Managing workplace stress to enhance safer practice in community pharmacy: a scoping study

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Executive summary

Background
Workplace stress is a current concern for community pharmacists. Role expansion, pressures to meet targets, perceived staff shortages, and long working days with few opportunities for rest breaks have left some pharmacists struggling to cope with increasing workloads and have led to concerns that patient safety is being compromised.

Organisational responses to these pressures could help ensure that neither pharmacists’ well-being nor dispensing errors are adversely affected. Yet we do not know what community pharmacies are already doing to manage workplace stress. Nor do we have evidence of cost-effective stress solutions that may be practicable in a community pharmacy setting.

It is widely acknowledged in the organisational literature that stress at work can have an adverse impact on employees, affecting physical and psychological well-being, and their relationships to their jobs, work colleagues, and life outside work. Moreover, employee stress can have serious implications for organisational performance: across all sectors of employment, it is the leading cause of long-term absence from work (and a common cause of short-term absence), can affect employee productivity, increase staff turnover, cause accidents and errors, lead to industrial disputes and damage company reputations.

Study aims and objectives
To identify organisational solutions to workplace stress which are suitable, acceptable and/or adaptable to the community pharmacy sector and therefore have the potential to improve pharmacists’ wellbeing and reduce the incidence of dispensing errors by:

a. identifying and synthesising existing evidence for the effectiveness of organisational interventions designed to prevent or manage workplace stress;
b. identifying and appraising current developments in stress prevention and management in UK community pharmacy organisations;
c. identifying any safe parameters of workload being used or proposed by community pharmacy organisations; and
d. gauging stakeholders’ views of what is needed, and what might be possible, in relation to stress prevention and management in the community pharmacy context.

Methods
- A secondary synthesis of existing reviews of the literature on organisational stress management and prevention interventions.
- A series of semi-structured interviews with three groups of respondents: senior representatives of community pharmacy stakeholder organisations (n=6); senior managers of community pharmacy employing organisations (n=11); and practising community pharmacists (n=16).

Findings

Literature review
The literature review provided evidence of the effectiveness of a range of organisational interventions for the prevention and management of workplace stress:
Individual-level interventions with the greatest volume of supporting evidence included stress management training, cognitive behavioural approaches and counselling. Evidence also existed for the effectiveness of exercise, relaxation/meditation, employee assistance programmes and return-to-work schemes.

Interventions focused on the interface between the individual and their organisation with the greatest volume of supporting evidence included interventions to increase employee participation, to improve communication and those involving skill training. Evidence also existed for the effectiveness of interventions aiming to improve co-worker and management support and teamwork, those aiming to increase employee autonomy, the introduction of appraisals, interventions increasing role-clarity, and introducing training in conflict resolution and time management.

At the organisational level, the greatest volume of evidence was found for the effectiveness of interventions modifying task or job characteristics, targeting ergonomics or other aspects of the physical working environment and those involving changes to work scheduling (including flexi-time, rest breaks and shift patterns). There was also evidence for the effectiveness of management training, the introduction of new technology or equipment, changes to organisational culture and skill-mix, the introduction of company policies or strategies and workload modifications.

The most commonly demonstrated benefits of implementing such interventions were identified:

- Benefits to the individual employee included reductions in perceived stress or strain, increases in job satisfaction and improved psychological well-being.
- Benefits to the organisation included reduced sickness absence, improvements in perceived organisational culture or climate and increased performance or productivity.

A model of best practice in organisational stress management and prevention which may be suitable for adoption by community pharmacy organisations was proposed:

- Sustained top management support is a pre-requisite to success.
- Interventions should be context specific. This requires organisations to undertake a tailored risk assessment ("stress audit").
- The strategy implemented should combine individual and organisational interventions.
- Success requires a participative and cooperative approach with employees.
- Action planning is vital with clear tasks and responsibilities laid out.
- Buy-in from middle management is required.
- If external change agents are recruited, they need to act as facilitators rather than dictators.
- For any changes to be enduring, stress management needs to be incorporated into the organisational culture.

Interviews
The interviews suggested a lack of agreement as to the extent of the problem of workplace stress in the community pharmacy sector or within organisations. Pharmacists all recognised stress as a growing problem, whether or not they had personal experience of it, whereas employers were more ambivalent.
The interviews provided further qualitative evidence of the major sources of workplace stress for community pharmacists and of its impact upon pharmacists, community pharmacy organisations and the quality and safety of service provision.

Community pharmacy employers suggested that a range of strategies capable of preventing or managing workplace stress were being implemented:

- Return-to-work schemes, counselling services, and coaching were the most frequently mentioned existing strategies which were aimed at individual pharmacists.
- Employer-organisation interface strategies included: appraisals, communication, management support, conflict resolution, management training, and encouraging autonomy and participation.
- Ensuring there was a supportive organisational culture, encouraging rest breaks, appropriate staffing levels and skill-mix, and improving the physical environment, technology and equipment, were the most often described existing organisational-level strategies.

However, interviews with the pharmacists suggested that they were either unaware of such employer efforts or else they believed that the strategies implemented were ineffectual or, sometimes, had the opposite effect and actually contributed to workplace stress.

Most employers used workload/staffing models to inform staff allocation to branch pharmacies. In addition to dispensing volume a number of variables could be included in these models: over-the-counter sales, other services, pharmacy size, and the average time taken to complete tasks.

Whilst there was some support, particularly amongst pharmacists, for setting safe workload parameters, a number of important barriers were raised including variation in pharmacist capability, complexity of the pharmacists’ role, the number of other variables contributing to safe dispensing levels, and the financial consequences of imposing safe limits without changes in remuneration.

Regarding which interventions might be suitable to prevent or manage workplace stress in community pharmacies, organisational level interventions and those focused on the interface between the pharmacist and organisation generally received more support from pharmacists than those focused on the individual:

- Interventions focused on the interface between the pharmacist and organisation included appraisals, time management training, management training, improved communication and increased autonomy.
- Organisational level interventions included changes to the organisational culture, rest breaks and modifications to staffing and skill-mix.
- Employers, however, made fewer suggestions overall for further development in stress management, and were more likely to support the implementation of individual level interventions, particularly stress management training and exercise schemes.

A number of barriers to implementing different strategies in stress prevention and management, and to the success of those strategies implemented, were raised by interviewees. These could generally be categorised as barriers pertaining to the pharmacist (e.g. problems with delegation, a reluctance to come forward with stress-related problems), organisational barriers (e.g. financial
pressures, organisational culture, role of middle managers) and external barriers (e.g. regulatory and contractual framework, economic recession)

**Facilitators** identified to the development of organisational stress management strategies included the availability of evidence (of the scale of the problem; of the costs to organisations of, for example, stress-related sickness absence; of the risk to patients; of what works; and of the potential cost savings from investing in stress management); buy-in from pharmacy staff and managers; strategies for facilitating rest breaks; and external levers for change (e.g. regulation, legislation and funding).

**Recommendations for further research**
The findings of this scoping study have highlighted a number of areas where further research is needed:

1. Economic analyses of the organisational costs of workplace stress in community pharmacies to build the business case.
2. Further systematic evidence of the relationships between workload (both subjective and objective), stress and errors.
3. Longitudinal analysis investigating the relationships of changing workloads, staffing and skill-mix to business outcomes (sickness absence, turnover, error reports, indemnity insurance claims).
4. Case studies to generate detailed information about stress management practices and provide examples of best practice from which other community pharmacies could learn.
5. Intervention studies (or natural experiments) to evaluate the effectiveness and cost-effectiveness of interventions implemented in community pharmacy organisations. In particular, to evaluate:
   a. Rest break interventions for pharmacists
   b. Management training for pharmacists, particularly in delegation skills
   c. Different skill mix interventions, including the deployment of a second pharmacist
   d. Training for middle managers in identifying and supporting stressed pharmacists
6. Action research in partnership with one or more community pharmacy organisations to evaluate the effectiveness of implementing the model of best practice in stress management and prevention identified from the literature review.
1 Background

1.1 Stress in community pharmacy

Workplace stress in community pharmacy is currently under the microscope. In 2009, Elizabeth Lee, a locum pharmacist working in a Tesco pharmacy mistakenly dispensed the wrong drug to a 72 year old woman who subsequently died. Although deemed not to be directly responsible for the woman’s death, this dispensing error led to Elizabeth Lee being sentenced to a suspended three month jail term. During the court hearing it transpired that she had been working ten hour shifts without a break when the error was made. In the same year, the Royal Pharmaceutical Society launched a campaign to address ‘workplace pressure’ in pharmacy. The launch event highlighted the impact that recent changes in the general pharmaceutical services contract, the regulation of pharmacies, changing ownership structures, new shift patterns and the effect of long working hours without rest breaks, erratic working, and the long distances some pharmacists had to travel to work were all having on pharmacist’s performance and well-being. Recently published findings from the annual Chemist + Druggist magazine ‘salary survey’ suggested that workplace stress currently tops the list of concerns for community pharmacists, with two-thirds of pharmacist branch managers and non-manager pharmacists reporting that they had suffered from stress at or as a result of work in the past 12 months. Furthermore, almost 90 per cent of employee pharmacists responding to this survey claimed not to have received any support from their employers in relation to workplace stress and around half believed that workplace stress had contributed towards increasing dispensing errors and near misses.

Over 850 million prescription items were dispensed by community pharmacies in England last year (2010/11), an increase of almost 60 per cent over the last ten years. In addition to escalating dispensing volumes, community pharmacists have faced increasing workloads from role expansion since the introduction of the 2005 general pharmaceutical services contract. The new contract specified three levels of service provision. Essential services, which all community pharmacies are required to provide, cover dispensing, repeat dispensing and clinical governance requirements. Advanced services, including medicines use reviews (MURs), and the new medicines service (NMS) introduced in 2011, are not mandatory and require training and accreditation of the pharmacist. Enhanced services are commissioned locally to meet assessed needs and include minor ailments schemes, smoking cessation clinics and medicines management services for long term conditions. The number of enhanced services delivered has risen to 30,962 and 2.1 million MURs were conducted in England in 2010/11, a rise of over 23 percent from the previous year. Despite the 2005 contract initially being received positively, evidence from a number of predominantly qualitative studies suggests that community pharmacists are struggling to meet their new responsibilities. These studies suggest that increasing workloads, pressures to meet targets, perceived staff shortages, and deteriorating working conditions have affected staff well-being and have led to concerns that patient safety is being compromised.

Systematic research evidence is now starting to emerge which quantifies current stress levels within community pharmacy in England in relation to other healthcare workers and identifies those aspects of the work environment (work stressors) which particularly contribute to perceptions of stress for pharmacists. From a survey conducted in 2010, using a widely-used, validated stress measurement
tool, we have shown that community pharmacists are significantly more troubled than NHS employees by seven out of eight major sources of work-related stress (work-life balance, work overload, job security, the nature of the job itself, work relationships, control and pay and benefits). Furthermore, we demonstrated that long working days, being a pharmacy manager and working for large multiples and supermarkets was associated with higher reported levels of a number of these stressors, more so than self-reported levels of workload (Jacobs et al., unpublished manuscript).

Our survey has also for the first time provided quantitative evidence supporting both the perceived link between stress and well-being – with concerns about work-life balance, the nature of the job, and work relationships being the most influential on health – and the link between high dispensing volume and perceived overload and pharmacists’ involvement in dispensing errors (Johnson et al., unpublished manuscript). Previous research has suggested that between 0.04% and 3.0% of items dispensed by community pharmacies contain a dispensing error (equivalent to between 340,000 and 25.5 million dispensing errors per year in England). These studies also suggested that organisational factors (e.g., workload, staffing, relationships with supervisors, insufficient work breaks) may be associated with the majority of these errors.11–13

Year on year increases in prescribing volume, current financial pressures and the policy drive towards expansion of private sector provision of healthcare (“any qualified provider”) are all likely to ensure that workplace pressures will continue to increase with fewer staff doing more work in community pharmacies. How community pharmacy organisations support the well-being of their staff may be instrumental in ensuring that these increasing pressures do not lead to any increase in dispensing errors and compromise patient safety. Yet we do not know what steps community pharmacy organisations are already taking to prevent or manage workplace stress for pharmacists. Nor do we have any evidence of cost-effective solutions to workplace stress that may be practicable in a community pharmacy setting. This scoping study aims to take the necessary first steps in answering these questions.

