a stated manner’, ranging from ‘1 (almost never)’ to ‘5 (almost always)’. For example, one item reads “I like to be there for others in times of difficulty”. Pommier (2011) found the CS to have good internal consistency (Cronbach’s alpha = .90), good split-half reliability (.90) and adequate convergent validity. For use in the current study, participants were asked specifically to consider how they ‘typically act towards others at work’, rather than considering how they generally act towards others, so as to specifically capture participants’ level of Compassion for Others within the workplace. For each participant an overall CS score was calculated as a measure of ‘Compassion For Others’ by reverse scoring the three negative subscales before then calculating an overall mean. This gives a minimum possible score of one and a maximum of five, whereby higher scores indicate greater Compassion for Others. During validation of the CS, Pommier (2011) found the mean score to be 3.57 in a sample of 510 undergraduate educational-psychology students. More recently, Neff and Germer (2013) found a baseline mean CS score of 4.17 amongst a sample of 54 individuals from the general public in the US, who had opted to take part in a Mindful Self-Compassion Program.

Data Analysis Procedures

Data was analysed in Studies One and Two using IBM SPSS Statistics version 22.0 (IBM Corp., 2013). Descriptive statistics were used to analyse the demographic data. Pearson’s Product Moment Correlation Coefficient was used to investigate the correlation between the dependent variable (Compassion for Others) and the predictor variable (Perceived Organisational Threat). A significance level of 5% was used in all data analysis procedures for Studies One and Two.

Results

Descriptive Statistics

Demographic Characteristics

Demographic data are available in Table 1. The majority (68.5%) of participants were recruited from Trust 1 and most (64%) were at least 40 years of age. A large proportion of

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participants were female (82.2%), which is in keeping with more general NHS workforce statistics (NHS Employers, 2017). Participants were recruited from a range of disciplines and job roles, with the largest group being classified as ‘Nursing’ (40.1%). Disciplines with small participant numbers were grouped together as ‘Other’ (making up 12.4% of the sample). Pearson’s Chi Squared tests were carried out on the categorical variables (age group, gender, and job role) to test for differences between NHS Trusts. For the purposes of the Chi Squared tests only, ‘job role’ was temporarily re-grouped as either ‘Nursing’ (40.1%) or ‘Other’ (50.6%) to ensure cell counts were sufficiently large for analysis. The Chi Squared tests revealed no relationships between NHS Trust and demographic characteristics ($p > .05$ for all tests). The mean number of years worked within the NHS was 16.04 years ($SD = 10.79$) though this ranged from less than one year to 46 years. A One Way ANOVA revealed that this mean differed significantly between NHS Trusts ($F(2, 298) = 6.549, p = .002$) and a Tukey post-hoc test revealed that the number of years worked in the NHS was significantly larger for Trust 2 than it was for Trust 1 ($p = .001$) only.

[Table 1]

Dependent Variable – Compassion for Others

Scale score means were calculated for the overall CS measure, and each of its six subscales, both within the overall sample and separately for each of the three NHS Trusts (see Table 3).

The Shapiro-Wilk Test was used to test for normality within each NHS Trust (3 groups) for each of these 7 variables (overall CS plus six individual CS subscales). Comparisons were then made between NHS Trusts using a One Way ANOVA or a Kruskal-Wallis Test (if a non-parametric test was indicated). In the case of a statistically significant result, post-hoc pairwise tests were carried out and the Pearson correlation, r , was used as a measure of effect size where a pairwise difference was found (as recommended in Field, 2013).

For all seven variables, the Shapiro-Wilk test gave a p -value of less than .001 for Trust 1 and therefore the Kruskal-Wallis test was used in all cases. The Kruskal-Wallis Test revealed that there was a significant main effect of group on the overall CS score ($H(2) = 8.126, p = .017$) and on three of the individual CS Subscales: Indifference ($H(2) = 9.914, p = .007$); Separation ($H(2) = 6.292, p = .043$); and Mindfulness ($H(2) = 7.975, p = .019$). In comparison to the other NHS Trusts, Trust 1 revealed the highest mean scores on positive subscales and the lowest mean scores on the negative subscales, suggesting the greatest level

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of Compassion for Others when compared to the other two Trusts. In comparison, Trust 3 revealed the lowest mean scores on the positive subscales and the highest mean scores on the negative subscales, suggesting participants from Trust 3 exhibit the least Compassion for Others. Effect sizes for the Trust 1 versus Trust 3 comparison were .183, .202, .160 and .179 for the overall CS score, CS Indifference subscale, CS Separation subscale and CS Mindfulness subscale, respectively.

The main effect of group on the CS Disengagement Subscale ($p = .054$) did not reach statistical significance, but does reveal a notable trend with Trust 3 having the highest mean score ($M = 2.07$, $SD = 0.8$). No significant main effect of group was found for the CS Kindness Subscale ($p = .233$) or the CS Common Humanity Subscale ($p = .235$).

Comparisons can also be made between the scores obtained by the overall sample and the mean scores or norms found in previous studies. The mean overall CS score of 4.09 suggests that the level of Compassion for Others found in the current study was similar to that of a small US sample of individuals who had opted to take part in a Mindful Self-Compassion Program (Neff & Germer, 2013). Both this sample, and the healthcare professionals in the current study had relatively high levels of Compassion for Others in comparison to a sample of 510 undergraduate educational-psychology students (Pommier, 2011).

Predictor Variable – Perceived Organisational Threat

Scale score means were calculated for each of the three main ASSET scales, both for the overall sample and for the three individual NHS Trusts (see Table 3).

The Shapiro-Wilk Test was used to test for normality within each NHS Trust (3 groups) for each of these 3 variables (ASSET scales). Comparisons were then made between NHS Trusts using a One Way ANOVA or a Kruskal-Wallis Test (if a non-parametric test was indicated).

For the ASSET scale ‘Your Health’, the Shapiro-Wilk test gave a p -value of less than .015 for Trust 1 and therefore the Kruskal-Wallis test was used. For the other two ASSET scales, the Shapiro-Wilk test gave a p -value of greater than .05 for all NHS Trusts and therefore one-way ANOVAs were used.

A One Way ANOVA revealed that there was a significant main effect of group on the ‘Attitudes towards your organisation’ scale of the ASSET ($F(2, 301) = 3.565$, $p = .030$). A

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Tukey post-hoc test revealed that the mean score was significantly higher in Trust 1 than it was in Trust 3 ($p = .047$) and significantly higher in Trust 2 than it was in Trust 3 ($p = .040$) suggesting that participants from Trusts 1 and 2 had significantly more positive attitudes towards their organisation than did Trust 3. The effect size for the Trust 1 versus Trust 3 comparison was .143 for the ‘Attitudes towards your organisation’ scale.

A Kruskal-Wallis Test revealed that there was a significant main effect of group on the ‘Your Health’ Scale of the ASSET ($H(2) = 7.641, p = .022$) with Trust 1 showing the lowest mean score and Trust 3 showing the highest mean score. This suggested that Trust 1 employees had better health and lower levels of stress than employees of Trust 3. The effect size for the Trust 1 versus Trust 3 comparison was 0.170 for the ‘Your Health’ scale.

The main effect of group on the ‘Perceptions of your job’ Scale of the ASSET (used as the measure of Perceived Organisational Threat; $p = .096$) did not reach statistical significance, but does reveal a notable trend with Trust 3 having the highest mean score ($M = 126.15, SD = 30.75$).

Scores on the ASSET questionnaire, as described in Table 2, suggest that in comparison to the general UK working population the NHS employees taking part in this study had more stress symptoms, higher perceived levels of most workplace stressors covered here, and felt their organisation was less committed to them as employees (Robertson Cooper Ltd., 2004). However, participants did also report fewer stressors related to pay and benefits, work-relationships and relationships and communication, in comparison to the general UK working population (Robertson Cooper Ltd., 2004).

[Table 2]

[Table 3]

Is Perceived Organisational Threat related to Compassion for Others?

