Developing resilience and wellbeing for healthcare staff during organisational transition: The salutogenic approach

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Abstract

This paper evaluates the impact a resilience and wellbeing coaching programme had on staff working for the National Health Service (NHS) in the UK, during a time when they were considered to be at risk of 'burnout' whilst trying to deliver a high profile change in service delivery. The programme and research methodology were designed to facilitate a micro/meso/macro salutogenic coaching approach. The programme utilised pedagogical methods relating to transformational learning, and positive psychology that underpins coaching practice. The purpose of the study was to ascertain whether the programme supported employees to remain engaged with work during difficult workplace transitions.

Keywords: Salutogenisis, Resilience, Coaching, Workplace Transitions.

Introduction

The term 'frontline' was originally used to define a place of military conflict, one where personnel were exposed to significant risk. Within the broader employment context, working in the frontline is commensurate with operational rather than executive roles (CIPD, 2012, Soloman, *et al,* 2005). 'Frontline occupations' are known to have the highest incidence of stress related absence from work. Top of these are health, teaching and educational professionals, and those employed in personal caring services (HSE, 2013; CIPD, 2014). While work may be inherently stressful (Chandola, 2010), there is a point when stress has a negative effect, and this may be determined not just by the stressors themselves but also by our resilience to them. If our resilience is eroded over time, or by an impactful event, then the likelihood of absence from work and error causation increases (Jeffcott *et al*., 2009; Ham & Hartley, 2013; NPSA, 2013).

Employees in an organisational environment that is undergoing significant change are more likely to experience stressors that bring about a declining resilience (Chandola, 2010). In such an environment, the main causes reported for stress related absence from work (work pressure, lack of managerial support and work-related violence and bullying), are more likely to surface (Kerr, *et al,* 2009). There are also tensions that may reduce our resilience to workplace stressors, one of which is connected to the 'emotional labour' associated with the work we do (Hochschild, 1983; Zapf, 2002; Smith, et al, 2009). In the National Health Service (NHS), the investment of emotional labour is concerned with trying to deliver a world class service, often as a first point of contact (front-line) (CIPD, 2012), for people who are frequently in distress. The tension employees experience (Zapf,

2002) is influenced by an environment that is going through significant change, contextualised by reducing resources (Chandola, 2010). The effect of this over time is disengagement from work and less optimum performance (Tedeschi & Calhoun, 2004; West & Dawson, 2012). Conversely, creating and environment and providing skills that contribute towards an engaged workforce produces amongst other things better clinical outcomes (Dromey, 2014), and because of the association of workforce engagement with wellbeing, being engaged with work also reduces staff absenteeism. Positive workplace wellbeing contributes not only to overall life satisfaction, but also to maintaining a safe working environment for self, co-workers, and teams (Tedeschi & Calhoun, 2004; Boorman, 2009; Lyubovnikova, *et al*, 2015).

The cost of poor wellbeing to employers is often couched in financial terms, and recent figures from the Health and Safety Executive (2013), the Chartered Institute of Professional Development (CIPD) (2014), and Price Waterhouse Cooper (PwC) (2013) have shown that there are significant financial losses to *all* employers who do not consider the wellbeing of their employees. Poor wellbeing ultimately causes an increase in sickness absence rates, the cost of which to UK employers in 2013 was an estimated £29 billion (PwC, 2013). Analysts have been exploring the impact unhealthy working environments have on healthcare staff for over thirty years (Frese, 1985; Tyler and Cushway, 1992; Baldwin, *et al*, 1997), yet it was the Boorman (2009) report that identified the staggering annual financial cost of poor health and wellbeing of NHS staff as a whole (555 m), which appears to have galvanised people into action. As a result, the drive for bringing about a healthier more resilient workforce has become a priority to the NHS (Boorman, 2009; RCP, 2015)

This paper presents the findings from an empirical qualitative study undertaken with employees in an NHS Trust. The participants were members of a high profile project delivery team, and were by nature of their occupations in the 'front line' of service delivery. The study ascertains the impact of a coaching programme, designed to support staff to develop lasting resilience and wellbeing.