### 1.2 What is workplace stress?

Workplace stress has been defined as “the adverse reaction people have to excessive pressures or other types of demand placed on them at work.” The Health and Safety Executive (HSE) also make the distinction between ‘stress’ and ‘pressure’ at work:

“There is a difference between pressure and stress. Pressure can be positive and a motivating factor, and is often essential in a job. It can help us achieve our goals and perform better. Stress occurs when this pressure becomes excessive. Stress is a natural reaction to too much pressure.”

It is widely acknowledged that stress at work can have an adverse impact on employees, affecting their well-being, both physical and psychological, as well as their relationships to their jobs, work colleagues, and life outside work. However, employee stress can also have serious implications for organisational performance. Not only is it the leading cause of long-term absence from work (and a common cause of short-term absence) but it can affect employee productivity at work, increase staff turnover and cause accidents and errors, lead to industrial disputes and damage company
reputations. Table 1.1 summarises many of the individual and organisational implications of workplace stress.

**TABLE 1.1 The impact of stress at work**

<table>
<thead>
<tr>
<th>Impact on individuals</th>
<th>Impact on organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical health</strong></td>
<td><strong>Sickness absence</strong></td>
</tr>
<tr>
<td>- hypertension/cardiovascular disease</td>
<td>- stress-related ill health</td>
</tr>
<tr>
<td>- digestive disorders</td>
<td>- stress-exacerbated ill health</td>
</tr>
<tr>
<td>- musculoskeletal complaints</td>
<td>- coping mechanism</td>
</tr>
<tr>
<td>- fatigue/exhaustion</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological well-being</strong></td>
<td><strong>Performance/productivity</strong></td>
</tr>
<tr>
<td>- anxiety/depression</td>
<td>- reduced motivation/commitment</td>
</tr>
<tr>
<td>- reduced ability to concentrate</td>
<td>- reduced concentration/ability</td>
</tr>
<tr>
<td>- low self-esteem</td>
<td>- presenteeism</td>
</tr>
<tr>
<td>- insomnia</td>
<td></td>
</tr>
<tr>
<td>- impaired interpersonal skills</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship to work</strong></td>
<td><strong>Staff turnover</strong></td>
</tr>
<tr>
<td>- engagement</td>
<td>- self-preservation</td>
</tr>
<tr>
<td>- motivation</td>
<td>- breakdown in working relationships</td>
</tr>
<tr>
<td>- commitment</td>
<td>- disengagement</td>
</tr>
<tr>
<td>- job satisfaction</td>
<td>- difficulties recruiting</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>- family/relationship difficulties</td>
<td>- error/accident/injury</td>
</tr>
<tr>
<td>- increased alcohol consumption</td>
<td>- workplace conflict</td>
</tr>
<tr>
<td>- increased smoking frequency</td>
<td>- industrial disputes</td>
</tr>
<tr>
<td></td>
<td>- damage to reputation</td>
</tr>
</tbody>
</table>

Summarised from the Chartered Institute of Personnel and Development (CIPD)\(^{17}\)

The HSE identifies the main causes of stress at work as job demands, control, support, roles relationship and change.\(^{18}\) The CIPD identifies the top five sources of work stress as workload/volume, management style, non-work factors (relationships/family), relationships at work and change.\(^{16}\) As Table 1.2 shows, both work content and work context can be sources of workplace stress.
### TABLE 1.2 Sources of stress at work

<table>
<thead>
<tr>
<th>Work content</th>
<th>Work context</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Job content</strong></td>
<td><strong>Role in the organisation</strong></td>
</tr>
<tr>
<td>● boring, monotonous tasks</td>
<td>● ambiguity about one’s role</td>
</tr>
<tr>
<td>● lack of variety in the job</td>
<td>● conflicting roles in the job</td>
</tr>
<tr>
<td>● underutilisation of skills and abilities</td>
<td>● responsibility for people</td>
</tr>
<tr>
<td>● unpleasant, aversive tasks</td>
<td>● boundary roles (customer contact)</td>
</tr>
<tr>
<td><strong>Workload and work pace</strong></td>
<td><strong>Career development</strong></td>
</tr>
<tr>
<td>● too much or too little work to do</td>
<td>● job insecurity</td>
</tr>
<tr>
<td>● understaffing</td>
<td>● lack of promotion potential</td>
</tr>
<tr>
<td>● time/deadline pressures</td>
<td>● under- or over-promotion</td>
</tr>
<tr>
<td>● inadequate tools or equipment</td>
<td>● work of ‘low social value’</td>
</tr>
<tr>
<td>● machine-pacing of work</td>
<td>● unfair performance evaluation</td>
</tr>
<tr>
<td><strong>Work hours/schedule</strong></td>
<td><strong>Interpersonal relationships</strong></td>
</tr>
<tr>
<td>● inflexible work hours</td>
<td>● lack of support from supervisor</td>
</tr>
<tr>
<td>● long hours</td>
<td>● lack of support from co-workers</td>
</tr>
<tr>
<td>● mandatory overtime</td>
<td>● bullying, harassment, violence</td>
</tr>
<tr>
<td>● unpredictable hours</td>
<td>● isolated or solitary work</td>
</tr>
<tr>
<td>● rotating shift schedules</td>
<td>● inadequate conflict resolution</td>
</tr>
<tr>
<td><strong>Participation and control</strong></td>
<td><strong>Organisational climate/culture</strong></td>
</tr>
<tr>
<td>● lack of participation in decision-making</td>
<td>● inadequate communication</td>
</tr>
<tr>
<td>● lack of control over work methods, work pace</td>
<td>● poor leadership</td>
</tr>
<tr>
<td>● work schedule</td>
<td>● discrimination (age, race, sex)</td>
</tr>
<tr>
<td></td>
<td>● violence, harassment, bullying</td>
</tr>
</tbody>
</table>

Modified from Murphy\(^{19}\) and Leka et al.\(^{20}\)

### 1.3 The business case for tackling workplace stress

For any organisation, developing and implementing strategies to prevent or manage workplace stress of necessity requires investment of time and resources. Particularly at a time of financial constraint, it may be difficult for businesses of any size to make such a commitment. Yet the business case for doing so is well established and persuasive.

#### 1.3.1 The costs to organisations of workplace stress

The National Institute for Health and Clinical Excellence (NICE) has estimated that psychological ill health within the working age population costs UK employers £28.3 billion per year (at 2009 pay levels).\(^{21}\) This can be broken down into £9.2 billion a year for sickness absence; £16.5 billion a year for reduced productivity at work (‘presenteeism’ can account for 1.5 times as much working time lost as absenteeism and can be even higher in higher paid staff); and £2.6 billion a year for turnover.\(^{22}\)

In its annual survey of absence management, the CIPD has reported that work-related stress is the most common cause of long-term absence from work and one of the top five causes of short-term absence.\(^{36}\) The average employee takes 7.9 days sickness absence per year, costing (on average)
£600 per employee per year. Those suffering from stress, anxiety or depression take, on average, 24.2 days off per year.

The Sainsbury Centre for Mental Health has suggested that a reduction of 30 percent in mental health related sickness absence (with equivalent reductions in presenteeism and turnover) can be achieved by organisations implementing an employee well-being strategy. Using this estimate, NICE has calculated that the effective management of psychological well-being could save an organisation with 1000 employees £250,000 per year (at 2009 pay levels). On the basis of their calculations, NICE have developed a costing tool for employers from which they can estimate the cost of mental ill health to their own organisation and the potential cost savings of implementing a strategy for preventing and managing workplace stress. That tool is available online at http://guidance.nice.org.uk/PH22/CostingTemplate/xls/English.

1.3.2 The legal and ethical considerations

In addition to purely financial considerations, employers are bound by a number of legal and ethical duties in relation to preventing or managing workplace stress.

Employers have a legal ‘duty of care’ that employees are not made ill or injured by work. This includes minimising the risk of stress-related illness or injury to employees. Much of the law regarding health and safety in the workplace can be found in the Health and Safety at Work Act 1974, although a number of other important regulations have been incorporated into UK law since becoming part of the European Union. Under the Health and Safety at Work Act, employers must have a written policy on health and safety at work that addresses the issue of stress in the workplace, which must be provided to all employees. Furthermore, the Management of Health and Safety at Work Regulations 1999 places an obligation on the employer to actively carry out a risk assessment of the workplace, including stress-related risks, and act accordingly. Other employer responsibilities under this duty of care includes taking measures to alleviate monotonous tasks, adapting work to the individual, and tackling the causes of work-related stress.

Employees suffering impaired psychological well-being through stress at work have a legal right to redress in the civil courts. The CIPD has published examples of cases where employees have successfully taken their employers to court after suffering from work-related stress. These include the case of a post office worker who was awarded £94,000 in damages in the high court after suffering a breakdown as a result of overwork and lack of training, and an accountant working for O2 who was awarded £110,000 damages after suffering from stress-related ill health due to working excessive hours with a demanding workload. In both cases, the employer had failed to act to support the worker despite clear evidence of there being a problem.

Irrespective of the legal responsibilities, it could be argued that employers have a moral duty towards their employees to prevent ill health through work. This can be seen to be a part of their Corporate Social Responsibility (CSR). CSR has been defined as

“The continuing commitment by business to behave ethically and contribute to economic development while improving the quality of life of the workforce and their families as well as of the local community and society at large.”
Given the potential impact of workplace stress on employee wellbeing described above, the relevance of managing workplace stress to employers’ CSR is clear.

1.4 Theoretical frameworks

Organisational stress management and prevention strategies or interventions have been categorised in a number of ways in the literature, including according to their level of prevention (i.e. primary, secondary or tertiary), their focus (i.e. on the individual employee or on the organisation) or their target or the aspect of the work environment being modified (i.e. socio-technical or psychosocial).

The primary, secondary, tertiary classification is adopted from the public health and preventative medicine literature. Primary prevention targets the causes of stress, aiming to prevent it from arising in the first place in any employee. Secondary prevention targets those experiencing workplace stress and aims to prevent any problems or stress-related illness arising. Tertiary prevention targets individuals already adversely affected by workplace stress and aims to rehabilitate employees either through staged return to work (if they have taken leave of absence) or by supporting them whilst at work.

A framework from organisational theory commonly adopted to describe stress management and prevention interventions is that proposed by DeFrank and Cooper. These authors expand upon the general distinction between individual and organisational interventions and propose three categories of intervention, those with a focus on the individual, those focusing on the interface between the individual and organisation, and those focused on the organisation. Examples of the former include counselling, exercise and stress management training; the middle category includes interventions to improve employee participation and autonomy, relationships at work and role issues; and the latter includes those targeting the organisational structure and culture, the physical environment and technology available, staffing and skill-mix.

A third classification sometimes used in the organisational literature distinguishes between objective/structural targets – so-called ‘socio-technical’ interventions – and those with more subjective targets relating to employees perceptions of their work environment – ‘psychosocial’ interventions. Targets included in the former category are staffing levels, work scheduling, workloads, the physical environment; psychosocial targets include employee participation, communication, co-worker support.

A degree of congruence can be seen between these different classifications, for example organisational interventions are more likely to have a primary preventative aim and tertiary preventative measures will only target the individual. However, there is also some overlap, for example interventions focused on the individual can offer primary, secondary or tertiary stress prevention. In this report, we have adopted DeFrank and Cooper’s typology of interventions in stress management and prevention to organise the findings both of the literature review and interviews.
2 Aim and methods

2.1 Aims and objectives

The overarching aim of this scoping study was to identify potential organisational solutions to workplace stress which are suitable, acceptable and/or adaptable to the community pharmacy sector and therefore have the potential to improve pharmacists’ wellbeing and reduce the incidence of dispensing errors. The study objectives were:

a. to identify and synthesise existing evidence for the effectiveness of organisational interventions designed to prevent or manage workplace stress;
b. to identify and appraise current developments in stress prevention and management in UK community pharmacy organisations;
c. to identify any safe parameters of workload being used or proposed by community pharmacy organisations; and
d. to gauge stakeholders’ views of what is needed, and what might be possible, in relation to stress prevention and management in the community pharmacy context.