The relationship between Perceived Organisational Threat, as measured by the ‘Perceptions of your job’ Scale of the ASSET was significantly, although weakly, negatively correlated with Compassion for Others ($r = -0.336; p < .001$). This suggests that as the level of

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organisational threat perceived by an individual increases, their ability to show compassion towards others at work decreases. These findings therefore lend support for Hypothesis 1. It is important to note, however, that the nature of correlational analysis means that relationships can be detected but causal inferences cannot be made.

[Table 4]

Discussion

Hypothesis 1 predicted that Perceived Organisational Threat experienced by healthcare professionals would be negatively correlated with their level of Compassion for Others at work. This hypothesis was supported; as Perceived Organisational Threat increased, Compassion for Others decreased. This is an important finding given the prevalence of threats and stressors faced by NHS employees currently. For example, government-driven threats to the NHS as an organisation (resulting in privatisation and competing for business; Unison, 2015), the threat of financial penalties if targets are breached (NHS Commissioning Board, 2013), and documented excessive workloads, time pressures and inadequate staffing levels (NIOSH, 2008) are all a cause for concern at present. Indeed, the NHS employees taking part in this study were found to have more stress symptoms and higher perceived levels of most workplace stressors in comparison to the general UK working population (Robertson Cooper Ltd., 2004).

Based on the findings of this study, it would be anticipated that this heightened perception of organisational threat and elevated level of perceived workplace stressors could result in a reduction in the healthcare professional's ability to feel compassion for others, and to deliver compassionate care.

Study Two

Introduction

In Study One, a significant negative correlational relationship was found between Perceived Organisational Threat and Compassion for Others at work, amongst NHS employees. Given the numerous threats towards, and indeed within the NHS, and the likelihood that NHS staff

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will continue to encounter such threats within the workplace (eg. NHS Commissioning Board, 2013; NIOSH, 2008; Unison, 2015), it is important to also explore ways to minimise the impact of this on the ability to deliver compassionate care. Whilst there is a relationship between Perceived Organisational Threat and Compassion for Others, there is also research to suggest that there may be aspects of compassion which buffer against the impact of threat.

Threat and Self-compassion

Research has begun to investigate how self-compassion interacts with the Threat system. Neff and Vonk (2009) found that self-compassion, as measured by the Self-Compassion Scale (SCS; Neff, 2003b), was positively correlated with happiness, optimism and positive affect, whilst being negatively correlated with self-worth instability, social comparison, public self-consciousness, self-rumination, anger and the need for cognitive closure/certainty, in a sample of over two-thousand participants.

In an experiment, Neff, Kirkpatrick and Rude (2007) found that greater self-compassion was associated with significantly less anxiety following a mock job interview, even after controlling for initial levels of negative affect. Furthermore, in a series of five experiments, Leary, Tate, Adams, Allen and Hancock (2007) investigated the role of self-compassion in the emotional and cognitive experience of negative life events. The authors found that participants who had greater levels of self-compassion were more likely to treat themselves kindly after negative life events, were less likely to under-value and be critical of their abilities, and were more able to accept responsibility for feedback, rather than externalising blame. Leary et al. (2007) also found that a greater level of self-compassion was associated with less catastrophising and personalising, less negative affect, and a decreased likelihood of feeling overwhelmed by negative emotion, as well as a greater sense of equanimity and humour. It is important to note that these studies focussed on undergraduate samples only, and failed to measure social desirability bias alongside the self-report questionnaires. Despite this, they provide reasonably strong evidence to suggest that higher levels of self-compassion may serve to buffer against the effects of negative experiences and cognitive processes which activate the Threat system.

Threat and Compassion for Others

Two studies have attempted to explore the impact of Compassion for Others on activation of the threat system. Pace et al. (2009) investigated the effects of a 6-week Lojong-based

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compassion meditation, where one practices developing spontaneous feelings of empathy and love for an ever expanding circle of people. Following these 6 weeks participants took part in a laboratory stress task involving public-speaking and mental arithmetic in order to induce anxiety and stress. The authors found that the compassion meditation did not significantly alter self-reported levels of distress or biochemical measures of anxiety when compared to a control group. However, within the meditation group, those practicing meditation more often did exhibit lower anxiety and distress levels overall. It is important to note that level of Compassion for Others was not recorded following the meditation, so it is difficult to know whether the meditation did indeed increase Compassion for Others.

Cosley, McCoy, Saslow and Elissa (2010) also asked individuals to engage with a stress task involving mental arithmetic and public speaking, though in this study one group was joined by neutral evaluators during the task, whilst another was joined by supportive evaluators. Compassion for Others was measured prior to the experiment using the Compassion subscale of the Dispositional Positive Emotion scales (Shiota, Keltner & John, 2006). In the supported group evaluators would interrupt with verbal and non-verbal praise. In this situation higher Compassion for Others was significantly correlated with lower blood pressure and lower cortisol levels during the task, suggesting lower levels of anxiety. In contrast, the neutral group showed no correlation between Compassion for Others and any of these physiological measures, despite the two groups having no significant physiological differences at baseline. These findings are interesting in that Compassion for Others seemed to play a role in buffering against the physiological effects of stress, but only when social support from the evaluators was present. It could be that individuals who are more able to give compassion to others are also more able to receive compassion and support from others, in line with Gilbert's (2009) idea about the flow of compassion. Yet when in the neutral group without this social support, participants' Threat systems were activated and they experienced anxiety despite their level of Compassion for Others, suggesting that Compassion for Others alone does not directly buffer against stress. These findings are also supported by the findings of Pace et al. (2009), whereby possible increases in Compassion for Others had little effect on the stress response in a task where support was not available.

Aims

In Study One it was found that an increase in Perceived Organisational Threat relates to a decrease in Compassion for Others at work, amongst the NHS employees who participated in

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this study. Given the prevalence of Perceived Organisational Threat within the NHS as an organisation, and the impact that this could therefore have on the ability of healthcare professionals to work compassionately, it is important to consider ways of minimising this relationship and the impact of perceived threat on Compassion for Others.

Firstly, research suggests that higher levels of self-compassion may have a buffering effect against activation of the threat system and the stress-response (e.g. Leary et al., 2007). For example, individuals who have greater levels of self-compassion: are more likely to treat themselves kindly after negative life events; less likely to under-value and be critical of their abilities; more able to accept responsibility for feedback; have less negative affect overall; and are less likely to be overwhelmed by negative emotion (Leary et al., 2007).

Consequently, the first aim of Study Two is to explore whether Self-compassion moderates the previously found relationship between Perceived Organisational Threat and Compassion for Others. That is (given the buffering effect of Self-compassion on activation of the threat system) does increased Self-compassion reduce the impact of Perceived Organisational Threats on the ability to feel compassion for others and to deliver compassionate care?

Hypothesis 2: Self-compassion will moderate the relationship between Perceived Organisational Threat and Compassion for Others; the relationship will be strongest when Self-compassion is low and weakest when Self-compassion is high.

In addition, research has found that Compassion for Others might also indirectly buffer against stress (Cosley et al., 2010), however this body of research is currently sparse.

Preliminary findings suggest that having higher levels of Compassion for Others may not directly buffer against threat and stress, but may increase one's ability or desire to draw on social support, which in turn can reduce levels of stress (Cosley et al., 2010). This could be conceptualised in terms of the flow of compassion (Gilbert, 2009); it may be that individuals with greater levels of Compassion for Others may also be more able to accept support and compassion from others. Given the sparsity of research in this area, it is unclear whether the level of compassion that NHS employees feel from their colleagues and their organisation impacts on their level of Perceived Organisational Threat, and their ability to maintain Compassion for Others in the face of such threat.

A second research aim of Study Two was therefore to investigate the impact of Perceived Organisational Compassion on activation of the threat system, and on Compassion for Others.

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Perceived Organisational Compassion here refers to the perceived degree to which an organisation fosters a culture of compassion, including the degree of social support that members of that organisation feel they receive at work. It was predicted that Perceived Organisational Compassion would also (in addition to Self-compassion) moderate the previously found relationship between Perceived Organisational Threat and Compassion for Others.