The employees who were participants to the study were in an unusually stressful working environment, they had already experienced protracted organisational change lasting some years, and during the lifetime of the project their NHS Trust was deemed by government watchdogs to have serious failures in care quality, and was required to enter 'special measures' (Monitor, 2014). Whilst the author of this study acknowledges that coaching is not a therapeutic intervention (Price, 2009; Hamlin, *et al*, 2009), coaching increasingly affords contact with employees who are experiencing anxiety from stressful working environments. As salutogenic coaching approaches focus on achieving an improved wellbeing whatever the circumstances, it may here that salutogenic coaching finds a foothold. The coaching programme in this study utilised a salutogenic coaching model (Grays, *et al*, 2014); the model engages employees with a process that enables them to develop a 'Sense of Coherence' (SoC, Antonovsky, 1979) about their workplace experiences. Through this process it is possible to identify individual and team situational awareness of resilience and wellbeing states, and engage employees with micro/meso/macro coaching experiences. The latter (macro) is particularly helpful in achieving team wellbeing for non- static team members (Edmonson, 2012).

The paper is structured in such a way as to present the learning programme methodology and the research methodology/methods. This enables the reader to understand that the learning programme was devised as an intervention, with intended outcomes depicted by the underpinning science and theories used. The methodology/methods were designed to enable the exploratory study to be philosophically and practically robust. The reader will engage with many concepts, some of these such as positive psychology and self-efficacy may be familiar, others such as salutogenesis may be less so, and because salutogenesis forms the cornerstone of the coaching model used, a fuller explanation is provided.

Background

As an effective organisational intervention, coaching has the potential to positively influence the workplace in a number of ways. For a long time, workplace coaching has been used to support employees experiencing career transition, to overcome challenges from organisational change, and to find ways to flourish in demanding working environments (Passmore & Fillery-Travis, 2011; Gray, *et al*, 2014). Within the NHS workplace, coaching is known to have supported clinical supervision, career development, and team working (Crow, *et al*, 2011; Reid, 2012; Woodhead, 2011). Coaching has become an integral part of NHS leadership programmes (such as those that are to be found in the NHS Leadership Academy and within the Faculty of Medical Leadership and Management), and has gained currency as an intervention that has the potential to positively influence clinical outcomes (McGonagle, 2014).

Coaching can be delivered on a one to one basis and as a programme to teams to enhance performance; whole shifts in organisations can be achieved when coaching goals are aligned with those of both the person being coached (coachee), and with direction of travel of the employing organisation. Coaching practice is structured through the use of coaching models and has a robust scientific basis founded in positive psychology (Williams, 2012; Seligman, 2007).

The coaching programme discussed in this paper is formulated on a wellbeing coaching model (Gray, *et al,* 2014) and was developed specifically for individuals and teams experiencing organisational transition. Why individual and collective wellbeing and resilience may be affected during transition is located around the lived experience of uncertainty and change (Terry and Jimmieson, 2003). These subjective experiences are often worsened when the experience is protracted, as people may develop feelings of having no control over their working lives (Chandola, 2010). Helping to re-establish a sense of direction and control is the work of the coach (Reid, 2012). This was achieved in the programme by supporting participants to regain control over individual resilience and wellbeing, and ultimately find ways in which to contribute to the resilience and wellbeing of team members. The programme facilitated the development of mindset that brought about a SoC (Antonovsky, 1979). This was important to achieve during the organisational transition period, as having a SoC is known to sustain a sense of hardiness and optimism (Eriksson and Lindstrom, 2005; Becker, et al, 2010), and would protect the participants from experiencing burnout. Ultimately the study explored how the programme could positively influence staff resilience and wellbeing, and as a consequence contribute towards workplace performance

Methodology

As the programme and research methodology for this paper are closely interwoven, each is presented separately for purpose of clarity.

Programme methodology

The coaching programme as an intervention has the potential to impact on the social actors (participants) within a social field (Bourdieu and Wacquant, 1992; Baker, 2005), In this study the social field incorporated the learning environment *and* the workplace. The programme was structured in three parts. The first part introduced participants to propositional knowledge relating to workplace stress, and to the salutogenic model and process. The second part involved one to one coaching with participants using the salutogenic model, and the third part focused on using the salutogenic model as a team.