2.2 Methods

2.2.1 Literature review

In the absence of published evidence of effective stress management and prevention interventions in community pharmacy, a scoping review of the wider literature from other sectors of employment was conducted to address the first study objective. A number of existing literature reviews, taking a variety of approaches, have been published over the last 15 years in both the peer-reviewed and professional literature exploring the effectiveness of work-related stress management and prevention interventions. These formed the basis for the current ‘review-of-reviews’. This method was selected over the originally proposed systematic review methodology on the direction of PTECO trustees to limit the time and staff cost devoted to this aspect of the study. Nonetheless, a systematic approach was taken to identifying, selecting, extracting and synthesising data from these existing reviews.

Published reviews were identified both through the existing knowledge of the research team and through keyword searching of the internet to capture publications from the professional and management literature published on the websites of regulatory and guidance agencies, and searches of electronic databases (including OVID: Medline; Cinahl; Embase; HMIC; International Pharmaceutical Abstracts; CSA: social science databases; ABI Inform) to capture publications from both the health and organisational sciences peer-reviewed literature. Keywords and free-text search terms varied by database but always included terms relating to work stress, intervention studies, and review papers. A set of inclusion and exclusion criteria (Table 2.1) were developed to limit the scope of the review and to guide the search process and subsequent selection of papers. Crucially, only reviews of interventions including an organisational element (i.e. targeted at the interface between the individual and organisation or at the organisational level, according to DeFrank and Cooper’s framework described in Chapter 1 of this report) were included; reviews of interventions
focused solely on the individual were not within the scope of this study (although some reviews included some elements of individual-level interventions).

**TABLE 2.1** Inclusion and exclusion criteria applied in identifying and selecting papers for review

**Inclusion criteria:**

*Sector of employment:* Any

*Location:* Developed countries (UK, W. Europe, US, Canada, Australia, NZ)

*Dates:* post-1995

*Design/study type:* Review papers only

*Publication type:* Both peer-reviewed papers and grey literature

*Focus of study:* Reviews of effectiveness or cost-effectiveness of organisational interventions to manage or prevent work-related stress

*Language:* English only

**Exclusion criteria:**

*Design/study type:* Non-empirical work

*Publication type:* Conference abstracts

*Focus of study:* Reviews of the effectiveness of interventions focused solely on the individual (with no organisational element)

A pro-forma was developed (Appendix 1) and used to extract data from each of the selected reviews in relation to any theoretical frameworks adopted, the review method, each of the interventions described (inc. original citation, study setting, intervention, method of evaluation, effectiveness), and the conclusions drawn (inc. success factors, barriers, methodological issues).

Every intervention described in the selected reviews with evidence for its effectiveness was categorised as focusing on the individual, the interface between the individual and organisation, or the organisation itself, according to DeFrank and Cooper’s framework described in Chapter 1, and ordered by its prevalence in the literature (Table 3.1). In addition, the benefits demonstrated by these studies were categorised as either benefits for the individual or benefits for the organisation and ordered according to their prevalence in the literature (Table 3.2). These findings are presented in Chapter 3. More detailed information about the individual reviews and the effectiveness of the different interventions described therein was tabulated and this is provided in Appendix 2.

Additionally, those factors associated with the success of the different stress management and prevention interventions identified in these reviews were summarised to produce a model of best practice, also described in the following chapter.
Finally, the findings from this literature review were summarised and, together with a summary of evidence of the causes and effects of work-related stress and of the business case presented in Chapter 1 of this report, developed into a briefing paper for distribution to participants in the second stage of this study, prior to the interviews being conducted. This briefing paper can be found in Appendix 3.

2.2.2 Interviews

To address objectives b to d (above), a series of semi-structured interviews were conducted between February and June 2012 with three groups of respondents: senior representatives of community pharmacy stakeholder organisations (referred to in the findings as “stakeholders”); senior managers of community pharmacy employing organisations (“employers”); and practising community pharmacists (“pharmacists”).

A purposive sample of seven stakeholder organisations was identified through the existing knowledge of the research team to represent a range of interests, including the professional body for pharmacy in England, trade associations and unions for community pharmacists, representative bodies for different groups of community pharmacy contractors/employers, and a support organisation for pharmacists in need. The chief executive, chair or managing director was approached from each of these organisations by email in the first instance and invited to participate. Of the seven organisations originally invited, interviews were secured with senior representatives from six, with the final organisation being represented by one of the pharmacy employers.

A purposive sample of community pharmacy employing organisations was identified through existing networks to include a range of organisational sizes and types from small pharmacy chains to large multiples and supermarkets. The superintendent pharmacist from each of these organisations (or other senior manager already known to the research team) was contacted by email in the first instance and invited to participate. Of the 14 employers originally invited, interviews were secured with senior management representatives of 11.

Practising community pharmacists were recruited using a number of different strategies. Some were recruited through existing networks of pharmacy colleagues. Others were recruited through the superintendent pharmacists already participating in the study, some of whom sent out open invitations to their employees or provided the researchers with a list of potential participants directly. An open invitation to participate was also sent, via CPPE, to all those pharmacists who had downloaded their training guide “De-stress you”. Finally, open invitations were placed on a number of internet social networking sites including the CPPE LinkedIn and Facebook pages and Greater Manchester RPS Local Practice Forum website. All open invitations included brief details of the aims of the research and the contact details of the lead researcher. Efforts were made to include pharmacists working in a range of organisational settings, from small pharmacy chains and independent pharmacies to large multiples and supermarkets. Of the 24 pharmacists with whom the research team originally had contact, interviews were secured with 16. Of those not participating, some withdrew after receiving further information about the study and others were turned down by the research team on account of a preponderance of volunteers from the same large multiple.

Prior to being interviewed, all participants received an information sheet detailing the aims of the study and what it would involve for them, listing any potential risks. They were asked to sign and
return the attached consent form before the interview was conducted. After consent was received, all participants were sent the briefing paper described above (Appendix 3) at least two days before the arranged interview. Respondents were advised to read it in advance of the interview and to have it to hand during the interview for reference and prompting.

The majority of the interviews were conducted by telephone although one employer and three pharmacists were interviewed face-to-face for reasons of convenience or at the request of the interviewee. Interviews lasted between 32 and 86 minutes with most lasting about an hour. The interview guides (Appendices 4 to 6) were informed by the literature and were designed to address the objectives of the study. Thus they were designed to explore:

- interviewees’ experiences of work-related stress in community pharmacy and its causes and effects;
- current strategies for preventing or managing workplace stress deployed in their own/community pharmacy organisations;
- the use of safe workload parameters;
- the transferability of different stress management and prevention strategies to the community pharmacy context;
- the barriers and opportunities for further developments in this area;
- the extent to which their own/community pharmacy organisations met the standards for best practice in stress prevention, and
- future research opportunities

The interview guides were modified slightly for each group of respondents to ensure relevance. The pharmacist interview guide was piloted with two practising community pharmacists.

All interviews were audio recorded, with permission, and transcribed verbatim. The qualitative analysis software package NVIVO 9 was used to help manage the thematic analysis process. A branching thematic framework of common and conflicting themes was developed, initially from the interview guides and later added to and modified using themes derived directly from the interviews.

The interview findings are reported in Chapter 4. It should be noted that this was a scoping study of a qualitative nature. The aim, therefore, was to identify the breadth and depth of experiences, views and opinions of pharmacists, employers and stakeholder organisations rather than to quantify responses in a statistically representative sample. Thus we have deliberately not presented findings in terms of the numbers or proportions of respondents expressing particular views which would be inappropriate and invalid. However, terms such as ‘most’, ‘some’ or ‘few’ are used judiciously where this helps to clarify the degree of commonality of views and experiences.
3 Literature review findings

3.1 Summary of the literature identified

Eighteen published reviews\textsuperscript{30-47} of organisational stress management and prevention interventions, published between 1997 and 2008, were included in this review. Twelve were from the peer-reviewed academic literature and six from books and reports. The methodologies used within these reviews varied from comprehensive systematic reviews to more selective reviews and multiple case studies. Four reviews did not describe the methods used. Many described the method and findings from individual evaluations of stress management interventions whilst others provided only a synthesised summary of the evaluations reviewed. Unsurprisingly, there was a degree of overlap between these reviews in terms of coverage.

A wide range of different sectors of employment was covered by these reviews in both the private and public sectors and across a range of different countries (UK, Europe, US, Australia). Private sector settings included a variety of manufacturing, retail, transport, forestry, mail, office and insurance company settings. Public sector settings included a variety of healthcare (hospital, community, mental health, public health), social care (care homes, child protection), education, government and police force settings.

The findings of each of these reviews are detailed in Appendix 2. Here we present a synthesis of the key findings in relation to (a) the components of organisational stress management interventions with evidence of effectiveness, (b) the positive outcomes that have been demonstrated and (c) the factors contributing to their success.

3.2 Effective organisational stress management and prevention interventions

The stress management and prevention interventions described in the literature have been categorised according to the theoretical framework suggested by DeFrank and Cooper\textsuperscript{29} which categorises interventions as those focusing on the individual, those focusing on the individual-organisational interface and those focused on the organisation.

Historically, stress management interventions have focussed predominantly on the individual (e.g. counselling, cognitive-behavioural approaches, relaxation, etc.), usually providing support to those already suffering from the effects of work stress or giving them the tools or resilience to cope with work stress when it arises (i.e. secondary prevention). Individual-level approaches also include interventions to assist those whose health has already been damaged by chronic stress (tertiary prevention; e.g. employee assistance programmes, return-to-work schemes). A large number of systematic reviews already exist of the effectiveness of such individually-focused interventions.\textsuperscript{29,48-50} Whilst not within the scope of the current review, some reviews selected here included studies with a purely individual focus. However, many organisational interventions also involved an element of individual stress management and these multi-faceted interventions were within the scope of the current review. We have therefore included those elements here.
Over recent years however, efforts have increasingly been focused on interventions to reduce the organisational causes of stress (primary prevention), either targeting those aspects of work at the individual-organisational interface (e.g. role clarity, co-worker support, autonomy etc.) or in relation to the organisational context (e.g. ergonomics, management style, work schedules). Table 3.1 summarises the types/targets of organisational stress management and prevention interventions for which the current review has identified some evidence of effectiveness, listed in order of their prevalence in the literature reviewed. It should be noted that most of the studies covered by these reviews were multi-faceted, containing a number of different elements from across these three categories.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Individual-organisational</th>
<th>Organisational</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stress management training</td>
<td>1. Participation</td>
<td>1. Task/job characteristics</td>
</tr>
<tr>
<td>2. Cognitive-behavioural approaches</td>
<td>2. Communication</td>
<td>2. Ergonomics/physical environment</td>
</tr>
<tr>
<td>5. Relaxation/meditation</td>
<td>5. Autonomy</td>
<td>5. Technology/equipment</td>
</tr>
<tr>
<td>7. Return-to-work schemes</td>
<td>7. Management support</td>
<td>7. Skill mix, job rotation</td>
</tr>
<tr>
<td></td>
<td>8. Teamwork</td>
<td>8. Company policy/strategy</td>
</tr>
<tr>
<td></td>
<td>10. Conflict resolution training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Time management training</td>
<td></td>
</tr>
</tbody>
</table>

3.2.1 Interventions focused on the individual

The individually-focused intervention most commonly included in organisational stress management or prevention strategies with evidence of effectiveness was stress management training. This was followed by cognitive-behavioural approaches and other forms of counselling. For example Poelmans et al.\(^5\) (cited in Kompier et al.\(^5\) and Semmer\(^4\)) evaluated an intervention in a Belgian pharmaceutical company which, whilst focusing on ergonomic improvements, also offered stress management training for employees. The evaluation demonstrated a reduction in sickness absence and resulted in stress no longer being stigmatised within the company. Cost savings in relation to the decreased absenteeism were also found to outweigh the costs of the intervention.

Other individual level interventions with evidence of effectiveness included exercise, training in relaxation or meditation techniques and opportunities for their practice, employee assistance programmes which are aimed at those experiencing work or personal problems which are affecting their performance and can include counselling together with a range of other services including financial, legal, stress management, anger management and referral to specialists,\(^5\) and return-to-work schemes for those who have taken long term sick leave and would benefit from a gradual return to work.
3.2.2 Interventions focused on the interface between the individual and organisation

At the individual-organisational level, a large number of interventions described in the review literature involved participative approaches to stress prevention and management and/or increased employee participation in decision-making within the company. For example, Landsbergis & Vivona-Vaughn\(^{54}\) (cited in Semmer\(^{43}\) and Parkes & Sparkes\(^{46}\)) evaluated a multi-faceted stress management programme in a ‘public health agency’ in the US implemented through the establishment of problem-solving committees representing all levels of employee. These problem-solving committees identified key causes of stress and developed new policies and procedures to deal with these although with mixed success. However, a later study by Mikkelsen et al.\(^{55}\) (also cited in Semmer\(^{43}\)) using the same approach in two Norwegian healthcare institutions demonstrated a positive impact on work-related stress, job characteristics, learning climate and management style.