Hypothesis 3: Perceived Organisational Compassion will moderate the relationship between Perceived Organisational Threat and Compassion for Others; the relationship will be strongest when Perceived Organisational Compassion is low and weakest when Perceived Organisational Compassion is high.

Again using the previous example of the nurse; the level of threat that she perceived whilst at work may have been high and thus may have been detrimental to her ability to give compassion. However, if she were to have improved self-compassion and perceived the organisation in general to be compassionate and supportive, she may be better able to cope with and manage the occupational stressors and Perceived Organisational Threat, thus reducing the impact of such stressors on her ability to give compassion to others.

Method

Design

A cross-sectional design was employed. Participants completed one survey, which allowed for the collection of both quantitative and qualitative self-report data via questionnaires, and enabled data collection for all three studies presented within this paper. Within Study Two, only quantitative data was analysed; the dependent variable was Compassion for Others. The predictor variables were Perceived Organisational Threat, Self-compassion, and Perceived Organisational Compassion.

Procedure

The procedure for Study Two was as detailed in Study One.

Participants

Please see Study One for participant details.

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Power Analysis

A power analysis calculation using G*Power version 3.1.3 (Faul, Erdfelder, Buchner & Lang, 2009) software was performed to find the required sample size to test for moderation by adding interactions to a multiple regression model for the dependent variable, Compassion for Others. The calculation was based on a requirement of 80% power and a 5% significance level. The effect size assumed was based on a study by George, Reed, Ballard, Colin and fielding (1993) which utilized the same method of analysis to investigate the moderating effect of two variables on the relationship between exposure to a particular client group and negative affect. The power calculation for the present study showed that, with linear multiple regression analysis assuming an R^2 of 0.2 for all predictor variables excluding the two interaction effects, and assuming a 0.05 increase in R^2 by adding in the two interactions to test moderation for Hypotheses 2 and 3, a sample size of 148 participants would be needed. This was an assumed effect size of $f^2=0.067$.

Measures

Demographics

Participants were asked to disclose their age, gender, the NHS trust within which they were employed, their job role/job title, and for how many years they had worked within the NHS.

Perceived Organisational Threat

A Shortened Stress Evaluation Tool (ASSET; Cartwright & Cooper, 2002) is a measure developed to assess risk of stress within a workforce with respect to a range of known workplace stressors. Specifically, the ‘Perceptions of your job’ scale of ASSET was used to measure ‘Perceived Organisational Threat’ as a predictor variable. Please see Study One for further details.

Compassion for Others

The Compassion Scale (CS; Pommier, 2011) was used to measure Compassion for Others. Please see Study One for further details.

Self-Compassion

The Self-Compassion Scale – Short Form (SCS-SF; Raes, Pommier, Neff & Van Gucht, 2011) is based on Neff’s (2003a) conceptualisation of self-compassion, described earlier. The

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scale contains 12 items, for example “I’m disapproving and judgmental about my own flaws and inadequacies”. Each item is rated on a five-point likert scale ranging from ‘1 (almost never)’ to ‘5 (almost always)’, asking participants to rate how often they ‘behave in a stated manner’. The SCS-SF is an abbreviated version of the original 26-item Self-Compassion Scale (SCS; Neff, 2003b) and the two measures are found to be highly correlated ($r > .97$; Raes et al., 2011). Raes et al. (2011) report that the English version of the SCS-SF has high internal consistency ($\alpha = .86$) when calculating a total Self-compassion score, however the subscales of the SCS-SF were found to have relatively low internal consistency (α ranged from .54 to .75). Consequently, the short form was selected for use in the current study to reduce burden on participants, however individual subscales were not analysed. For each participant an overall SCS-SF score was calculated by reverse-scoring the items on the three negative subscales before then calculating an overall mean. This gives a minimum possible score of one and a maximum of five, whereby higher scores indicate greater Self-compassion. Norms were not available for the SCS-SF, however Lockard, Hayes, Neff and Locke (2014) found a mean SCS-SF score of 2.80 amongst a sample of 1,609 students attending for counselling at colleges or universities in the US.

Perceived Organisational Compassion

The Compassionate Organizations Quiz (COQ; Simon-Thomas & Nauman, 2013) is a 16-item questionnaire measuring how participants think, feel and act in a given organisation in order to assess how successfully that organisation fosters compassion in its employees. Participants respond using a five-point likert scale ranging from ‘1 (never)’ to ‘5 (always)’. Four items represent non-compassion, whilst the remaining 12 items represent compassionate organisational experiences. For example, one item reads “The leaders in my organisation take time to talk and listen to people who are having a hard time”. Participants were instructed to “please consider the ‘organisation’ to be the NHS trust within which you are employed, and keep that organisation in mind as you answer the questions”. At the time of writing there are no published data relating to the reliability or validity of this measure. Participants were given an overall COQ score as a measure of ‘Perceived Organisational Compassion’ by reverse-scoring the four non-compassion items before then calculating an overall mean. This gives a minimum possible score of one and a maximum possible score of five, such that higher scores represent greater Perceived Organisational Compassion. At the time of writing, no existing data is available on the normative scores for the COQ.

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Data Analysis Procedures

Descriptive statistics were used to analyse the demographic data. Pearson's Product Moment Correlation Coefficient was used to investigate correlations between the predictor variables. To include the maximum number of participants for each analysis, participants were included in each correlation if they completed the two questionnaires relevant to that analysis, rather than excluding participants that did not complete all four questionnaires from all analyses.

Linear Multiple Regression analysis was then completed in three stages to explore the degree to which the predictor variables could explain the variance in Compassion for Others, and to carry out a moderation analysis to explore Hypotheses 2 and 3 after controlling for demographic variables.

Results

Descriptive Statistics

Demographic Characteristics

Demographic data are available in Table 1 and are discussed in Study One.

Dependent Variable – Compassion for others

Please see Study One and Table 3.

Predictor Variables

Scale score means were calculated for all measures and can be found in Table 3. The Shapiro-Wilk Test was used to test for normality within each NHS Trust (3 groups) for each of the 12 variables displayed in Table 3. Comparisons were then made between NHS Trusts using a One Way ANOVA or a Kruskal-Wallis Test (if a non-parametric test was indicated).

As for Study 1, in the case of a statistically significant result, post-hoc pairwise tests were carried out and the Pearson correlation, r , was used as a measure of effect size where a pairwise difference was found.

Perceived Organisational Threat

Please see Study One and Table 3.

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Self-compassion

For this scale, the Shapiro-Wilk test gave a p -value of greater than .05 for all NHS Trusts and therefore a one-way ANOVA was used.

The one-way ANOVA revealed that there was a significant main effect of group on the SCS-SF score ($F(2, 287) = 10.063, p < .001$). A Tukey post-hoc test revealed that the mean SCS-SF score was significantly higher in Trust 1 than it was in Trust 3 ($p < .001$) suggesting that participants from Trust 1 were significantly more self-compassionate than those from Trust 3. The effect size for the Trust 1 versus Trust 3 comparison was .256 for the SCS-SF.

Comparisons can also be made between the scores obtained by the overall sample and the mean scores or norms found in previous studies. The SCS-SF mean of 2.98 found in the current study suggests that the healthcare professionals taking part had slightly higher levels of Self-compassion than did the large sample of students recruited by Lockard et al. (2014).

Perceived Organisational Compassion

For this scale, the Shapiro-Wilk test gave a p -value of greater than .05 for all trusts and therefore a one-way ANOVA was used. No significant main effect of group was found from the one-way ANOVA for the COQ ($p = .678$).

Are the predictor variables related?