The programme utilised the sciences of positive psychology, neuroscience, and pedagogy. Positive psychology was used as it is known be useful in identifying individual and team strengths (Kauffman, 2006; Hultgren, 2013). Neuroscience informed a process that helped to change mindsets (Schwartz, 2005), and by doing so change behaviours. Pedagogy determined the structure of the programme in order for opportunities for transformational learning to take place (Mezirow, 1991). Transformational learning required participants to relate learning to direct life experiences, and engage in critical reflection through rational discourse (Arthur, 1994). During coaching episodes, participants experienced guided *inductive* reasoning (Arthur, 1994) and co-construction (Hosking and Morley, 2004), which enabled them to identify schemata that did not contribute to resilience and wellbeing and replace them with others that did. Achieving transformational learning within an organisational setting often requires 'leverage' (Meadows, 1999), leverage was provided in terms of organisational permission (provided by the project leader) to implement individual and team coaching action plans.

The programme was underpinned by the theories of '*Salutogenesis*' and '*Best Self*'. Salutogenesis was coined by Antonovosky (Antonovsky, 1979; 1987) which requires us to focus our attention on what is 'healthy' or 'working well'. The process was applied at an individual (micro) peer (meso) and team (macro) level with the participants. The participants learned how to develop a SoC (Antonovsky, 1979) through the process of understanding their current work situation (Comprehension), ascertain how they are dealing with the current situation (Management), and what wisdom/learning could be gleaned from the current situation (Meaning). In addition, coachees (participants) were asked to discover and utilise what Antonovsky called 'General Resistance Resources' (GRRs). GRRs are all of the resources that help a person not only cope but also flourish during difficult experiences, and are effective in avoiding or combating a range of psychosocial stressors that lead to poor wellbeing.

The notion of 'best self" was determined by De la Vega (2009), who identified that if we are able to locate who our 'best self" is, then wherever we are in relation to this (the furthest point is known as the periphery), we can construct a way back to being that person. It is vital that coachees master this part of the resilience and wellbeing coaching process; as through it they become re-familiarised with someone they have lost sight of (themselves), and by focussing on this person (best self) they have a strong goal to move towards. The programme required the coachee (participant) to identify their proximity to being their 'best selves' on a 'pathway'. The pathway is divided by a total of seven spaces; each space can represent a subjective interpretation of resilience and wellbeing for each participant, and a collective interpretation of each space for the team. By populating each space, the participants began to make sense of workplaces experiences that can lead to a lack of wellbeing.

Developing a salutogenic mindset and resilience is achieved through a process (Harrop, *et al,* 2006) that incorporated micro, meso and macro elements. The first (micro) related to learning how to self-coach and experience coaching in a one to one coaching relationship, in the second (meso) the coachees experienced peer coaching, and lastly coachees experienced resilience and wellbeing coaching as a team (macro). Each component is a powerful transformational learning experience which creates sufficient cognitive dissonance to facilitate a sense of self-efficacy, and a shared responsibility for team member's wellbeing.

The learning environment

Transformational learning is a 'deep' form of learning (Marton and Säljö, 1984), to encourage this, the programme utilised pedagogical methods that encourage reflection and personal insight. Coaching is known to facilitate learning (Griffiths and Campbell, 2009) as the coach acts as learning guide, contributing towards a generative learning environment through the use of insightful coaching questions. In addition, the programme incorporated graphic recording. This served three purposes,

firstly of itself graphic recording facilitates insightful discussion and the sharing of ideas (Gray and Jones, 2015); secondly through the graphic recording process, knowledge could be captured and visually depicted on the coaching wellbeing model (Gray, *et al,* 2014) template, and lastly, graphic recording provided an additional method of data collection for this study.

Research methodology and methods

This was an empirical phenomenological case study, concerned with capturing the lived experience (Stake, 1994; Creswell, 2013), of participants' developing resilience and wellbeing, in response to participation in the programme. It was accepted that the participant's constructed reality of resilience and wellbeing at work prior to the programme, may have multiple interpretations, and amount to unsurfaced thoughts and experiences. In order to make sense of qualitative data, the wellbeing model (Gray, *et al,* 2014) was used to provide 'wellbeing frames' with which to both capture and analyse data.