Interventions which included an element of improving communication within organisations were also common in the review literature and demonstrated evidence of effectiveness. For example, Kompier et al.\(^{56}\) (cited in Semmer\(^{43}\)) and Cartwright et al.\(^{57}\) (cited in Giga et al.\(^{58}\)) evaluated interventions which included an element of improving communication within the organisation. The former evaluated a series of 13 natural experiments in bus companies across Germany and a number of Scandinavian cities, five of which included an element of improving communication, all of which demonstrated reduced levels of sickness absence. The latter evaluated a multifaceted intervention in a large UK government department to improve both formal and informal communication and increase employee participation on the basis of the findings of a stress audit. It demonstrated increases in job satisfaction, perceptions of control and influence and decreases in perceived stress.

Skill training, co-worker (or peer) support initiatives and increasing employee autonomy were also common elements of successful interventions which focused on the interface between the individual and the organisation. For example, Heaney et al.\(^{59}\) (cited in Michie and Williams,\(^{60}\) Semmer\(^{43}\) and Murphy\(^{38}\)) evaluated a training initiative for caregivers in homes for people with learning disabilities and mental health problems in one US state. Training was given in the importance of support at work, problem-solving approaches to work-related problems and the skills needed to implement these approaches. Improvements were demonstrated in perceived social support, coping ability, team climate and, for those most at risk of quitting, mental health.

Other individual-organisational level interventions with evidence of effectiveness included appraisals; improvements in management support and teamwork; increasing role-clarity; conflict resolution training; and time management training.

3.2.3 Organisational level interventions

The most common effective organisational level interventions for preventing work-related stress reviewed in the literature included a focus on modifying task or job characteristics. These included measures such as changing the production speed in a confectionary manufacturing company (Wall and Clegg,\(^{62}\) cited in Semmer\(^{43}\); integrating maintenance and support tasks with production in the Finnish forestry industry (Kalimo & Toppinen,\(^{64}\) cited in Kompier et al.\(^{65}\)) and a variety of other ‘job enrichment’ programmes included in a number of reviews. Job enrichment involves increasing the variety and complexity of job tasks whilst also increasing worker autonomy\(^{66}\) and has been shown elsewhere to improve job satisfaction and motivation.\(^{66,67}\)
Also commonly demonstrating evidence of effectiveness in the selected reviews were interventions involving ergonomic improvements or other changes to the work physical environment. Examples here include a study by Beerman et al.\(^68\) (cited in Kompier et al.\(^59\)) which evaluated a stress management programme in a German hospital which established ‘health circles’ (employee discussion groups for developing strategies to improve working conditions) to implement a number of changes including ergonomic and technical improvements including to shower and washroom facilities. This study demonstrated reductions in perceived stress and subjective improvements in communication and social support. Evans et al.\(^70\) (cited in Semmer\(^71\)), reported a multi-faceted stress management intervention in Stockholm bus drivers which included a number of ergonomic improvements including improvements in bus-related traffic management systems and demonstrated a decrease in observer-reported hassles, heart rate at work and distress after work.

Evidence for the effectiveness of interventions including changes to work scheduling (e.g. the introduction of flexi-time, implementing rest break strategies or changes to shift rotations) was also commonly demonstrated in these reviews. For example, a review focusing specifically on the impact of rest breaks suggested that rest breaks incorporating relaxation sessions and respite activities (e.g. napping, relaxing and socialising) are more likely to reduce job-strain and enhance mood than doing chores (e.g. working with customers, running errands and work preparation). Rest breaks are also a potentially important means of reducing the risk of errors and accidents, while at the same time helping to maintain or even enhance job performance.\(^72\)

Other organisational level interventions with evidence of effectiveness included management training; improvements in or introduction of new technology or equipment; efforts to modify the prevailing organisational culture; changes to skill mix or job rotation; the introduction of new company policies or strategies explicitly around stress management and prevention; and modifications to workload.

### 3.3 The benefits of organisational stress management and prevention interventions

The reported benefits of organisational stress management and prevention interventions were varied and included benefits for the *individual* and those for the *organisation*. Table 3.2 summarises the various benefits demonstrated by different interventions for reducing or managing work stress, listed in order of their prevalence in the reviewed literature.

From the current review, the most commonly described benefits for individual employees included increases in job satisfaction, psychological well-being, and perceived autonomy, and decreases in perceived stress or strain, physical or physiological signs and symptoms, and burnout. The most commonly described benefit for the organisation by far was decreased sickness absence, with fewer reports of increased productivity or performance and improvements in the organisational climate or culture and in perceived working conditions.

A number of reviewers\(^32,38,39,73-78\) suggested that more evidence exists in the wider organisational literature for the effectiveness of individual-level interventions – however, these tend to benefit the individual rather than the organisation and benefits can be short lived. The effectiveness of organisational interventions can be harder to demonstrate but some authors concluded that they
were more likely to benefit both the organisation and the individual and that these benefits could be longer lasting. Methodological difficulties inherent in demonstrating the effectiveness of organisational stress management interventions included:

- A high risk of failure in organisational development projects in general (between 50 and 80%)
- Barriers to implementing a rigorous experimental design including difficulties around randomisation and/or identifying a control group
- If participation is voluntary, those most at need may not volunteer
- High attrition rates
- The likely timescale of demonstrable organisational effects
- Change in itself is stressful and may prevent any positive effects of the intervention being demonstrated

Moreover, difficulties existed in attributing particular benefits to particular interventions. Firstly, many of the interventions described in the literature were multi-faceted, with a number of components targeting both the individual and the organisation. It is therefore impossible to say which components were responsible for the success of the intervention and for which outcomes. Secondly, there was variation in the outcomes measured in different studies dependent upon the aims of the research and the needs of the organisation involved. Thirdly, interventions may have had a differential effect on different groups of employees which, unless adequately powered sub-group analyses were conducted, could have masked the true effects of the intervention.

<table>
<thead>
<tr>
<th>TABLE 3.2 Demonstrated benefits of interventions for work stress prevention and management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increases in:</td>
</tr>
<tr>
<td>1. Job satisfaction</td>
</tr>
<tr>
<td>2. Psychological well-being</td>
</tr>
<tr>
<td>3. Perceived autonomy</td>
</tr>
<tr>
<td>4. Perceived social/ supervisory support/ teamwork</td>
</tr>
<tr>
<td>5. Motivation</td>
</tr>
<tr>
<td>6. Perceived influence</td>
</tr>
<tr>
<td>7. Meaningfulness of work</td>
</tr>
<tr>
<td>8. Task significance</td>
</tr>
<tr>
<td>9. Self esteem</td>
</tr>
<tr>
<td>10. Coping ability</td>
</tr>
<tr>
<td>11. Perceived identity</td>
</tr>
<tr>
<td>12. Organisational commitment</td>
</tr>
<tr>
<td>Organisational benefits</td>
</tr>
<tr>
<td>1. Sickness absence</td>
</tr>
<tr>
<td>2. Organisational climate/culture</td>
</tr>
<tr>
<td>3. Performance/productivity</td>
</tr>
<tr>
<td>4. Working conditions</td>
</tr>
<tr>
<td>5. Turnover</td>
</tr>
<tr>
<td>6. Cost-benefits</td>
</tr>
<tr>
<td>7. Patient/customer satisfaction</td>
</tr>
<tr>
<td>8. Service quality</td>
</tr>
</tbody>
</table>

| Decreases in:                                |
| 1. Perceived stress/strain                   |
| 2. Physical/physiological signs/symptoms     |
| 3. Burnout                                   |
| 4. Role conflict/ambiguity                   |
| 5. Fatigue                                   |
| Reductions in:                               |
| 1. Customer complaints                       |
| 2. Medication errors                         |
| 3. Malpractice claims                        |
| 4. Accidents                                 |
3.4 Factors for success

Whilst evidence has been shown to exist for the effectiveness of a wide range of different stress prevention strategies through this review (above), it was also clear from this literature that there is no one-size fits all, off-the-peg solution for an organisation seeking to reduce work stress and improve the well-being of its workforce. However, most of these authors suggested a number of different criteria, derived from the evidence they reviewed, which may be necessary for the success of such endeavours and which we have synthesized and summarise here:

1. Sustained top management support is a pre-requisite to success. This is necessary to ensure timely access to the resources required to develop and implement effective stress management and prevention strategies. Given the need for additional investment, obtaining this support requires a strong business case, particularly at times of economic hardship.

2. Interventions should be context specific. This requires organisations to undertake a tailored risk assessment (or “stress audit”), involving sub-group analyses of different sections and levels of employee. The risk assessment should therefore be able to identify the causes of workplace stress for different groups of employees and pinpoint potential targets for intervention.

3. The strategy implemented should combine individual and organisational interventions designed on the basis of the risk assessment. A wide range of interventions focusing on the individual, the organisation and their interface have been shown to be effective in different contexts and with different benefits. The risk assessment should be used as a starting point to identify a range of suitable interventions for any particular organisation to maximise the potential benefits to employee and organisation alike.

4. Success requires a participative approach. Employees should be involved in all stages of implementation, from design through to evaluation. Cooperation and open communication between management and employees is needed and employees should be recognised as experts, best placed to identify what might be beneficial for them in their own work context. Many of the successful interventions evaluated in the literature involved the establishment of cross-organisational groups representing all levels of employee to consider the findings of risk assessments and to develop, implement and evaluate appropriate strategies to address the stressors identified. A participative approach can help to empower employees, thus having a positive effect on stress in itself, and may also ensure that changes will be accepted, as opposed to changes imposed from above which risk being resisted or undermined.

5. Action planning is vital with clear tasks and responsibilities laid out. Without adequate project management, even the most promising proposals will not come to fruition. Cross-organisational involvement in the planning process will help ensure that tasks are taken forward by those most likely to engender change.

6. Buy-in from middle management is also required. Without this, sustained progress will flounder. Middle managers are increasingly being recognised as the lynchpins of organisational change and quality improvement, implementing and monitoring senior management directives, providing leadership and support for frontline employees and influencing the strategic direction of an organisation. However they can also constitute an important source of resistance to change and should therefore be included in the planning process.
7. If external **change agents** are recruited, they need to act as facilitators rather than dictators of the necessary approach. The involvement of organisational psychologists and academics in facilitating change was endorsed by some authors but it was recognised that they should not come with pre-conceived ideas about which changes should be implemented. Some authors also stressed the importance of the perceived independence of external facilitators and evaluators to promote trust amongst employees and minimise resistance to any changes proposed.

8. For any changes to be enduring, stress management needs to be incorporated into the **organisational culture** – “how things get done around here”. It must be recognised as an important issue in strategy and policy documents and not sidelined. It should acknowledge the role of the organisation as well as the individual. Senior management support is vital here, who should be seen to lead by example to encourage buy-in from middle management and ensure that any top level organisational values are incorporated into the culture of the organisation.

Together, these eight factors for success represent an evidence-based model of best practice in organisational stress management and prevention which could be adopted by community pharmacies seeking to address workplace stress for pharmacists.
4 Interview findings

4.1 Characteristics of respondents

Thirty-three interviews were conducted in total: 16 with frontline community pharmacists (‘pharmacists’), 11 with senior management representatives from community pharmacy employing organisations (‘employers’) and six with senior representatives from community pharmacy stakeholder organisations (‘stakeholders’).