Relationships between each of the predictor variables was assessed using Pearson's Product Moment Correlation Coefficient (see Table 4). As detailed in Study One, Perceived Organisational Threat was significantly, although weakly, negatively correlated with Compassion for Others. Perceived Organisational Threat (as measured by the 'Perceptions of your job' Scale of the ASSET) was also significantly, although weakly, negatively correlated with Self-Compassion, and was significantly and moderately, negatively correlated with Perceived Organisational Compassion. This suggests that as the level of organisational threat perceived by an individual increases, they are less likely to perceive their organisation as compassionate, and they are less able to show compassion towards themselves and others at work.

Additionally, significant, although weak, positive correlations were found between Self-Compassion, Compassion for Others, and Perceived Organisational Compassion. This suggests that the more self-compassionate an individual is, the more compassionate they are

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to others, and the more they perceive the organisation they work in to be a compassionate organisation. It is important to note, however, that the nature of correlational analysis means that relationships can be detected but causal inferences cannot be made.

Is the relationship between Perceived Organisational Threat and Compassion for Others moderated by Self-Compassion and/or Perceived Organisational Compassion?

A hierarchical multiple regression model was used to further investigate whether there was an association between Perceived Organisational Threat and Compassion for Others. In Stage one of the regression analysis, the four demographic variables (age, gender, number of years' experience in the NHS, and job role) were entered into a regression model. This first stage of the model was statistically significant, $F(9,244) = 2.897, p = .003$, and these variables explained 9.7% of the variance in Compassion for Others ($R^2 = .097$). Gender was significantly associated with Compassion for Others ($\beta = 0.322, SE = 0.094, t = 3.428, p = .001$) with females gaining greater CS scores, indicating higher levels of Compassion for Others (mean female CS score = 4.14, $SD = 0.53$; mean male CS score = 3.79, $SD = 0.61$). No significant association was found for age, number of years' experience in the NHS, or job role ($p > .05$).

In stage two of the analysis the three predictor variables (Perceived Organisational Threat, Self-Compassion, and Perceived Organisational Compassion) were centred, and then entered into a regression model alongside the four demographic variables (age, gender, number of years' experience in the NHS, and job role). This second stage of the model was statistically significant, $F(12,229) = 7.416, p < .001$, and these variables together explained 28% of the variance in Compassion for Others ($R^2 = .280$), in comparison to the 9.7% of variance explained by demographic variables alone. Results indicated that greater Self-Compassion ($\beta = 0.165, SE = 0.044, t = 3.766, p < .001$) and greater Perceived Organisational Compassion ($\beta = 0.200, SE = 0.066, t = 3.043, p = .003$) were both significantly associated with greater Compassion for Others. However, the association between Perceived Organisational Threat and Compassion for Others was not found to be significant ($\beta = -0.001, SE = 0.002, t = -0.785, p = .433$) once the other two predictor variables were accounted for. Gender ($\beta = 0.345, SE = 0.088, t = 3.945, p < .001$) continued to be significantly associated with Compassion for Others, whilst age, number of years' experience in the NHS, and job role failed to reach significance ($p > .05$).

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Stage three of the analysis was carried out in order to test for moderation (so as to explore Hypotheses 2 and 3), and the results are summarised in Table 5. Here, the three centred predictor variables (Perceived Organisational Threat, Self-Compassion, and Perceived Organisational Compassion) and the four demographic variables (age, gender, number of years' experience in the NHS, and job role) were entered into a regression model alongside two interactions ('Self-Compassion by Perceived Organisational Threat' and 'Perceived Organisational Compassion by Perceived Organisational Threat'). This third stage of the model was statistically significant, $F(14,227) = 6.444, p < .001$, and the total variance in Compassion for Others explained by all variables included in stage three of the hierarchical multiple regression analysis was 28.4% ($R^2 = .284$). Results indicated that neither the interaction between Self-Compassion and Perceived Organisational Threat nor the interaction between Perceived Organisational Compassion and Perceived Organisational Threat were significant. This suggests that Hypotheses 2 and 3 are not supported; neither Self-Compassion nor Perceived Organisational Compassion moderate the relationship between Perceived Organisational Threat and Compassion for Others. This is expected given that stage two of the regression analysis showed that there was no significant association between Perceived Organisational Threat and Compassion for Others once the other predictor variables and the demographic variables were taken into account.

[Table 5]

Discussion

The results firstly indicated that Compassion for Others, Self-Compassion and Perceived Organisational Compassion were all found to be positively correlated, such that an increase in any one of these variables was related to an increase in the other two. Further, as Perceived Organisational Threat increased, Compassion for Others, Self-Compassion and Perceived Organisational Compassion all decreased. These findings suggest that the three components of the flow of compassion (to self, to others, and from others) as described by Gilbert (2009) are related. That is, fostering one form of compassion can positively impact on the other aspects of compassionate flow. These findings also reveal that each of the three aspects of compassion can also be negatively impacted by activation of the threat system, and an increase in Perceived Organisational Threats.

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Despite the correlational relationship between Perceived Organisational Threat and Compassion for Others, the moderation analysis revealed that Perceived Organisational Threat was no longer a significant predictor of an individual's level of Compassion for Others once accounting for other variables. Instead, only greater Self-Compassion, greater Perceived Organisational Compassion and Gender (specifically, being Female) were found to be significant predictors of greater Compassion for Others. Comparisons between the three NHS Trusts revealed that participants from Trust 1 were found to have more positive attitudes towards their organisation, higher levels of Self-compassion, higher levels of Compassion for Others, and were also found to have better physical and psychological health than participants from Trust 3. Interestingly, however, there were no significant differences between Trusts in terms of demographic characteristics, their perceived level of organisational compassion, or their perceived level of organisational threat.

Study Three

Introduction

As described previously, the current threats to the NHS as an organisation are well-documented and are a regular focus within the media (Triggle, 2017a; 2017b). For example, government-driven threats exist in the form of privatisation and the need to compete with other providers for business (Unison, 2015). In line with this, there is increasing focus on targets and performance monitoring, with individual NHS trusts being at risk of financial penalty if targets are breached (NHS Commissioning Board, 2013). It is reported that NHS employees are managing excessive workloads, have increasing time pressures and operate on inadequate staffing levels (NIOSH, 2008) in addition to the stressors associated with extreme suffering in service-users and interpersonal conflicts amongst colleagues and managers (NIOSH, 2008). However, it is important to consider that those threats most frequently documented within the media, or which have the most impact due to risk and finance, may not be the threats that are most prevalent to employees.

In Study One, quantitative data revealed that the NHS employees who took part in this survey did indeed have more stress symptoms and higher perceived levels of most workplace stressors in comparison to the general UK working population, including stressors related to overload, work-life balance, job security, and control, as well as the job characteristics

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themselves (Robertson Cooper Ltd., 2004). The aim of Study Three was to gain qualitative data so as to add richness to the quantitative data used in Studies One and Two, and to allow for more in-depth exploration of the troubles and threats most pertinent to NHS employees at present. In doing so, intervention points for minimising stress and Perceived Organisational Threat can be better tailored to the most troubling areas of the healthcare professional's job.

Method

Design and measures

Qualitative data was collected via self-report responses to an open question, which was presented at the end of the overall survey (as outlined in Study One); participants had a free-response box with the question 'What is the biggest thing that troubles you about working in your organisation?'.

Participants

Please see Study One for details of procedure, and the overall sample of participants that completed the survey. 235 participants (74.8% of the overall sample) contributed to Study Three by providing written responses to the open question.

Data Analysis Procedure

Qualitative data collected via the open question ('What is the biggest thing that troubles you about working in your organisation?') was analysed using thematic analysis, following the six-step approach outlined by Braun and Clarke (2006). First, the data was repeatedly read by the first author and semantic patterns were noted. Secondly, the data set was systematically coded. Initially, data were deductively coded according to the eight subscales of the 'Perceptions of your job' scale of the ASSET questionnaire (as outlined in Study One and Table 2). Following the initial coding process, the codes were reviewed by the first and second authors to generate, omit, combine and divide codes. Thirdly, codes were organised into themes by the first and second authors. Fourthly, the themes were organised and reviewed in relation to other themes, codes, and the raw data set. Fifth, superordinate and subordinate themes were labelled and defined before finally presenting these in tabular format alongside examples in preparation for this report.