Data was collected during the three-part programme using the following methods. On part one and part three of the programme, data was captured by asking the participants to populate the 'wellbeing frames' with rich descriptions of what is was like for them to be in 'periphery' and 'best self' spaces. Since initial testing (Grays, *et al*, 2014) the model has been developed to include a numerical pathway (1 = best self and 7 = periphery. This was done to enable coachees to develop a situational awareness of their own resilience and wellbeing in each of the spaces from 1 -7, and to record and monitor their resilience and wellbeing over time. From a research perspective the numerical pathway also serves as a Likert scale, and can be used to capture data relating to shifts in wellbeing.

On the part two of the programme data was collected during one to one (N=4) coaching episodes. The coaching episodes utilised the wellbeing model. The data was recorded as individual participant coaching profiles. The profiles contained data relating to 'best self' and 'periphery' statements, and individual pathway descriptions identified during the coaching session. Coachee descriptions also corresponded to a self-selected place on the Likert scale. This process resulted in the participants having a tool with which to numerically identify their wellbeing, and a personalised descriptive pathway that illustrated each of the 7 places on the Likert scale. Collectively the profiles also provided a wellbeing picture of the team which was used in part three of the programme.

The researcher coach also kept a coaching journal which contained reflections on the coaching programme and the research as it unfolded.

Post completion of the programme, a qualitative questionnaire (N=5) elicited impact of the programme in relation the individual, the workplace, and delivery of project. Longer term impact was ascertained by using a simple follow up email asking participants '*what number are you on the pathway today, and, what are you doing to bring yourself back to your best self'* . As each participant had a working understanding of what 'being a number' meant, this provided an easy dialogue between participants who knew that if a colleague responded with a 5 or a 6, they were likely to need some peer support.

The subjectivity of the qualitative data produced in this study is not questioned (Stake, 1994; Creswell, 2013), but is deemed part and parcel of knowledge generation, and necessary for understanding the field in question. A measure of reliability and validity data is achieved through triangulation of data sources (data captured during training, data captured during coaching, data recorded in a reflective coaching journal, and data from qualitative questionnaire). The analysed data was subjected to review from both the participants themselves and from a coaching peer (Guba & Lincoln, 1994).

Ethical considerations

Ethical approval was sought from the R&D committee of the NHS Trust. Participants were informed that taking part in the study was on a voluntary basis and they could still access the training programme whether or not they chose to participate. Participants were ensured of confidentiality, anonymity, opportunities to confirm/disconfirm and edit data, and to withdraw from the study at any time. Permission to disseminate findings was granted on these grounds.

Data analysis

The data produced for the study were, apart from participant recordings on the pathway Likert scale, qualitative in nature.

Analysis included:

1) presenting data back to participants at intervals for confirmation/editing,

2) researcher scrutiny for emerging themes, and

3) peer review.

Qualitative data were collected through graphic recording on part one and part two of the programme. Collection was facilitated using predetermined 'best self' and 'periphery' 'frames', which were presented back to the participants in the learning field. The participants were invited to confirm/disconfirm data captured under each frame, which provided a face validity of their offered descriptions. Graphic recording is a method of collecting data in the field, and enables participants to confirm or disconfirm data as it is presented 'live' on multimedia screens (Gray & Jones, 2016). The descriptions were then subjected to researcher scrutiny to identify emergent themes. The emergent 'best self' themes were; opportunities to learn, positive emotions, new beginnings, increase in money, and opportunities for personal development. The emergent 'periphery' themes were, not knowing, negative emotions, loss of identity, money worries and loss of control.

The themes and descriptors were peer reviewed by an independent academic coach, and then depicted in a new graphic recording of the event, the graphic recording was presented back to the (N=5) participants and they were asked to comment on validity of the thematic representation.

Data captured during individual coaching sessions formed part of a reflective journal for researcher/coach and used to develop individual profiles for the participants. The profiles were given to corresponding participants (N=4) who were asked to scrutinise and edit the profiles to ensure accuracy.

Data were collected post programme intervention by the use of three open ended qualitative questions, the questions were: -

1. Can you tell me *if* the resilience and wellbeing programme has had an impact on you, how?

2. Can you tell me *if* the resilience and wellbeing programme has had an impact on your workplace practice what this is?