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Role</th>
<th>Years qualified</th>
<th>Type of pharmacy</th>
<th>Is interviewee managed by a pharmacist?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist 1</td>
<td>Pharmacy manager</td>
<td>22</td>
<td>Supermarket</td>
<td>No</td>
</tr>
<tr>
<td>Pharmacist 2</td>
<td>Pharmacy manager</td>
<td>37</td>
<td>Small chain</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacist 3</td>
<td>Second pharmacist</td>
<td>25</td>
<td>Independent</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacist 4</td>
<td>Owner</td>
<td>30</td>
<td>Independent</td>
<td>N/A</td>
</tr>
<tr>
<td>Pharmacist 5</td>
<td>Pharmacy manager</td>
<td>10</td>
<td>Medium chain</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacist 6</td>
<td>Owner</td>
<td>43</td>
<td>Independent</td>
<td>N/A</td>
</tr>
<tr>
<td>Pharmacist 7</td>
<td>Relief pharmacist</td>
<td>13</td>
<td>Large multiple</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacist 8</td>
<td>Locum</td>
<td>12</td>
<td>Independent, supermarket</td>
<td>N/A</td>
</tr>
<tr>
<td>Pharmacist 9</td>
<td>Relief pharmacist</td>
<td>10</td>
<td>Large multiple</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacist 10</td>
<td>Locum</td>
<td>33</td>
<td>Independent, supermarket</td>
<td>N/A</td>
</tr>
<tr>
<td>Pharmacist 11</td>
<td>Second pharmacist</td>
<td>10</td>
<td>Large multiple</td>
<td>No</td>
</tr>
<tr>
<td>Pharmacist 12</td>
<td>Pharmacy manager</td>
<td>7</td>
<td>Large multiple</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacist 13</td>
<td>Pharmacy manager</td>
<td>6</td>
<td>Large multiple</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacist 14</td>
<td>Lead pharmacist</td>
<td>34</td>
<td>Large multiple</td>
<td>No</td>
</tr>
<tr>
<td>Pharmacist 15</td>
<td>Locum</td>
<td>10</td>
<td>Small chain, large multiple, supermarket</td>
<td>N/A</td>
</tr>
<tr>
<td>Pharmacist 16</td>
<td>Pharmacy manager</td>
<td>36</td>
<td>Medium chain</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Of the 16 pharmacists interviewed (Table 4.1), seven were pharmacy managers (or the lead pharmacist), three were locums, two were relief pharmacists, two were second pharmacists, and two were pharmacy owners. They demonstrated a wide range of experience, having been qualified for between six and 43 years (mean = 21 years). Five worked for independent pharmacies, two for small chains, two for medium chains, seven for large multiples, and four for supermarkets (>16 due
to locums working in variety of settings). Three were currently managed by non-pharmacists and eight by pharmacists (locums and pharmacy owners were self employed).

TABLE 4.2 Characteristics of interviewees representing community pharmacy employing organisations

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Role</th>
<th>Type of pharmacy</th>
<th>Are pharmacists line managed by a pharmacist?</th>
<th>Are branch managers pharmacists?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer 1</td>
<td>Business Development Manager</td>
<td>medium chain</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employer 2</td>
<td>Managing Director (Owner)/Superintendent Pharmacist</td>
<td>small chain</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employer 3</td>
<td>Superintendent Pharmacist</td>
<td>supermarket</td>
<td>No</td>
<td>Yes, but non-pharmacist store manager</td>
</tr>
<tr>
<td>Employer 4</td>
<td>Superintendent Pharmacist</td>
<td>medium chain</td>
<td>Yes</td>
<td>Yes, though starting to introduce non-pharmacist branch managers</td>
</tr>
<tr>
<td>Employer 5</td>
<td>Training and Development Manager</td>
<td>small chain</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employer 6</td>
<td>Superintendent Pharmacist</td>
<td>large multiple</td>
<td>Mixture</td>
<td>Yes</td>
</tr>
<tr>
<td>Employer 7</td>
<td>Superintendent Pharmacist/Director of Professional Standards</td>
<td>large multiple</td>
<td>Mixture</td>
<td>Mixture</td>
</tr>
<tr>
<td>Employer 8</td>
<td>Superintendent Pharmacist/Director of Professional Standards</td>
<td>large multiple</td>
<td>Mixture</td>
<td>Mixture</td>
</tr>
<tr>
<td>Employer 9</td>
<td>Superintendent Pharmacist</td>
<td>supermarket</td>
<td>No</td>
<td>Yes, but non-pharmacist store manager</td>
</tr>
<tr>
<td>Employer 10</td>
<td>Superintendent Pharmacist</td>
<td>supermarket</td>
<td>No, but area managers are pharmacists</td>
<td>Yes, but non-pharmacist store manager</td>
</tr>
<tr>
<td>Employer 11</td>
<td>Superintendent Pharmacist</td>
<td>large multiple</td>
<td>Yes</td>
<td>Yes (95%)</td>
</tr>
</tbody>
</table>

Of the eleven employers interviewed (Table 4.2), nine were superintendent pharmacists, four held other senior management positions and one was the owner of a small chain (some had dual roles). They represented two small chains (<15 stores), two medium chains (50-150 stores), four large
multiples (200+ stores), and three supermarket chains (200+stores). The organisations they worked for had a variety of existing management structures. Most commonly, the pharmacy manager would be the pharmacist. However, in supermarkets the overall store manager was always a non-pharmacist and in some of the chains and large multiples, a non-pharmacist store manager could be responsible for the general management of the pharmacy whilst the pharmacist retained management responsibility for the pharmacy side of the business. Line management arrangements also took a variety of forms with some pharmacists being managed by non-pharmacists and others being managed by pharmacists. This has importance later when we consider the causes of workplace stress for community pharmacists.

Seven stakeholder organisations were represented in this series of interviews, six through separate stakeholder interviews and one through one of the employer interviews. These were:

- The Royal Pharmaceutical Society (England) (RPS)
- The Pharmacists’ Defence Association (PDA)
- The Company Chemists’ Association (CCA)
- The National Pharmacy Association (NPA)
- The Association of Independent Multiple Pharmacies (AIMp)
- The Independent Pharmacy Federation (IPF)
- Pharmacist Support

4.2 Awareness of stress in community pharmacy

4.2.1 Pharmacists

When asked directly, all of the pharmacists we interviewed perceived that workplace stress was a current problem within community pharmacy. Some pharmacists spoke in general terms about the profession, some about their own organisation or pharmacy and others about their own experiences of stress at work.

Of those pharmacists talking in general about the profession, all reported that workplace stress was a current problem for community pharmacists. In relation to their own organisation or pharmacy, the majority reported that work stress was currently a problem, with some qualifying this by suggesting that stress within their own organisation was no worse or indeed less problematic than in other organisations. Only one respondent perceived that stress was not a problem within their own organisation. All pharmacists responding in relation to themselves reported having personally experienced stress at work either currently or in the past. Of those experiencing stress currently, two stated it was manageable either through locum working or their personality type. Those no longer experiencing stress as a problem had either relinquished management responsibilities, changed jobs or were working fewer hours.

“I don’t know of a pharmacist who doesn’t complain about stress.” [Pharmacist 12]

“I would say stress is the biggest problem for pharmacists working in my organisation, yes […] It has definitely been a significant problem [for me] in the past. Much less of a problem now because essentially I sort of work for fewer hours in store than I did in the past so that has probably meant it’s a lot easier. And because I’m spending fewer hours in store I don’t
have to take on so much responsibility for the day to day running of things and the continuity as well, so in the past yes, at the moment not really, much better.” [Pharmacist 11]

4.2.2 Employers

The employers we spoke to varied as to whether they perceived that stress was a problem for community pharmacists within their organisation. A small number (mostly the smaller pharmacy chains) talked openly about stress as a problem for their pharmacists currently. Others demonstrated an awareness of increasing workplace stress for community pharmacists generally but did not perceive it to be a problem within their own organisation. Some highlighted that some pharmacists were better able to cope with increasing/changing workloads than others. Others that the causes of stress were often multifactorial and that stress-related absences were not always work-related.

“But we've had, what, 300% increase in prescription volume in the last 20 years; we’ve had resources being removed, time; you've got all these direct pharmacy schemes, and the inability to source products; you've got the extra pharmacist time required in MURs and medical services. All piled one on top of each other, you know, and each having an incremental effect. So without doubt, there's unbelievable levels of stress ... it's infinitely more stressful than it was five years ago.” [Employer 2]

“I'm aware that it's a problem in pharmacy, if recent surveys are to be believed. I think it will be naïve in the extreme to think that it wasn't a problem in [name of organisation]. However, our last employee survey, which was in 2010, tended to suggest that stress wasn’t particularly a problem.” [Employer 8]

4.2.3 Stakeholders

The majority of stakeholder organisation representatives believed that work-related stress was a big issue for pharmacists currently.

“Well firstly I am a pharmacist, and I’ve worked in community pharmacy for 35 years so I'm well aware of the stresses and strains, but those increase almost daily as workload increases and expectations and regulation increases, as well as non-regulated bureaucracy. We are in a profession and an industry which is very target-driven and very challenged financially in the general economic environment, but also within the NHS commissioning environment. So all of that is increasing stress on a regular basis, and frequently we are asked to do more for less, which increases the stress.” [Stakeholder 4]

A notable exception to this was the representative interviewed from the Company Chemists Association (CCA) who appeared unaware that work stress was currently problematic for community pharmacists, and for those working for the larger multiples and supermarkets in particular, until reading the briefing paper sent out as part of this study.

Q: And are you aware then if stress is a problem for pharmacists working in community pharmacies at the moment?
A: Well only through reading your paper ... I did notice that one of the findings was that, off some recent research, was that those employees in multiple pharmacies and supermarket pharmacies are more troubled by stress than those in independent or smaller
companies which I think is a concern, so that may well be a catalyst for us to look at that within the association. It would also be dependent on whether or not our member companies wanted to work on that matter as a group or whether they were happy doing it individually ... So that’s, I guess it’s the first I’ve heard of that actually. [Stakeholder5]

4.3 The causes of stress in community pharmacy

All interviewees were asked about what they perceived to be the main causes of work stress (‘stressors’) in community pharmacy. Identifying the key causes of stress is an important stage in developing and targeting interventions to reduce or prevent stress for pharmacists. The causes identified by respondents were categorised according to the framework described in Chapter 1 (Table 1.2,) based on the wider literature on work-related stress. This framework recognizes nine categories of work stressors relating to work content (‘job content’, ‘workload and work pace’, ‘working hours’, ‘participation and control’) and work context (‘role in the organisation’, interpersonal relationships’, ‘organisational culture’, ‘home-work interface’, ‘career development, status and pay’). To this framework we have added two further categories – individual characteristics and external factors – on the basis of the themes emerging from the interviews. These findings are ordered according to their prevalence in the data.

4.3.1 Work content

4.3.1.1 Job content, workload and work pace

The aspects of community pharmacists work mentioned most frequently by all types of respondent (pharmacists, employers and stakeholder organisations) related to the first two categories of work stressor, ‘job content’ and ‘workload and work pace’, combined here as a result of inextricable linkages in the interview data. Increasing work volume, particularly around dispensing and advanced/enhanced services such as medicines use reviews (MURs), coupled with the extended range of tasks now a part of a pharmacist’s role, often making conflicting demands on their time, were commonly identified as causes of work stress for pharmacists.

Dispensing volumes are known to have increased by almost 60 per cent between 2001 and 2011 (Health and Social Care Information Centre, 2011) and this marked increase was cited by most as a source of work stress for pharmacists.

“I think the worst of it is workload and work pace, especially because we used to be quite a quiet pharmacy. We used to do about 200 items a day, so obviously that’s nearly, crikey, we do about 650 to 700, so it’s increased quite dramatically.” [Pharmacist 13]

With the introduction of the 2005 general pharmaceutical services contract however, pharmacists now have to deliver a range of advanced and enhanced services alongside dispensing this increasing volume of prescriptions, adding greatly to pharmacists’ perceived stress levels.

“I think we expect them to deliver the advanced services, you know, the new medicines service and the MURs. You know ... that’s part of their regular job, you know. And also, enhanced services, if they’re available in the local area. That, put together with, you know,
the core dispensing services, I think some pharmacists find it difficult to balance it all.” [Employer 1]

Additional tasks expected of pharmacists during their working week, and compounding this situation, were listed by respondents and include: the paperwork and administrative tasks required by regulatory and commissioning bodies; over-the-counter sales; filling and checking dosette boxes; repeat dispensing systems; and delivery services.

“They used to send people round checking up every year, making sure you’d filed the paperwork – some of it was so silly – that you’d done everything to the letter; which in real life doesn’t happen. And then that you’d done the fire drill every week, you’d done this every week, you’d filled in all this paperwork – which was really just ticking boxes – and it got to be that it’s almost a full-time job to do that. But of course it’s a full-time job to be a pharmacist as well; and I found I just couldn’t do both.” [Pharmacist 14]

“Also [name of pharmacy] do what they call managed repeat service - I don’t know whether you’ve come across that - where we pick up prescriptions from the doctors for people and we dispense them and have them ready for when they come in, and that service takes quite a while and there’s lots of errors sometimes made if prescriptions aren’t ordered, so that’s a major source of stress in some shops.” [Pharmacist 7]

Some aspects of the pharmacist’s working environment added to the stress of fulfilling all of these conflicting responsibilities, according to respondents, including the physical environment in which they worked, constant interruptions from patients, staff and phone calls, obstructive information technology and other equipment, and problems with the medicines supply chain.