Results

Analysis of the data revealed five super-ordinate themes, as follows:

1. Change
2. Overload and resources
3. Work relationships
4. Communication, leadership and direction.
5. Personal factors

Whilst the first four super-ordinate themes related to troubles and threats located within the organisation, the fifth super-ordinate theme, ‘Personal factors’, was identified to collate those troubles located more within the individual. From these super-ordinate themes, a number of sub-ordinate themes were identified, these can be found in Table 6 and are described below.

1. Change

Participants highlighted that they have experienced, and continue to experience, a vast amount of change within their organisation. Participants described change as a threat on account of the frequency of these changes, but also on account of the process of change and feeling that they lack control within this, as well as negative outcomes following change.

Control over change

Participants revealed a lack of control with regards to whether or not change happens, or decisions made. There was a sense that change had been ‘enforced’ or implemented without consultation, and several participants spoke of change being imposed by ‘management’ or individuals who do not understand the day-to-day running of the services participants were working in.

“lack of consultation with clinicians about organisational change. Change is imposed on services and clinical staff and these decisions are made by people who have not been in clinical practice for years.”

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Impact of change

Change was perceived to impact negatively on services, staff and service-users; participants revealed that this can create uncertainty and insecurity around the future of services and for jobs. The negative impact of change was largely spoken of with regards to organisational restructuring, which was seen to lead to job losses and reduced flexibility of working.

“the new business driven models pay ‘lip service’ to service users but the changes actually impact negatively on both staff ability to do their job and service user experience.”

Amount of change

Several participants described change as “constant” and talked of “change for change’s sake”, whereby changes occur within services that seem to be working well, or without clear purpose. The frequency of change was described as tiring, stressful, and unsettling.

“we've all been through so much change change change - it gets tiring particularly keeping staff engaged and motivated.”

2. Overload and resources

Troubles relating to the difficult nature of the work and the increasing level of complexity and risk that NHS employees work with. In addition to the complexities of the job, participants spoke of increasing amounts of additional stresses and pressures. This includes performance monitoring and target-driven working, increasing amounts of paperwork, poor working environments and a lack of financial resource. Troubles were also largely attributed to a lack of staff, and growing workloads. Throughout, there was a sense that participants were troubled by these factors largely because of the impact this has on the quality of care they can provide and the decreasing amount of time and effort they can dedicate to service-users.

Physical, financial and staff resources

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Participants described a shortage of resources, both in terms of the working environment and the finances available for services, but also in terms of staffing. This shortage of resources was linked to associated time pressures for staff, increased waiting times for service-users and increased workload overall. There was a sense that staff and services are stretched beyond manageable limits, with participants commenting on the possibility of “mistakes” being made, and “unsafe practice”. Data also revealed a “culture of going the extra mile”, with participants describing concern for decreasing standards, having less time to commit to service-users, and not enough staff to “give the level of care that people deserve”

“The lack of resources mean that staff have too many demands and too much stress on them which erodes their ability to cope and be compassionate.”

Time devoted to technology, admin and paperwork

In addition to the stretch on resources described above, participants identified growing levels of paperwork and an increasing amount of time dedicated to administration/technology. This again was linked to a lack of time to spend with service-users, and a lack of time to dedicate to face-to-face working, which participants expressed concern about.

“too much repetition of paperwork and using computerised systems to monitor daily activities which means clinical staff have less time with patients and doing the job they're supposed to be doing.”

Target-driven culture

There was a sense that the current culture within the organisation means striving to achieve targets, with a reliance on managing finances, “chasing performance outcome measures”, and creating an effective business. The troubles related to this target-driven culture can be considered in two ways. Firstly, participants again described how this culture detracts from their ability to maintain quality care, and to dedicate as much time as they would like to service-users:

“driven by models and targets, it feels that we are forgetting that there are people involved in this process”

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Secondly, participants expressed how this target-driven culture leads to fears of making mistakes or losing their job, and worries that the targets will not be reached. There was a sense that staff are being constantly monitored and judged on the basis of performance indicators, and do not receive the support needed to maintain effectiveness at work:

“The necessity to meet corporate and commissioned targets interferes with the Trust offering individualised solutions to supporting people to keep attending work.”

Work-life balance

Issues or stresses related to the amount of time dedicated to work, or the impact this has on other areas of life. Participants expressed that they work long hours and unpaid overtime, or take work home, so as to meet the targets and demands as outlined above. There was a sense that the balance is tipped, with work being prioritised over other areas of life:

“I am missing my own children's growing up because I am trying to do the best job I can for my clients whilst being placed under unrealistic pressures by my supportive but pushing ahead manager and those above her.”

Nature of the work

Whilst participants wrote of the added pressures of resources, targets, and increasing workloads, there were also troubles related to the work itself. This was attributed to risk of violence and aggression towards staff, an “us and them culture between staff and service-users”, and the complexity of service-users worked with. Again there was a suggestion that staff were insufficiently supported with this, and that risks were increasing.

“Too much violence and aggression suffered by staff that seems to be ignored by the Trust and the Police.”

3. Work relationships

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Work relationships with immediate colleagues were often seen as different to those with managers or senior professionals. Troubles were largely attributed to difficult relationships with management, which included experiences of bullying, a lack of support and compassion, and feeling untrusted or under-valued. When describing relationships with immediate colleagues, participants often reported that they were more isolated than they would like.

Lack of support, humility and compassion

Feeling a lack of care, support and compassion from the organisation toward its staff. Many participants wrote of ‘management and the organisation’ as being separate from immediate colleagues and front-line professionals. Those in more senior positions were seen to be less caring and compassionate towards participants, than were their immediate colleagues. Notable examples included the use of a sickness policy, which staff felt was unsupportive, and a lack of support for staff suffering from stress.

“I feel that while individual team members can be very supportive during difficult times, the organisation sees it as an inconvenience to their targets.”

Bullying and punishment

Feeling like there is culture of blame and judgment, whereby individuals who do not meet targets are viewed as “inadequate” or inefficient”. Punishment was seen as a threat from managers and more senior colleagues, with several participants describing blame and punishment to the point of “bullying”. This related to anxiety about seeking help or sharing feelings, for fear of the consequences.

“Managers do not listen if staff report feeling overwhelmed by the demands of their job. Their immediate response is that it is not the job that is wrong, but the individual i.e. they have poor time management or organisational skills. To admit to feeling stressed is to reveal that you are weak.”

Trust and Monitoring

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As above, participants reported working within a culture of blame and judgement. In line with this, participants wrote of being watched and monitored, or feeling untrusted to work effectively. This was linked to feeling that their integrity or honesty was being questioned, and again heightened anxiety about performance at work.

“There is far too much emphasis on monitoring time and a sense of no trust in staff’s integrity which leads to increases in dissatisfaction at work, stress and sometimes paranoia.”

Isolation

Despite feeling that immediate colleagues were often supportive, there was a sense that teams were becoming “fragmented” and that staff were becoming more isolated at work on account of the time pressures and competing demands. Participants reported fears of missing information, but also of feeling lonely at work.

“Isolation from my team... I rarely see my boss even, so I feel a long way off - even though I feel they probably do care about me. Stress and lack of opportunity to share with colleagues how that feels or what we might do about it.”

Not feeling valued

A lack of respect or recognition, and not feeling that their expertise or hard work is acknowledged and valued. Participants highlighted value in terms of recognition from managers by way of development opportunities and praise, but also in terms of pay and financial benefits.

“The fear I will not be allowed to achieve my potential and I am not always treated with the respect I feel I deserve.”

Inequality

Troubles relating to inequality amongst colleagues, or feeling that others are not “pulling their weight” within teams, but also a lack of consistency between teams. Participants

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identified inconsistencies with regards to ‘equal opportunities’ and differing levels of support dependent on job role.