3. Can you tell me *if* the resilience and wellbeing programme has helped you to deliver the FH project, how?

The responses were thematically analysed and ultimately clustered under three headings. The three emerging themes from the questions were,

1. The improvement of personal resilience and wellbeing facilitated through the learning process and visual aid.

2. Realising how individual resilience and wellbeing impacts the workplace for others.

3. Contributed to the delivery of the NHS project by improving individual and team wellbeing.

Findings

The findings from the study are presented in relation to each part of the programme.

Part one of the programme

The data produced on day one of the programme, was surfaced through the exploration of thoughts, emotions and memories for participants of their own wellbeing during a time of organisational change. This was conducted at micro (self coach), meso (peer coach) and macro levels (group discussion). The descriptions were classified within the 'best self' and 'peripheral' spaces; responses are depicted in Table 1 below.

While the responses are polarised between 'best self' (positive) and 'periphery' (negative) they initiated a situational awareness for both spaces. This was important as employees who are experiencing organisational change with a lowered wellbeing status may concentrate on periphery experiences alone, and by doing so increase the likelihood for a downward spiral of ill-health (Antonovsky,1987; Steyn, 2011; Tedeschi and Calhoun, 2004; Lewis, 2014). By cultivating an awareness of the positive, we are alerted to possibilities to be proactive about our own wellbeing, and encourage us to locate the GRRs that make us resourceful and over time resilient.

Identifying best self and periphery spaces during workplace transition	
Core – Best Self	**Periphery**
Learn lots. The process of transition can be positive as well as negative. Transferring skills are taught New skills to learn Gaining confidence/skills/knowledge Opportunity to realise your own potential Developing self and others Opportunities to develop and change	 Feeling like a novice Go from knowing to not knowing
Feeling excited, nervous, uncomfortable Having the confidence to move to apply Having a proud family, sense of wellbeing from this Joy Given choices Chance to change things Taking control, able to choose any path or opportunity	Reduced job satisfaction Pressures to deliver Self-doubt – am I up to it? Weight of expectation Fear of failure Anxiety regarding increased responsibility Lack of confidence Fear of getting it wrong and making mistakes Uncertainty Lack of security Lack of security Fear of the unknown Mushroom management Insecurity
New relationships to forge Meeting new people Leaving teams behind, making new teams and relationships Excitement of a new challenge Fresh start A clean sheet New beginnings	Who am I? Start to question work identity Have I made the right career choice? loss of status Concern re: 'fitting in' Put into a box
Increased money Someone investing in you New wardrobe, looking the part! More money!	Financial loss Money worries
Being challenged Sense of achievement Increased responsibility	Too many things to juggle Lack of ownership and accountability Limited by interpretations of policy Lack of control due to external influences Some things are out of my control and decisions made without me impact on me in a negative way

Table 1: Descriptions of 'Best Self' and 'Periphery' during organisational transition

Part two of the programme

Deepening the potential for impact of the programme was achieved through one to one coaching (Micro) sessions, as during these sessions coachees (participants) could explore more fully and learn (Mezirow, 1991; Griffiths and Campbell, 2009) to differentiate the places they could occupy on the pathway (and accord each space a description and a number on the 1-7 Likert scale – Table 2).

Due to issues of client confidentiality, verbatim coaching conversations are not disclosed in this study. Instead the (N=4) overarching coaching outcome identified by each of the coachees (participants in italics) is presented alongside the pathway numbers self recorded during part one and two of the programme. Participant number 5 shows that during part two of the programme she moved further towards a periphery state.

My best self includes having a part to play in ensuring environment of compassionate leadership during cultural adversity. Participant 1	
Part one of programme Pathway number = 7	Part two of programme Pathway number = 2
I need to say 'no' more as this will help me to manage the chaos of change, and will bring me back to best self Participant 5	
Part one of programme Pathway number = 4	Part two of programme Pathway number = 7
I can identify a career path during this difficult time if I focus on a part of my best self which makes my work meaningful Participant 4	
Part one of programme Pathway number = 5	Part two of programme Pathway number = 3
While I may go to the periphery, I can bring myself back and restore trust, loyalty and respect. Participant 2	
Part one of programme Pathway number = 7	Part two of programme Pathway number = 2

Table 2: Coaching outcome and pathway numbers over time

Part three of the programme

In order to broaden and build (Macro) (Fredrickson, 2001) the impact of the programme, the third part of the programme focused on team resilience and wellbeing. This provided opportunities to explore susceptibility of team resilience and wellbeing to external stressors, and share how collective team wellbeing, defined through interdependence and interconnectedness (Lewin, 1947; Edmonson, 2012), contributes towards workplace performance. Engaging with the programme at team level was timely as programme participants fell into a category identified by Edmonson (2012) as transitory. This made them vulnerable to workplace stressors due to isolation from a supportive peer group, and made the utilising any team broaden and build positive emotions (Frederickson, 2001) more challenging.