“I can understand there is an idea that dispensing openly and at the front of the counter where patients can see what you’re doing, I can understand why that would be an attractive thing for a company to do, but it opens you up to so many distractions. Because if you’re dispensing somewhere that’s quite a calm and controlled environment you already have the distractions of the telephone, you colleagues, as well as other things that go on within the dispensary. But when you add patients in the mix to that and they’re reaching over the counter and interrupting you as you speak and you’re having to constantly work under those conditions, you’re bound to make a mistake.” [Pharmacist 11]

Insufficient staffing levels within the pharmacy were also commonly cited as a reason why the job content and workload were increasingly stressful, either because of staff absences, staffing levels not increasing as workload increases, or staffing levels actually being cut.

“But in terms of the work here we’ve had last month, for example, it was equating to about 16 to 20% increase in workload. Our items went up fifteen hundred items in one month… which is quite significant actually. We’ve also been cutting staff hours because of the remuneration changes in the NHS. And so probably are getting to the point where people are now starting to creak around the edges and notice a change, and our efficiency is at max to be quite honest with you, I just wonder when it will start tailing off because of stress, start tailing off possibly because of increased workload and pressures. I get the drift that there’s a
change in staff attitude slightly because of the stresses and strains they’re very concerned.”
[Pharmacist 16]

4.3.1.2 Working hours

Working long days could be stressful both for independent pharmacists, having to put in the extra work involved in running a business outside of normal working hours, and for employee pharmacists, having to work long shifts associated with extended opening hours and 100 hour pharmacies.

“We’ve obviously got the added responsibility of owning and managing the pharmacy. So there are business issues. It’s probably only those sort of administrative things that will probably keep me awake at night or have me working till the late hours, after midnight, writing a letter or seeing something through or having a meeting that’s gone on late. And we work here until 7 o’clock. So by the time I get home it’s 7.30. If I need to sort of go over anything that’s left from the day, to do with the business or any other issue, even if it’s not - if I wasn’t an owner/manager, there was a pharmacist and we had a meeting or a visit from an inspector or something due to happen then there may be some preparation going on in the evening. And that’s going to be probably after you’ve got home, eaten, we’re talking about mid evening.” [Pharmacist 6]

In addition to this, many pharmacists reported that their inability to take a rest break during the working day added to the stress of the long hours and heavy workloads. Apart from in pharmacies which closed for lunch, which are becoming increasingly rare, the general expectation amongst the pharmacists we spoke to was that pharmacists did not take a break and continued to work, or were available to other staff and/or customers, if they left the dispensary to eat lunch. Many were concerned with the effect that this was having on their ability to do their job effectively and safely.

“If somebody was watching me from above, they would see an ant scurrying from one thing to the next all day long, never sitting down, barely having time to eat lunch, certainly not having a break, certainly never having a break. No, just enough time to go to the toilet basically. Sometimes I say, ‘I’ve just got to go, sorry!’... And I think that that’s – for safety and stress – is really bad, because if you don’t have chance to just sit down quietly and re-group your thoughts and you’re working solidly all day for 10 hours or 9½ hours, it can cause problems. Definitely.” [Pharmacist 2]

4.3.1.3 Participation and control

 Whilst some pharmacists felt they had a degree of autonomy when making clinical decisions, many, particularly those working for larger organisations, had very little control over the way in which they carried out their work, and some felt that they were not listened to (or asked) regarding difficulties they faced or improvements they felt would be beneficial.

“I think there’s clinical autonomy. I think when it comes down to other issues, or other aspects I don’t think there is any autonomy really. Certainly where I work it’s very regimented, you need written permission to sneeze and there’s a lot of bureaucracy and a lot of red tape. Because I know with other companies if you make a suggestion and say, “This might be something that would be really good for my patients,” they would probably look
into and maybe even happy to give you the resources to see it through. Whereas where I work it has to be seen by the line manager who will not give you an answer, he’ll take it to somebody else to an area manager who won’t give you an answer, they’ll take it to a regional manager. That regional manager won’t give you an answer they’ll take it to somebody, and by that point you’ve lost interest … So eventually you just stop making suggestions. [Pharmacist 11]

However, for at least one of the pharmacists we spoke to, too much autonomy was also seen as a source of stress, as it added to an already heavy workload.

“But I sometimes feel that, even though we are part of a small chain, we are left to our own devices quite often and, when you ask for support, you don’t necessarily get individual support. You may be, say, ‘Well, speak to so-and-so because he’s done it before,’ or, ‘We’ll look into it,’ but nothing ever happens. So I think you have to make a lot of decisions on your own … Recently all our SOPs needed reviewing because they were coming up to or over the two years where you’re supposed to review them. I took them all home and reviewed them and did them all and I said, ‘Look, some of them aren’t your head office SOPs that I’ve inherited because I’ve taken over as manager [they] aren’t exactly what we do so I’m making some changes.’ ‘Yeah, that’s fine, just email us back with what changes you’ve made.’ I’m thinking to myself, ‘I shouldn’t have had to do that really.’ I should have got a little bit more support there, I should have had somebody saying, ‘These are the changes I want you to make, please do them and send them back to me,’ but of course there was a time factor involved as well. So I spent basically the whole of my Christmas break reviewing and rewriting the SOPs.” [Pharmacist 2]

4.3.2 Work context

4.3.2.1 Role in the organisation

Respondents reported a number of sources of stress in relation to different aspects of the community pharmacists’ role including their patient-facing role, management role, business role and particular issues for employee pharmacists, pharmacy owners and locum/relief pharmacists.

Community pharmacists are unique amongst health professionals in providing open access to patients with no appointment system or gatekeeper to regulate demand. This is one of the reasons why pressure from patients was one of the most commonly cited sources of stress for those pharmacists we spoke to.

“The fact that you’re working as a sole practitioner, and the fact that you’re … it’s open access. Any idiot could walk into any pharmacy and create havoc. And what are you going to do? You know, at least a GP’s sitting in his consultation room and can manage his time, to an extent. But you’ve almost got no control over your destiny, you’re just on the receiving end of whatever comes in, and you never know what it’s going to be … in a way that no other … I can think of no other health professional, or any other professional of any description that is as exposed to the bedlam of primary care, that pharmacists are. I think it’s unique.” [Employer 2]
This could sometimes be compounded by fears for the pharmacists’ own safety – a source of stress mentioned by a small number of pharmacists.

“I’ve had – we had a robbery and we were – I was held a knifepoint and we were all made to lie on the floor. Talk about workplace stress, there you go, you know. On the grand scale of things, that’s far worse. I did have one lady who, after that, you could visibly see that she would – she was patient-facing so she was on the counter. And so she was visibly paling, you know, if somebody came on a motorcycle near the front of the shop or somebody was unfamiliar. And we ended up being able to refer her to the PCT’s occupational health.” [Pharmacist 4]

Another important source of stress for pharmacists in relation to their patient-facing role was their responsibility for patient safety and the knowledge that any dispensing error they are involved in could potentially cause harm to the patient.

“Oh, I do worry, yeah, because I wouldn’t want to make a mistake and do somebody any harm, and as far as I know I never have done – actually done any harm – but I know I’ve made mistakes; everybody’s made mistakes. But as far as I know at the moment I’ve never hurt anybody because of one. But you do worry about it, and you worry about the consequences of it constantly really. But when you are put under stress you’re more likely to do it so, yeah, I do worry about it more then. But it’s a vicious circle, the more you worry the more you worry. And the more stress it causes.” [Pharmacist 14]

Fear of litigation and the risk of imprisonment following a dispensing error only heightened the stress perceived in relation to the responsibility for patient safety, with some respondents suggesting that this source of stress has increased since the case of Elizabeth Lee who was prosecuted for making a dispensing error.

“There is now an air of huge caution in the NHS in case you fall foul of something and get sued for it, which is a stress that didn’t occur in the good old days where the pharmacist was a trusted person and you didn’t have to write down every conversation you ever had with somebody just in case it might come back and bite you. I think that’s a general stress in society, to be honest, but it’s particularly... it’s raised its head in pharmacy over the last 10 years much more than it ever did do. And people do worry if they make a dispensing error that they are going to be struck off. Or, since the Elizabeth Lee case – I might be imprisoned or all sorts. So I mean that is a stress you could well do without.” [Employer 5]

A further aspect of the community pharmacists’ role which was commonly cited as a source of stress was their management responsibilities, both for the pharmacy business and for pharmacy staff. Indeed, stress relating to management responsibilities sometimes led to pharmacists choosing to relinquish this aspect of their role.

“Yes, and that is what now is more stressful than it was five years ago because there is a paper – a massive paperwork burden. And over the last 12 months a financial burden that has not been there. So in the back of my mind now all the time is how’s my cash flow going to be at the end of this month? Can I manage - am I going to end up in my overdraft? Not
my own personal overdraft, my business overdraft. It’s – if I don’t do the paperwork then that affects my cash flow.” [Pharmacist 4]

“Pharmacists are choosing not to be managers, which is why the non-pharmacists are taking the jobs. It isn’t worth it. They pay you about £3,000 a year more to be the manager of a shop, but the stress is doubled. I mean it’s stressful enough being a pharmacist, your decisions can kill people; and then when they’re pestering you about all these, the other things, I mean the workspace has just quadrupled and probably more since I...you know, the things you have to do every week, you know, fire checks, you even have to check a ladder before you use it; it’s just got excessive. You’ve got enough to do as a pharmacist without worrying about what you need to do as a manager as well.” [Pharmacist 14]

One related factor that a number of interviewees from employer and stakeholder organisations in particular were keen to stress was that pharmacists entering the workplace were immediately expected to take on management responsibilities without adequate training and with little management skills or experience. The subsequent difficulties they faced in delegating duties to other staff to manage workloads and in dealing with interpersonal conflicts could therefore add to the stress experienced by pharmacists.

“So pharmacists emerge from university having had very little in terms of management training in a very variable situation, and they’re thrust into a situation of leadership with a team of people. So if you think of the newly qualified pharmacists who may be put in charge of a small pharmacy with maybe, say, eight staff, all of whom will be experienced, all of whom will be older, and that’s a very tough situation, and very often they haven’t got the equipment and skills with which to deal with that in terms of resolving conflict within the team, time management for themselves personally, the ability to delegate to others, to appraise and things like that. And while some of these are often available from companies, it may be a year before they get on that course and it may be not tailored to their particular needs. And I think this is perhaps an unrecognised issue that many pharmacists have. It’s hard because you’ve got to put your hand up and say I have a shortage of skill here and I need the help. So it’s those sorts of non technical skills that pharmacists in a position of management as well as being a professional often contribute to their workplace stress.” [Stakeholder 1]

It was clear from interviews that some stressors were perceived to be associated with different groups of pharmacists, dependent upon their role in the organisations. For example, the pressure to meet targets was specific to employees of larger organisations (described in more detail below) whereas pharmacy owners suffered from the pressures associated with running their own business and locum/relief pharmacists faced difficulties associated with working in unfamiliar working environments with differing standard operating procedures and unfamiliar, and sometimes hostile, staff.

“But I think that if you’ve got your own business, you are under an enormous amount of pressure. If you’re an independent and you can’t take holidays because you can’t afford a locum because you’ve got to pay for the holiday and the locum. You can’t trust the locum to run the business satisfactorily because they might dispense differently from you and order things in that you don’t need or you don’t want or they might not give the same level of care
that you give the patients. So that can be stressful. Your staff might — what happens if one of your staff’s off sick while you’re on holiday? You’ve got all of those things to think about. Who’s going to do the banking? Who’s going to pay the bills? I think for an owner/proprietor it’s very difficult, but in an organisation it’s a little less stressful. Or if you’re working for a multiple, although they put extra pressure on targets to reach, at least if you’re not there they will send in somebody else to do the same job.” [Pharmacist 2]

“What I find hard is when you go somewhere where no-one knows what’s going on, no-one will help you. There’s, well if you’ve not been there for a while, you don’t know where everything is. If you’ve never been there, you don’t know what their system is. Even though it’s all supposed to be the same, there’s slight variations on the same thing wherever you go. Where do they keep this and where do they keep that? [...] That’s fine, you can handle that, but when no-one will help you and they just ignore you, the dispensing staff because you’re not the regular pharmacist and if they don’t know you, you’ve been there for the first time, they will ignore you for the first half of the day because they think you’re a stupid locum and they won’t speak to you. It’s only by lunch time that they realise actually you can do the job and you’re trying, then they start to help you.” [Pharmacist 9]

4.3.2.2 Interpersonal relationships

Interpersonal relationships were often cited by the pharmacists we spoke to as causes of stress. This was most commonly with regard to relationships with co-workers and with managers but also included the professional isolation experienced by pharmacists and relationships with other local healthcare providers, particularly GPs.