“In administration we do not get the support that the clinical teams regularly receive and yet we are often the front line staff taking the brunt of people's distress and anger. It is our job, but at the same time it would be helpful to hold regular meetings with senior staff to be able to offload this”

4. Communication, leadership and direction

A fourth theme involved troubles related to a lack of clear direction from leaders, and a lack of communication around the rationale and purpose of change. One participant described decision-making as a “knee-jerk reaction” and many highlighted a lack of understanding and a lack of communication between “front-line” professionals and management.

“lack of vision and long term strategic thinking to benefit patients and carers”

“Lack of communication from managers who appear to have no idea what people at shop floor level do.”

Personal factors

The final super-ordinate theme relates to troubles attributed to the individual, rather than being located within the organisation as such. Concerns were highlighted about ageing, physical disabilities, and mental health problems. Participants also wrote of lacking confidence or assertiveness skills.

“as I get older, as keen as I am to do my work, I get more tired than I used to”

“I have a disability and worry about the impact it has on my team and working with patients/colleagues.”

Discussion

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Thematic analysis was used to further explore the nature of the Perceived Organisational Threats that were quantified in Studies One and Two. Participants' troubles about working in their NHS Trust were broad, spanning five super-ordinate themes.

One of the most prominent super-ordinate themes was 'Overload and resources' which included troubles relating to a lack of time to dedicate to clinical work, or a lack of financial and physical resources, resulting in poorer care provision and over-stretched staff. This seems to echo news stories on increasing waiting times (Triggle, 2017a) and NHS funding cuts (Triggle, 2014), for example. The super-ordinate theme of 'Change' was also one of the most important themes, with many participants contributing. 'Change' revolved largely around the lack of control healthcare professionals feel they have over changes to their organisation, and their feelings of uncertainty about the future. Again, this is perhaps unsurprising given the recent political and media focus on changes to the NHS, including ideas around privatisation of the NHS and service re-structuring (Triggle, 2013). However, many participants commented not on the changes themselves, but rather on the process of change, and highlighted the need for staff to feel consulted about such changes, and to feel that they are informed. The fact that these two super-ordinate themes are large, and encompass the threats most pertinent to a large number of participants, is in keeping with the quantitative data reported in Study One and in Table 2. That is, scores on ASSET revealed that the NHS employees in this study reported higher levels of workplace stressors than the general UK working population on the following subscales: Work-life balance, Overload, Job security, Control, and The job (Robertson Cooper Ltd., 2004). Indeed, the stressors comprising these five subscales do roughly map on to the sub-ordinate themes encompassed within the super-ordinate themes of 'Change' and 'Overload and resources' identified within Study Three.

A third super-ordinate theme was of 'Communication, leadership and direction' which professionals suggested was lacking within their NHS trust. This was linked to the fourth, and perhaps the most surprising, super-ordinate theme - 'Work relationships'. Many participants revealed experiences of bullying from colleagues and managers, a culture of blame, judgement and punishment, and a lack of support, compassion and humility between professionals. Indeed, throughout these themes there was a sense that participants perceived their immediate colleagues differently to management and more senior professionals, with the latter being considered less caring or compassionate, and more judgemental and punitive. This is in stark contrast to the 'common culture' of compassion called for within the Francis

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Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). However, it is interesting to note that the NHS employees in this study reported lower levels of workplace stressors than the general UK working population on the following ASSET subscales: Work Relationships; Resources and Communication; Perceived commitment of organisation to employee; and Pay and Benefits (Robertson Cooper Ltd., 2004; as reported in Study One and Table 2). It is these four ASSET subscales which most accurately map onto the super-ordinate themes of ‘Communication, leadership and direction’ and ‘Work relationships’. This therefore raises some discrepancy between the threats identified on the ASSET questionnaire, and the threats identified within Study Three. This perhaps suggests that whilst the threats related to ‘Communication, leadership and direction’ and ‘Work relationships’ may be pertinent to some of the NHS employees who took part in this study, these threats are less reflective of the overall sample’s opinion than those threats comprising the super-ordinate themes of ‘Overload and resources’ and ‘Change’.

In addition to the troubles located at the organisational level, there was a final super-ordinate theme of ‘Personal factors’ relating to personal competency, with individuals also expressing concern about the impact of their age or disability.

[Table 6]

Overall Discussion

In Study One, it was hypothesised that Perceived Organisational Threat experienced by healthcare professionals would be negatively correlated with their level of Compassion for Others. This hypothesis was partially supported in that a significant correlational relationship was found; as Perceived Organisational Threat increased, Compassion for Others decreased. In Study Three thematic analysis was used to explore the nature of these perceived threats. Participants’ troubles about working in their organisation were broad, spanning five super-ordinate themes. ‘Overload and resources’; ‘Change’; ‘Communication, leadership and direction’; ‘Work relationships’; and ‘Personal factors’.

Study Two sought to investigate factors that could minimise the effect of this Perceived Organisational Threat, reducing its possible negative impact on Compassion for Others at work. In line with this, Hypotheses 2 and 3 predicted that the relationship between Perceived Organisational Threat and Compassion for Others would be moderated by Self-compassion

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and Perceived Organisational Compassion. This moderation effect was not supported as the relationship between Perceived Organisational Threat and Compassion for Others was not found to be significant once other variables were accounted for. Instead, Self-Compassion and Perceived Organisational Compassion were found to be stronger predictors of Compassion for Others. Specifically, an increase in an individual's compassion for the self, or an increase in an individual's perceived compassion from their organisation (their employing NHS Trust) significantly predicted an increase in Compassion for Others at work.

Although Hypotheses 2 and 3 were unsupported, these findings further existing knowledge. Firstly, the significant positive relationship between Self-compassion and Compassion for Others is, to the authors' knowledge, a novel finding. Additionally, the finding that Perceived Organisational Compassion is predictive of Compassion for Others presents, to the authors' knowledge, another novel finding. These relationships do however make theoretical sense when considering CFT theory as Gilbert (2009) proposes that compassion involves the flow of compassion to the self, to others, and allowing compassion to flow from others to oneself. As discussed earlier, Gilbert (2009) suggests that the Affiliative system, specifically, is linked to developing a compassionate motivation which can help to balance the three emotion regulation systems. In line with this theory, the findings of the current study suggest that developing the Affiliative system (and by association a compassionate motivation) through improving organisational compassion and employees' self-compassion, will generate improvements in Compassion for Others.

A final predictor of Compassion for Others identified within the present study was gender, with females seemingly demonstrating significantly greater levels of Compassion for Others. This finding is consistent with previous literature (Pommier, 2011). One explanation for such differences put forward by Seppälä (2013) suggests that males and females have a similar capacity for compassion, but that the genders may express compassion differently on account of evolutionary adaptations. For example, following childbirth mothers need to be attuned to the needs of the baby and need to have compassionate motivation to alleviate their baby's distress. For this reason, the Affiliative system may be particularly important for females. Likewise, in evolutionary terms males may have needed to provide physical protection and resources for mother and baby, perhaps relying more on the Drive system. This too would suggest that males and females have the same capacity for compassion, but may express it differently. Whilst males may exhibit fiercer or more protection-focussed forms of

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compassion in general, the common representation of compassion (involving kindness, nurturance and emotional warmth) may be more attributable to females (Seppälä, 2013).

Indeed, the CS (Pommier, 2011) which was used in the present study to capture Compassion for Others focusses more on this ‘feminine’ expression of compassion. This may be why females in the present study, and in Pommier’s (2011) study using the same measure, were found to have greater levels of Compassion for Others than males.

Indeed, one of the limitations of this study is the use of questionnaires and the specific measures chosen. Self-report data was necessary given the need to capture participants’ own perceptions of compassion or threat, however the use of self-report data does unfortunately allow for bias. It must also be acknowledged that there was a dearth of measures available for each variable and as such, the measures chosen were not ideal. As described earlier, the compassion measures may neglect some of (what can be considered) the more ‘masculine’ traits of compassion, such as protection or courage (Seppälä, 2013). Additionally, the particular troubles captured within the measure of Perceived Organisational Threat may not be fully inclusive of the threats relevant to healthcare professionals within the NHS, although this challenge was partially overcome through the collection of qualitative data.