The participants began by identifying descriptions of the collective (Team) 'best self' and 'periphery' space'. The descriptions emerged through shared conversations, so were open to challenge and clarification and consensus from the whole team. This ensured the final illustration (Figure 1) had been subjected to face validity by the team.

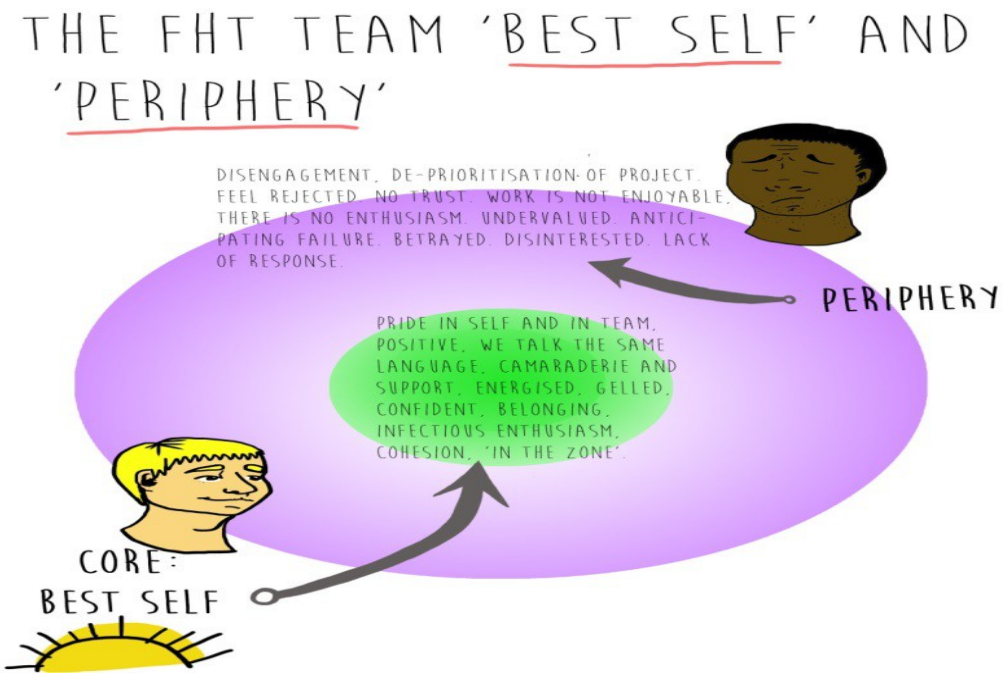

Figure 1: Capturing best self and periphery data through graphic facilitation

Knowing about team 'Best Self' and 'Periphery' enabled participants to be mindful of how each were coping; as a process it contributed towards team coherence by fostering a sense of camaraderie and fellowship through shared experiences (Schwartz, *et al*, 2005; Stake, 1994). In order to make explicit the vulnerability of team wellbeing within an organisational climate, we began by ascertaining a collective sense of team wellbeing. The team recorded this as being 2 on the pathway (Likert scale), the robustness of this reported sense of wellbeing was tested when we proceeded to discuss foreseeable impacts that impending organisational changes were likely to have. This resulted in a team wellbeing shift down to a collective 4. The process demonstrated the requirement of the participants to appreciate how external events may quickly impact *on* them (Antonovsky, 1979), and the need to develop a collective resilience *to* them.

We proceeded to explore Team 'interconnectedness' and 'interdependence' (Lewin, 1947, Edmonson, 2012) through a coaching lens. This process facilitated the Team locating the skills and knowledge that each team member (participant) brought (strength) to the project (Interconnectedness), and surface what each Team member (participant) brought and required emotionally (caring, passion, enthusiasm) from their Team mates (Interdependence). This latter emotional aspect established an emotional intelligence for the Team, something often overlooked but is vital to establishing team culture. As both Interconnectedness and Interdependence aspects are strengths (Kauffman, 2006) in coaching practice, they were viewed as assets of the Team and formed part of the Team GRRs.