Co-worker support and trust, or a lack of these, were important sources of stress for some pharmacists. Conversely, those with strong, supportive teams appeared better able to deal with the pressurised working environment of a busy community pharmacy.

“Yeah, when [name of pharmacy] first bought this pharmacy I stayed with the independent guy who owned it and went to work at his other pharmacy, and I hated it. It was similar in the items and stuff, but the staff were just not like my staff. And they wouldn’t help, they wouldn’t do it if they didn’t physically have to, you had to stand over them and make them do their job, and I found that more stressful than actually the job, trying to make them do their job. I did find that really, really stressful and obviously that’s the reason that I chose to come back. [...] And I was really unhappy at work, I used to get a bit upset because I didn’t want to go back. I didn’t have time off poorly or anything like that, I still went every day. But I did hate it, absolutely detested it, and it was solely the staff were the reasons.” [Pharmacist 13]

However, in other instances, strained relationships with managers were a more important source of stress for pharmacists. This could be in relation to a perceived lack of support from managers when it’s needed, accusations of bullying (particularly around meeting targets), or other aspects of management style. It was usually in relation to store or area managers (middle managers) and often in situations where those managers were not themselves pharmacists.
“What I have seen with some of the area managers is that they actually, I think, sometimes relish an environment where they promote fear. In other words, ‘If you don’t achieve your MURs target, you won’t get a bonus.’” [Pharmacist 10]

“So the last place that I worked, they had a succession of area managers who came from all sorts of different organisations. So didn’t know what the issues were that were specific to pharmacy, they were just coming in and saying, ‘You’re not doing enough of this; you’re not doing enough of that.’ And it was just basically coming from numbers on a bit of paper. I mean, I had one guy when we first started, he didn’t really even know what an MUR was, but was telling me to do more of them.” [Pharmacist 12]

Some pharmacists also lacked the confidence to stand up to managers, making difficult relationships even more stressful, which may relate in part to the professional isolation in which the majority of community pharmacists work.

“Because as pharmacists you’re very isolated. You all work in pharmacies but on a day to day basis you will never have the time to phone each other and have a chat, or even to catch up once a week, let alone once a month, you absolutely never have the time to do that. You never have meetings where all of you are brought together; you never have any kind of interaction with the other. The most interaction I will get with other pharmacists will be, I’ll ring them up and say “Have you got this on your shelf, we need some of it can we borrow it from you?” Or “We’re sending a patient over to your store with a prescription” and that’s as much interaction as you will get with another pharmacist in your company. So because you don’t have time to compare notes in that sense (we’re not even sent together for training purposes and so on – you never have time to do things like that) it makes it difficult to know where you stand in comparison to everybody else. Which I think works well for the company because they never have a situation where a collective group of you say, “This isn’t right for me, for her, for him and all of these people, so obviously we’ve all tried it, it’s not working, it’s not a problem that we’ve got, it must be a problem with the organisation.”” [Pharmacist 11]

The professional isolation of pharmacists was also cited in relation to wider healthcare systems, with a lack of communication and poor relationships with GPs a further source of stress for pharmacists.

“[Pharmacists] are very much excluded from the general NHS aspects and you have to fight to become included in it. So you ended up working very much in isolation within your own business […] And in terms of change, it’s continuously changing. We’ve just had – we, again as in our pharmacy – have had the electronic prescription service in this starting ten days ago. It’s absolutely hell because it’s turning everything on its head again and there is no support network, there is no backup for it, there is nobody coming in to hold your hand, there is nobody telling you what you should be doing anymore, you have to work it all out yourself, because every pharmacy in itself is different. But basically there has been more work offloaded from the GPs and on to the pharmacies, and maybe in 12 months time they’ll catch up with the payments system on it.” [Stakeholder 3]
4.3.2.3 Organisational culture

The perceived culture of some community pharmacy organisations, which put the quest for profit before the quality and safety of patient care, was often reported as a source of stress for pharmacists. This led to reports of relentless pressures to reach targets for service delivery which could be more stressful than the actual workload.

“And I have to say that in community pharmacy, one of the things that drives the workload, the stress, the pressure, is this consumer driven environment that all retailers have been brought up in. So you are getting more and more people in organisations who are from a retail background, a consumer driven background, not a healthcare background, they’re not pharmacists, they only understand targets, customer service, they don’t really get the fact that there’s a professional who’s providing the service and they need a certain level of autonomy and authority, because if they’re not seen in that way by the management and the staff, they’re certainly seen in that way by the public. But we do have this, even in the public; they’ve got an expectation, the public, which is now medicines are almost a normal consumable commodity. And it’s not helped by the culture of organisations offering three for two on medicines, for instance. It’s not helped by ‘the customer is king’; speed is the most important thing. You look at most of the research now and because of the way, mainly, I say mainly, large organisations are driven by volume and are competing against each other for volume, it’s turned out not to be in the best interests of the patient. Number one because speed is now king, so the public expect that medicine to be safe, they just don’t even consider that. You ask them what’s the most important thing now and safety hardly comes into it, it’s speed.” [Stakeholder 2]

Moreover, some respondents perceived that their employing organisations were correspondingly not fulfilling their duty of care for the health, safety and well-being of staff. It was noted by those who had been working in pharmacy for many years that organisational cultures had changed over time; and by those with experience of working in a number of different organisations that the ‘worst’ or most stressful cultures more commonly prevailed in the large multiples and supermarkets.

“It is a lot more stressful, even though item-wise, in terms of prescription volume, [name of supermarket] is more stressful than when I’m in [name of independent pharmacy]. [Name of independent pharmacy] almost matches possibly the hospital environment, I would have said; slightly more clinical. Whereas the supermarket, you get people ring you and asking you, you know, what the promotion is for on DVDs, and all sorts. They’ve come through to pharmacy and you’re just thinking, ‘What am I doing here [laugh]?’ You do prescriptions but there’s so much distraction, or a manager just pops in and, you know, drags someone out, or someone comes in just to check the roof. There’s too many things going on, with the noise in the background and there’s so much that could get you distracted. And the tannoy, oh God, that never stops [laugh]! So, you know, these are things that cumulatively make you feel like you have to concentrate a lot, lot harder. So by the time you leave, even though you’re not so busy, you’re worn out just by…it’s the environment, the ambience, is not too calm […] So although I enjoy the job and I think I cope well with stress, I think, with the advent of supermarket pharmacies, et cetera, the professional image has gone down. You don’t feel like a professional when you’re in the supermarket, you just feel like you’re working in another department in the store.” [Pharmacist 8]
4.3.2.4 Home-work interface

Some pharmacists spoke about difficulties they were having at home in relation to their own health, their family's health and relationships and the way in which that could sometimes make work pressures more stressful.

“But I've got a little boy and he just wasn't sleeping, and that really did have a big impact on me. That was my week where I had to stand back and the others pulled me along. And I did make two mistakes that week, so all I've done is just reviewed how I do stuff, what time I go to bed. I mean obviously I can't help my little boy being poorly and stuff like that, but I just think well, if he is I just know that I'm going to have to get as much sleep as I can, maybe take a few extra breaks in the day just to make sure that I'm still alert.” [Pharmacist 13]

Others, particularly independent pharmacists, reported that their work-life balance was affected by regularly having to take work home with them.

“Oh, I have to take work home. I have to do paperwork at home when I’m doing claims for NRT supply and things like that. I’ll bring all the paperwork home and work on it and prepare it and then email myself at the shop with the papers [...] I review my students’ work at home; their – if they've got a project to complete, then I would do that at home. There’s absolutely no time to do that at work. Absolutely not.” [Pharmacist 2]

Employers also recognised that issues at the home-work interface could be a cause of stress for employee pharmacists. There was some suggestion that they could perceive this as a greater source of stress than the job itself.

“I think at the moment I’ve got two people are off long-ish term illness with stress related conditions. How much is entirely down to work is always the $64,000 question, isn’t it? I think work has played a part in the stress, but it’s not predominantly the reason they’re off. It’s domestic related and character related. I mean one lady’s off and found her elderly mother dead in bed, but she’s not capable of working either once she’s in that frame of mind, the idea of work stresses her for that. The other guy, one of area support pharmacist has just had his two months off with stress which again, it was domestic issues which he felt were affecting him at work, rather than work being the primary reason for his stress, and so recognised that actually for the benefit of patient safety he was better off not at work.” [Employer 4]

4.3.2.5 Career development, status and pay

Although mentioned less frequently, the absence of opportunities for career progression for community pharmacists or increases in pay commensurate with number of years’ experience was sometimes raised as a source of stress.

“Absolutely no job satisfaction whatsoever, unfortunately, if you work in community, in terms of career progression. You either go up the ranks in management or you do a diploma and stop at that as a clinical pharmacist, if you want to focus on the clinical side. I want absolutely nothing to do with management so once I got my diploma a few years ago I sort of plateaued and that’s about as far as you can go so absolutely no job satisfaction from that respect. You do get obviously lots of moments where you speak with patients and you feel...”
like you’re doing a good job and the patients will tell you you’re doing a good job. But sometimes it starts to feel like you’re doing the same thing over and over again and working in a factory, then there’s very little job satisfaction.” [Pharmacist 11]

Pay and job security also, are increasingly, becoming sources of stress for pharmacists. The current financial climate is driving community pharmacy organisations to make savings in relation to pay and conditions for employee and locum pharmacists alike. Moreover, the number of new pharmacists qualifying is starting to outstrip the number of positions available.

“In addition to that, universities are producing more pharmacists now. So that’s affecting people finding jobs. That’s stressing them out.” [Pharmacist 8]

“Well I think unusually in pharmacy there is now... if you start looking round in the national press, there are threats of things like redundancies, like reduced locum rates, all of the things that were unheard of in community pharmacy. I think they will be, over the next 12 months, an issue for everybody, and we may well be in that boat as well. So I mean that will be an added stress for those who feel that their job may be under threat.” [Employer 5]

In addition, some pharmacists, in their role as managers and small businessmen, were experiencing stress associated with maintaining profit levels in a time of recession.

“We’ve had people who are in the role of having to restructure for example, again because of the current climate, for whom that is causing stress because it’s not a nice thing to do is it for anyone really to have to restructure, usually that means redundancies, people losing their jobs, so that’s certainly been another cause of stress.” [Stakeholder 6]

4.3.3 Individual characteristics

Most employers and a number of pharmacists and stakeholder respondents were keen to stress that all pharmacists were different and that what might be a source of stress to some, other pharmacists would relish. The role of personality type was therefore raised as a cause of stress at work.

“From my experience, I’ve come across individual pharmacists, practitioners who are themselves exceptionally organised individuals and like an organised and orderly environment, and they tend to be the ones that cope well when external force is upon them: customer demand or commercial requirements, whatever it may be, if they’re heightened they tend to be able to cope better. And then there are individuals who struggle. Often they’re less organised individuals. They tend to find it difficult or challenging to operate in an orderly way, and that creates I think incremental or additional pressures that perhaps somebody of a mindset of the former type wouldn’t feel or experience. So I think there’s something about the self, the person, their organisational skills, their self or personal disciplines.” [Employer 7]

There was also a perception held by some that pharmacists, on the whole, were able to take on board or ‘soak up’ any work pressures they faced. However, it was also recognised that there had to be a limit to the extent to which that could happen before a pharmacists’ well-being or patient safety were compromised.
“I think that, on the whole, pharmacists are very strong people. It’s not a career for a weak person and we tend to accept all the pressures without actually much complaint and I think that is a big failing for pharmacists.” [Pharmacist 2]

“Well, a lot of pharmacists are very self-sacrificing. So what you’re not seeing is huge increases in error. I think that moment will come when, all of a sudden, they will go into complete overload and the error rate will just suddenly go vertical. That hasn’t yet happened, I think because pharmacists just soak it all up. So they do it, you know...they do it by sacrificing their work-life balance and sacrificing themselves.” [Employer 2]

4.3.4 External factors

As suggested above, a number of external, contextual factors were also reported by study respondents as contributing factors to (rather than direct causes of) workplace stress for community pharmacists. These include cuts or shortfalls in the contractual remuneration of general pharmaceutical services, the current recession and general economic climate, competition between pharmacy businesses and aspects of the regulatory framework for community pharmacy.