It is important also to recognise that the measures used within this study do not give a direct measure of compassionate behaviour, such that caution must be taken when predicting that an increase in one’s Compassion for Others score represents an increase in one’s compassionate behaviour towards others. Initial findings into this relationship however are promising.

Condon, Desbordes, Miller and DeSteno (2013) compared the effects of an eight-week mindfulness meditation and an eight-week compassion meditation to a waitlist control group. Following the randomly-assigned eight-week intervention/waitlist period participants were assessed for compassionate responding in an experimental paradigm. Participants were invited to the laboratory with the intention of completing tests of cognitive ability, but whilst in the waiting room were unknowingly assessed to see whether or not they would give up their chair for someone visibly in pain. Condon et al. (2013) found that individuals in both meditation groups were more than five times more likely to offer their chair up in order to help the individual who was suffering. The findings of Condon et al. (2013) therefore provide initial support for the idea that compassionate behaviour may increase following an intervention designed to increase compassionate motivation, however the authors did not report whether or not this was also reflected on questionnaire measures. Further research is

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therefore needed in order to ascertain whether an individual's score on a measure of compassion accurately reflects the degree to which they behave compassionately.

In addition, the measures used in the current study represent the participants' responses at a single point in time, and therefore cannot identify how an individual's level of compassion may change/ be maintained across situations or towards different individuals or groups. For example, it may be that a nurse relates more compassionately to other nurses than to managers, or vice versa. Empathy (believed to be one of the key attributes required for compassion; Gilbert, 2009) for example is thought to be greater between individuals who perceive themselves as more similar (Hogg & Vaughan, 2005). It is therefore necessary to recognise that other factors not measured within the current study, such as situational context and the relationships between individuals, may also impact on one's level of Compassion for Others and will be important to explore with further research.

Finally, it is important to recognise that only one of the Trusts sampled had widely delivered CFT-based training to their employees, and interestingly this Trust was found to have lower levels of compassion and higher levels of stress symptoms than the other two Trusts. One interpretation of this is that there may have been misunderstanding of the concept of compassion- it is not possible to know whether different participants were interpreting compassion in the same way. It may also be that participants who had undertaken training in the CFT model had a greater understanding, or were less naïve/more honest about the challenges to compassion, and thus reported less compassion. It will be important for future research to try and untangle these findings by specifically measuring the effect of knowledge and training in compassion and the CFT model.

Conclusions and implications for practice and future research

Despite its limitations, this study appears to be the first of its kind which incorporates each aspect of the flow of compassion; to the self, to others, and from others to the self, with threat. In addition, it has given strength to the idea that compassion is a systemic issue, to be tackled at all levels of the NHS and not just within individual employees. At present, the focus of most interventions available for healthcare professionals is on managing stress (e.g. Irving, Dobkin & Park, 2009). Whilst these may be effective for stress management (Irving et al., 2009) the findings of the present study suggest that these interventions may not be the

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most efficient way to maintain or promote compassion for others within healthcare. Given the current drive for service-users to “receive effective care from caring, compassionate and committed staff, working within a common culture” (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) it will be important to consider the role of self-compassion and Perceived Organisational Compassion in the development of staff interventions. This may involve the use of interventions based on CFT (Gilbert, 2009), and importantly should involve all individuals within the organisation. It will also be necessary for future research to begin to explore the use of any alternative interventions for healthcare professionals, and to assess their efficacy. Finally, this study has also highlighted the threats and troubles most important to the individuals who took part. Whilst issues of overload or change may be less controllable due to the external pressures placed on the NHS, improvements in communication, in leadership, and in involving individuals in decisions could make a real difference. These are improvements that can be made from within the organisation, and should be considered alongside interventions, training and service development plans.

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Table 1. Demographic characteristics of the overall sample and each of the three individual NHS Trusts.

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	Overall sample	Trust 1	Trust 2	Trust 3
	N= 314	N= 215	N= 43 (13.7%)	N= 46 (14.6%)
		(68.5%)		
Age Groups				
20-29 years	32 (10.2%)	27 (12.6%)	2 (4.7%)	3 (6.5%)
30-39 years	71 (22.6%)	48 (22.3%)	9 (20.9%)	11 (23.9%)
40-49 years	100 (31.8%)	69 (32.1%)	13 (30.2%)	17 (37%)
50+ years	101 (32.2%)	66 (30.7%)	19 (44.2%)	15 (32.6%)
Gender				
Female	258 (82.2%)	185 (86.0%)	34 (79.1%)	35 (76.1%)
Male	49 (15.6%)	29 (13.5%)	9 (20.9%)	11 (23.9%)
Job Role				
Nursing	126 (40.1%)	81 (37.7%)	23 (53.5%)	20 (43.5%)
Psychology, Psychotherapists and Counsellors	59 (18.8%)	43 (20.0%)	4 (9.3%)	11 (23.9%)
Physiotherapy, OT and SALT	28 (8.9%)	24 (11.2%)	1 (2.3%)	3 (6.5%)
Health Care Assistants and Support Workers	33 (10.5%)	32 (14.9%)	-	6 (13.0%)
Other	39 (12.4%)	23 (10.7%)	10 (23.3%)	2 (4.3%)
Mean Number of years worked in NHS (SD)				
	16.04 (10.79)	14.97 (10.46)	21.4 (11.87)	16.24 (10.18)

Note: OT – Occupational Therapy; SALT – Speech and Language Therapy; SD – Standard Deviation.

Table 2. Mean scores obtained within the current study for each of the scales and subscales of the ASSET questionnaire, alongside the normative scores based on 25,352 public and

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private sector workers in the UK (Robertson Cooper Ltd., 2004). Standard deviations (SD) given in parentheses.

ASSET subscale	Mean score of overall Sample	Normative mean
'Perceptions of Your Job' Scale	117.99 (28.94)	-
Work Relationships	21.04 (7.96)	21.85 (2.85)
Work-life balance	13.04 (4.22)	12.42 (1.24)
Overload	13.40 (4.78)	11.33 (1.27)
Job Security	12.07 (3.80)	11.66 (0.81)
Control	13.93 (5.06)	13.02 (0.98)
Resources & Communication	12.67 (4.39)	12.82 (0.94)
The Job	28.71 (6.26)	25.46 (2.77)
Pay & Benefits	3.12 (1.58)	3.44 (0.33)
'Attitudes towards your organisation' Scale	31.81 (9.01)	-
Perceived commitment of organisation to employee	16.03 (5.64)	20.11 (1.24)
Perceived commitment of employee to organisation	15.79 (4.18)	15.58 (2.53)
ASSET 'Your health' Scale	41.76 (11.62)	-
Physical Health	15.77 (4.23)	13.82 (0.77)
Psychological Well-being	26.00 (8.20)	23.15 (1.38)

Note: ASSET – A shortened Stress Evaluation Tool (Cartwright & Cooper, 2002)

Table 3. Mean scores for each variable within the overall sample and each of the three NHS Trusts (Standard deviation given in parentheses).