Team GRRs	
Interdependent (skills & knowledge)	Interconnecting (emotion)
• Networker • Researcher resource investigator • Monitor/audit • Project management skills • Technical expertise • Clinical skills • Patient engagement knowledge • Project support • Informatics	• Camaraderie • Engagement • Can do spirit • Compassion • Vision and belief • Wellbeing coherence • Communicator • Innovation into action • Having a Sense of Coherence

Table 3: Team GRRs

Follow up impact

The three interventions within the programme were spaced over a ten-week period; this allowed for participants to practice using the model and apply it practically through their 'homework'. On the final day of the programme the participants were asked to answer three qualitative questions that asked them to consider what (if any) impact the programme had had on their personal wellbeing, what (if any) the programme may have had on their workplace practice, and finally, if the programme had helped to deliver the FH project, how? The (N=5) participants answered that the programme had positively impacted on all three areas, these are discussed below.

1. The improvement of personal resilience and wellbeing.

Overall, the responses stated that having a visual representation with which to make sense of how well they felt at work, and be able to use this to monitor their wellbeing, facilitated an improved wellbeing, and with that improved workplace performance. This outcome is significant as it demonstrates that the model supports participants to gain traction in moving away from the periphery, and in doing so experience a sense of having control over their own workplace situation. This is partially due to the visual model alerting participants to be situationally aware of 'triggers' that can move them in either direction on the pathway; once aware they become proactive about creating conditions for their own and team wellbeing, and acknowledging that a sign of resourcefulness is to ask others for help (Antonovsky, 1979).

Ability to identify my 'best self', understand my emotional and physical triggers that direct my 'place' on a visual scale. Visualising the 'best self' always enable me to re-set my mindset, or if not seek support to bring me back to a better space. Participant one

Gave me the insight to stop and ask myself, how am I doing/feeling. Made me actually stop and think about me and verbalise how I am feeling and relate it to a scale of wellbeing. Recognising triggers also low self-esteem, not sleeping or confident and in control. Participant four

2. Realising how their own resilience and wellbeing not only impacted on their workplace performance but also affected the resilience and wellbeing of others at work.

One of the insights gleaned by the participants was an understanding that not only did their own performance at work suffer because of a lowered individual wellbeing, but a realisation that being closer to a 'periphery' state negatively affected their colleagues, and so had the potential to lower the resilience and wellbeing of workplace teams. As a result, the participants proactively used 'self coach' techniques to improve their own wellbeing, and also began to use the techniques to support their colleagues in work.

I have noticed my 'score' on wellbeing impacts others so if I'm around a '5-7' I know I can be negative and proactively self coach back to a better place. I have used the technique to help others in my clinical team with positive outcomes. Participant 2

I recognise triggers and reflect on how I relate to colleagues and put in interventions to bring myself back to equilibrium and nearer my 'best self'. Also more aware of this with my colleagues and often consider whether they are in a good place and how I can potentially modify own behaviour to help progress. Participant 5

3. The delivery of the NHS project

The participants reported that the resilience and wellbeing programme had supported them to deliver the NHS project, primarily by having a common dialogue and process that enabled them to care about each other during a difficult organisation transition. The process and language provided a team identity, team culture and contributed towards a sense of purpose.

It has helped the team building process, making it easier to approach other members of the team and being more open about challenges and issues. It provides a common ground and language which improves our communication. Participant 4

In terms of developing closer working relationships and team working, having an improved sensitivity towards own other team members sense of wellbeing and modifying own behaviour to support each other. Has helped me to develop strategies to manage how I feel and how to get myself back to my best self. Participant 5

Discussion

The programme had an initial positive impact on participants because they experienced a transformational understanding (Mezirow, 1991) of their individual and team resilience and wellbeing at work. Participants realised that workplace transitions have the potential to provide both positive and negative experiences, and that while the working environment was stressful, much remained within their control. Regaining a sense of balance (Gray, 2011) contributed to the emergence of a salutogenic mindset (Antonovsky, 1987; Eriksson & Lindstrom, 2005) which continued to orient participants towards 'best self' status (De la Vega, 2009) and increased resilience to workplace stressors.