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Variable	Overall			
	Sample	Trust 1	Trust 2	Trust 3
ASSET 'Perceptions of Your Job' Scale	117.99 (28.94)	116.23 (27.58)	115.37 (33.97)	126.15 (30.75)
ASSET 'Attitudes towards your organisation' Scale	31.81 (9.01)	32.22 (8.60)	33.42 (7.67)	28.74 (11.75)
ASSET 'Your health' Scale	41.76 (11.62)	40.75 (11.93)	42.19 (11.90)	45.35 (9.27)
SCS-SF	2.98 (0.73)	3.11 (0.70)	2.83 (0.68)	2.62 (0.73)
CS overall	4.09 (0.55)	4.15 (0.53)	4.12 (0.48)	3.85 (0.61)
CS Kindness Subscale	4.10 (0.78)	4.14 (0.80)	4.14 (0.68)	3.96 (0.76)
CS Indifference Subscale	1.87 (0.70)	1.80 (0.66)	1.89 (0.71)	2.18 (0.76)
CS Common Humanity Subscale	3.94 (0.75)	3.97 (0.71)	3.94 (0.92)	3.77 (0.76)
CS Separation Subscale	1.85 (0.79)	1.78 (0.75)	1.81 (0.72)	2.14 (0.89)
CS Mindfulness Subscale	4.05 (0.79)	4.13 (0.76)	3.97 (0.92)	3.80 (0.74)
CS Disengagement Subscale	1.82 (0.71)	1.77 (0.70)	1.80 (0.58)	2.07 (0.80)
COQ	2.89 (0.66)	2.92 (0.64)	2.88 (0.73)	2.82 (0.69)

Note: ASSET – A shortened Stress Evaluation Tool (Cartwright & Cooper, 2002); SCS-SF – Self-Compassion Scale – Short Form (Raes et al., 2011); CS – Compassion Scale (Pommier, 2011); COQ – Compassionate Organizations Quiz (Simon-Thomas & Nauman, 2013).

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Table 4. Inter-correlations between the predictor variables (Figures shown depict Pearson’s r).

	Compassion for Others	Self- Compassion	Perceived Organisational Compassion (COQ score)
Perceived Organisational Threat (ASSET ‘Perceptions of your job’ score)	r= -0.336 *	r= -0.302 *	r= -0.661 *
Compassion for Others (CS score)	-	r=0.313 *	r= 0.391 *
Self-Compassion (SCS-SF score)	-	-	r=0.283 *

Note: ASSET – A shortened Stress Evaluation Tool (Cartwright & Cooper, 2002); SCS-SF – Self-Compassion Scale – Short Form (Raes et al., 2011); CS – Compassion Scale (Pommier, 2011); COQ – Compassionate Organizations Quiz (Simon-Thomas & Nauman, 2013).

* p<.001

Table 5. Stage three of the multiple regression analysis to test for a moderating effect of Self-compassion and Perceived Organisational Compassion on the relationship between Perceived Organisational Threat and Compassion for Others.

Variable	β (SE)	t	95% CI	p-value
Demographic variables				
Age Groups				
20-29 years	.207 (.14)	1.486	(-.07, .48)	.139
30-39 years	.005 (.10)	.052	(-.20, .21)	.959
40-49 years	-.025 (.08)	-.310	(-.19, .14)	.757
50+ years	-	-	-	-
Gender				
Female	.349 (.09)	3.960	(.18, .52)	<.001
Male	-	-	-	-
Job Role				
Nursing	.073 (.10)	.736	(-.12, .27)	.462
Psychology, Psychotherapists and Counsellors	.147 (.11)	1.297	(-.08, .37)	.196
Physiotherapy, OT and SALT	.152 (.13)	1.188	(-.10, .40)	.236
Health Care Assistants and Support Workers	-.016 (.13)	-.132	(-.26, .23)	.895
Other	-	-	-	-
Mean Number of years worked in NHS	.004 (.004)	.871	(-.01, .01)	.385
Predictor variables				
Perceived Organisational Threat	-.001 (.002)	-.742	(-.004, .002)	.459
Self-compassion	.166 (.04)	3.765	(.08, .25)	<.001

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Perceived Organisational Compassion	.208 (.07)	3.125	(.08, .34)	.002
Interactions				
Perceived Organisational Threat x Self-compassion	.001 (.001)	.915	(-.001, .004)	.361
Perceived Organisational Threat x Perceived Organisational Compassion	.001 (.002)	.494	(-.002, .004)	.622

Note: OT- Occupational Therapy; SALT – Speech and Language Therapy.

$R^2 = .284$

Table 6. Super-ordinate themes and descriptions of the sub-ordinate themes with example quotes, identified through thematic analysis of participants’ responses (N=235) to the question “What is the biggest thing that troubles you about working in your organisation?”

Super-ordinate theme	Sub-ordinate theme	Description	Example quotes
1. Change	Control over change	Troubles related to a lack of control or a lack of input when change is made	<p>“Having to deal with enforced staff and team changes which are detrimental and difficult to manage has been a major burden.”</p> <p>“I have not been asked my expertise on my new contract.”</p>
	Impact of change	The impact of change on services, staff and service-users and the uncertainty and insecurity that this creates around the future and jobs	<p>“all the changes make others feel very insecure”</p> <p>“Changes in structure that may mean not being able to provide the flexibility that the clients require.”</p>
	Amount of change	The frequency of change and “changing for changes sake”	<p>“I dislike the feeling of constant change and chaos as the trust strives to improve standards and meet targets”</p>

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			“the never ending changes”
2. Overload and Resources	Physical, financial and staff resources	Shortage of resources, including staff members and time pressures on staff – associated waiting times for service-users and increased workload for staff	“Lack of time to respond to every client and family with the space they deserve.” “Constant lack of resources, and yet buildings are heated to tropical levels. Very poor use of technology.”
	Time devoted to technology, admin and paperwork	In addition to fewer staff resources there are more paperwork and admin duties to complete	“Too much technology takes time away from patient care” “being buried in paper work and having to use poorly designed computer data inputting systems.”
	Target-driven culture	Overall sense that the culture is to strive to achieve targets above all else- conflict between targets and patient care	“driven by models and targets, it feels that we are forgetting that there are people involved in this process” “Driven [by] business concerns rather than what constitutes good clinical practice.”
	Work-life balance	Issues or stresses related to the amount of time dedicated to work, or the	“spend extra time at home catching up with computer work frequently.”

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impact this has on other areas of life “I had worked over 200 unpaid hours extra in the space of 6 months just trying to keep up.”

Nature of the work Troubles related to the difficult nature of the work and the complexity or risks of clinical work “Working with patient group is becoming more risky and unsafe.”
“dealing with difficult situations”

3. Work relationships	Lack of support, humility and compassion	Feeling a lack of care, support and compassion from the organisation to its staff	“This culture does not genuinely foster a sense of compassion for ourselves and for our colleagues.” “I think the whole organisation needs to consider the wellbeing of the staff working for it in a detailed and considered way; not just a 'tick box' exercise.”
	Bullying and punishment	Feeling like there is culture of blame and judgment, leading to bullying and punishment	“I have seen Bullying” “I feel that the organisation uses a 'big stick' and takes a punitive approach rather than supportive approach should someone be experiencing a difficult time professionally.”

	Trust and monitoring	Feeling untrusted to do the job or feeling constantly watched, judged, or monitored by the organisation	<p>“Worried to be ill in case of going on sickness monitoring.”</p> <p>“Feel that I am being watched all the time through statistical information and not on a face-to-face basis. I am an honest person but sometimes feel this is questioned.”</p>
	Isolation	Feeling isolated or disconnected from colleagues	<p>“Working as a bank worker I feel alone and don’t fit in anywhere its quite lonely”</p> <p>“Isolation from my team. I rarely see them because team meetings are held at a time when I cannot attend. I rarely see my boss even, so I feel a long way off - even though I feel they probably do care about me.”</p>
	Not feeling valued	Feeling a lack of respect or recognition, and not feeling valued through pay and benefits	<p>“Not being shown any appreciation of the hard and difficult work that we do”</p> <p>“I am going to be down-banded due to money savings”</p>

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	Inequality	Troubles relating to inequality or feeling that others are not ‘pulling their weight’	<p>“Attitudes like ‘I’m not doing that it's not part of my job role’.”</p> <p>“There doesn’t seem the care for employees there once was... diversity and equality should apply to all not just patients”</p>
4. Communication, leadership and direction		Lack of clear direction from leaders, and a lack of communication around the rationale and purpose of change	<p>“When there are changes in service provision people are unaware of this or what this might mean.”</p> <p>“lack of vision and long term strategic thinking to benefit patients and carers”</p>
5. Personal Factors		Troubles attributed to personal factors	<p>“I have a disability and worry about the impact it has on my team and working with patients/colleagues.”</p> <p>“Not as confident or assertive as other staff members.”</p>