Through continued use of the model, participants began to develop a situational awareness towards wellbeing, which enabled them to be resourceful about activating GRRs, once GRRs were activated participants were back in control, thereby completing a virtuous cycle of resilience.

Part two of the programme focused on one to one coaching using the wellbeing model, this provided the opportunity for the researcher as coach, to achieve a sense of 'verstehen' by listening first-hand to the experiences of the participants negotiating a highly stressful working environment. This of itself

contributed towards data analysis and interpretation of findings, and, a transformative learning experience for both the coach as researcher and the participant as coachee.

Ascertaining whether the programme had a longer term impact on participants was achieved through follow up emails at one month intervals asking each participant 'what number are you today'? This elicited a range of responses that identified a number with a description for example,

'I am ok 3-4 not bad considering I don't know whether I'm coming or going', Participant 4

'Today I am a 3! Not bad me thinks for a Monday……. what number are you? Participant 3

'Thank you for sending this through – timely as we're having another dip but we've had some supportive emails flying around this morning!!! Participant 5

By continuing to refer to the model this way indicates that the programme has had an effect on underlying mental schemata (Dreifuerst, 2009), and that by cognitive and behavioural repetition, it is suggested the construction of new schema relating to resilience and (Atherton, 2010) would be achieved over time (Dreifuerst, 2009; Gray, 2011). Having said that, individual and team wellbeing are not fixed states (Gray, *et al,* 2014), so it would be natural for individuals and the team to experience returns to the 'periphery' as the working environment continued to change. The new potential however is for the participants to have an enhanced resilience when sliding towards the 'periphery'. By providing them with coaching knowledge and skills may mean they will be able to navigate emerging situations (Appelbaum & Goransson, 1997) differently, and have an opportunity to play out new roles accordingly (Hosking, and Morley, 2004).

Limitations

The limitations of the study include those that usually surface with a small qualitative case study (Stake, 1994). Which means that while the data is 'rich, and a true representation of participant experience of changing resilience and wellbeing in response to the programme; the findings however are non-generalisable. While validity of the data was assured through, participant and researcher scrutiny, and subjected to peer review, the long term reliability of impact of the programme may vary. This is because while the programme facilitates a process where participants are able to re-establish control over their resilience and wellbeing, and in so doing remain engaged with work while navigating a stressful environment, the context in which coaching programmes as interventions take place are subject to variation. The robustness of the programme was however tested by a number of workplace stressors. Firstly, the stressor of delivering a significant change in service delivery; secondly delivering a significant change in service delivery during a time of protracted uncertainty over job security, and thirdly delivering a significant change in service delivery during a culturally difficult time in organisational history when the Trust entered special measures.

Conclusion

The programme achieved impact at micro, meso and macro levels, and in so doing served as a self-help tool for participants to manage a very stressful working environment, and remain engaged (RCP, 2015) with delivering a high profile change in service delivery. The programme also introduced the importance of a wellbeing team culture, and demonstrated that sustaining interdependence and interconnectedness is better achieved if the team have a tool to monitor team wellbeing and provide proactive support.

The implications for theory is the further validation of a salutogenic coaching approach to workplace wellbeing, and a demonstrable practical use of the developed tools for use in practice. The participants engaged with the visual model and with the dialogue that provided a method of team communication. Rather than having to undertake a lengthy process of evaluating their individual resilience and wellbeing, the numbered pathway served as a mechanism for gaining traction towards a 'best self' space. The author suggests that while the learning programme has incorporated positive psychology, neuroscience and pedagogy, it is by combining these with salutogenic theories that a contribution to coaching is made. In order to sustain lasting (Appelbaum & Goransson, 1997) resilience and wellbeing, future participants will need to continue to revisit and use the wellbeing model, and remain resourceful with regards taking responsibility for their own and colleagues' wellbeing (Harrop, 2006).

The working conditions in the NHS are likely to continue to remain extremely stressful and create conditions for disengagement and absence from work. The implications for future research are that we should continue to explore ways in which to support staff who work in these conditions, as the resilience and wellbeing of NHS staff can be improved (Antonovsky, 1987; Boorman, 2009), and with it care delivery of care (Boorman, 2009; West & Dawson, 2012; RCP, 2015).

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