Pharmacy employers from large multiples and independents alike, backed by a number of respondents from stakeholder organisations, often raised the issue of contractual remuneration not keeping pace with increases in workload. This was cited as a major factor in staffing levels not being increased to match increases in workloads and, in some cases, having to be cut. It was therefore perceived as an important contributory factor to work stress for pharmacists who were expected to do “more for less”.

“Well in my understanding of stress, stress is not having an expectation being met, so if you are expecting something to happen and something different happens, then it causes stress. And in that respect we are not being paid properly for our prescriptions, we are not being paid fairly for the work that we do, the Government is continuously...or developing and changing the arena where we work in by putting in new services, but not recognising a lot of the work and commitment that is there and has been done in the past. And there are also massive pressures to try and improve standards and to change processes, especially within independents. Basically for the last ten years, we have had to work harder for significantly smaller increases in the repayment remuneration.” [Stakeholder 3]

In relation to this, the current economic climate affecting businesses generally was recognised as contributing to the financial pressures faced by community pharmacies, as was competition from other local pharmacies, particularly those opening under the ‘100 hour pharmacy’ exemption to control-of-entry regulations.

“But obviously it’s hard times. It’s hard times for pharmacy and it’s hard times for us therefore as well, so that does mean that some of the things that might have made your life easier in the past, we can’t afford to provide for them. So we can’t afford to provide extra staff to cope with any of these new things, because the sums don’t add up. [...] and it’s particularly tough at the moment and even more tough than it should be because of the influx of 100 hour pharmacies which are popping up left, right and centre and taking away business from existing pharmacies.” [Employer 5]
The regulatory environment in which pharmacies operate was also raised as an external factor contributing to pharmacists' stress. This was mainly in relation to the administrative burden placed on pharmacists but also included the responsible pharmacist regulations which were perceived to be one reason why pharmacists were unable to take a rest break.

“There are a number of things as well that are in the contractual framework, certainly in England, that are adding to the amount of work that pharmacists are doing. And I’m not entirely sure that some of that is often completely necessary. I suppose one of the beauties of working for a multiple is that we take the majority of the work that we can away from pharmacists; for example, the annual complaints report done for the PCTs, CPPQ, both of which are quite task intensive. And I’ve not seen one jot of evidence that PCTs have done anything with it. So I think there’s an awful lot of administrative workload which is not necessarily value adding.” [Employer 8]

“Well, there is a rule that you can leave the premises now, the responsible pharmacist rule, whereby you can leave for up to two hours a day. For example, if you’re doing deliveries or you’re doing medicines use reviews in a patient’s home or you’re going to a meeting with the doctor’s surgery, but nothing can happen whilst you’re away. They can’t dispense, they can’t hand out medicines, they can’t counsel, they can’t do MURs, they can’t – basically they can’t do anything. So, what is the point? I can’t leave, I would never leave the shop. If I have to pop out for two minutes to go and get a bottle of water, I have to send somebody. I rarely, rarely – if you were to ask the staff how often I’ve left the shop in the last year and a half, they would probably say once.” [Pharmacist 2]

### 4.4 The effects of stress in community pharmacy

To help build the business case for tackling workplace stress in community pharmacy, all interviewees were asked about their own experiences of the impact of workplace stress on themselves as individuals, on community pharmacy organisations and on the quality and safety of patient care. The themes arising from the responses were then categorised according to the framework derived from the work stress literature described in Chapter 1 (Table 1.1) which classifies the impact of workplace stress as effects on the *individual* ('psychological wellbeing', 'physical health', 'relationship to work', 'other') and effects on the *organisation* ('sickness absence', 'performance/productivity', 'staff turnover', 'other'). These findings are reported in order of their prevalence in the data. We report the findings in relation to the impact on the *quality and safety of patient care* as a separate category due to its importance in the community pharmacy context.

#### 4.4.1 The impact of stress on individual pharmacists

##### 4.4.1.1 Psychological well-being

Many of the pharmacists we interviewed reported that their psychological well-being had suffered as a result of workplace stress, either now or in the past. Pharmacists reported having periods of anxiety and/or depression, insomnia, irritability with others, low self-esteem and difficulty concentrating.
“So I was waking up at 3 o’clock in the morning thinking, ‘I’m about to go into a panic attack.’ It’s anxiety and it’s all to do with feeling like I’m failing in my role.” [Pharmacist 1]

“Yes, I mean for me personally there are periods when I’ve actually felt short term anxiety, headache, inability to concentrate, greater risk of making mistakes, not working efficiently...in other words having to duplicate work to make sure you get right, so it’s more difficult to get it right first time.” [Pharmacist 10]

4.4.1.2 Physical health

A similar number of pharmacists reported that their physical health had been adversely affected by work-related stress. In particular, pharmacists reported suffering from fatigue, headaches, musculoskeletal problems and digestive disorders, either currently or in the past.

“I think the most significant thing I realised was when I obviously started doing this job as well as that and it was Easter just gone when I went to working full time in a store and I had a headache I couldn’t shift for three days. I realised that this was my life prior to changing my work pattern and at the time it was just a case of “Oh I get headaches” and not quite realising that the cause of the headaches was just because of the work environment. So I’d say physical health suffered and just feeling so tired all the time.” [Pharmacist 11]

4.4.1.3 Relationship to work

Some pharmacists described the way increasing workplace pressures were impacting upon their job satisfaction, reporting that they were feeling de-motivated and felt little commitment to their employer or, for a small number, the pharmacy profession. In some cases, stress had contributed to pharmacists relinquishing management responsibilities, changing jobs or deciding to become a locum. In one instance, the interviewee had relocated to another part of the country. In others, pharmacists knew of colleagues who had left the profession entirely or were considering leaving themselves.

“Definitely job satisfaction, ‘cause that’s partly why I decided to hand in my notice ‘cause I’d got to the point of – I hated my job, which in 20+ years of working as a pharmacist I found really awful to feel ‘cause I’ve always loved my job.” [Pharmacist 1]

“So I think things like that just, you know they make you feel a lack of commitment towards your employer, a lack of motivation. So I would say those are the sorts of things that as a result of work stress, the effects that I personally felt I would say those are the most important ones.” [Pharmacist 11]

“I know an excellent pharmacist not many miles from here, about three miles from here, who I’ve admired in terms of he’s very knowledgeable, he’s very fair and objective, and he’s just walked away he’s saying I can’t cope with it anymore. Now I was totally shocked when I heard that. He’s been in this organisation a long time and I just thought well if it’s got to him it really is bad. No resources, fewer staffing, more work put on him, taking more work home, it’s not good is it?” [Pharmacist 16]
4.4.1.4 Other individual effects

A number of pharmacists described the way stress at work was affecting their home life, taking work home with them, making them too tired to socialise, bad-tempered with other family members and affecting relationships with partners.

“There’s sometimes when you come in from work and you’re just absolutely washed out by the end of the day because it’s been so frantic. For instance at Christmas time it was absolutely awful because of the sheer volume that we were dispensing, so I was coming in, having something to eat then going to bed, because I was just so tired. And it’s not great for your family life either when you’re getting in exhausted and you can barely string a sentence together to have a conversation with your family.” [Pharmacist 12]

Rarely, there was some suggestion made that stress could be associated with increased alcohol consumption or substance misuse, but this was not a common theme to arise from these interviews.

“I don’t want to make assumptions really here. Certainly people who contact the addiction helpline are stressed, that’s clear. I think that I’d have to go back and have a look at individual cases to see what people said because I don’t want to sort of just jump to conclusions really. My impression without looking is that certainly there’s a link between workplace pressure and how people deal with it. We have had calls from, not always from the person themselves, but sometimes from a family member saying “I’m worried about my partner, they’re under a lot of stress at work and they seem to be drinking a lot,” you know, so we’ve definitely had that kind of enquiry.” [Stakeholder 6]

4.4.2 The impact of stress on community pharmacy organisations

4.4.2.1 Sickness absence

Sickness absence was one of the most commonly mentioned implications of workplace stress for community pharmacy organisations. Some of the pharmacists we spoke to had themselves been absent from work with stress-related illness or knew of others who had. Pharmacist Support reported that they were often approached by pharmacists off work with stress. However, whilst some, particularly pharmacists, perceived that there was a clear link between work stress and absenteeism, other respondents, often employers, were more ambivalent as to the extent of such stress-related absence and whether or not work stress was the primary cause. It was suggested by one respondent that this may be due to the stigma attached to admitting to having mental health problems at work.

“Yeah, I’ve had a member of staff who’s been off for stress-related illness, and in other organisations I’ve had it as well, so I think it is a big problem in pharmacy. You do see it a lot where people are off with stress-related illnesses. I know a few pharmacists who’ve been off with anxiety and depression caused by stress. It’s never happened to me personally but there have been times when you just feel so crushed by the weight of responsibility that you’ve got any everything that’s going on with targets and everything else, that it does affect you a little bit, definitely.” [Pharmacist 12]

“I’m sure stress does cause sickness absence but I don’t have any evidence of that. I know we have had in the past two pharmacists I’m aware of that were off with stress, but I don’t know
the causes of that. But again, two out of 500 pharmacists, I think, is quite a low percentage. I don’t know how that compares with the national average.” [Employer 9]

“I don’t know because it’s a bit like the elephant in the room really. Nobody likes to know that their workforce might be unhappy, but you’ve only to look sometimes at, I think, sickness and absence records and how much it costs companies. ‘Cause I know within, obviously, my ex-company, within the first start of the financial year it was, like, thousands of pounds of sick pay. […] ‘cause you did sometimes think, ‘Actually, are all these people off sick or is it stress-related?’ And again, because people are embarrassed about mental health or what they perceive as a sign of outward weakness, they just – they don’t open up about it.” [Stakeholder 2]

4.4.2.2 Performance/productivity

Some pharmacists and employers recognised that the reduced motivation, commitment and concentration as a result of work stress described above could have a knock-on effect on both individual and business performance and productivity for the pharmacy.

“If you’re not stressed about things and you feel more relaxed and you’re able to get a lot more done. But sometimes I think it’s difficult to get organised when you’re stressed because you’re trying to do hundreds of things at once, and it means that you’re a lot less productive as an employee I think.” [Pharmacist 12]

“There will certainly be examples within the organisation, and any organisation I’m sure, where performance of the business unit will not have been at the level that you would have expected if an individual’s not personally performing to the level you would expect them to, because if they fail to play their role in the way that you would expect them to operate then definitely.” [Employer 7]

Furthermore, it was acknowledged that presenteeism in pharmacists who are stressed at work may affect both their performance and productivity, and those of the business.

“[Pharmacists] do generally tend to be people who want to carry on and provide the service for the public, because they know if they’re not there […] then they’ve got to get a pharmacist from somewhere else to keep the service going. Full stop. Otherwise they can’t keep the service going. So there is almost an inherent responsibility that they keep that service going. So my worry, to be honest with you, is presenteeism; how many people are turning up who are not fit to work, and are not fit to practice, and it is a serious patient safety issue, to my mind.” [Stakeholder 2]

4.4.2.3 Staff turnover

Work stress is known to be a cause of increased staff turnover generally, and there was some evidence from these interviews that this may be the case in community pharmacy. For example, the reports of pharmacists having left their jobs due to work stress (above). From the employer interviews, however, it was difficult to demonstrate a clear link between work stress and staff turnover in community pharmacy with some, again, ambivalent as to whether work stress was a primary cause of staff turnover and others reporting decreasing turnover rates.
“If I look at turnover rates, then, you know, particularly in the first year after recruitment, we have relatively... I mean, not high compared with the store, but relatively high turnover rates. So you know, that might be an indicator that the way we do things is not acceptable to everybody, and, you know, there is a group of people who are stressed but are not telling us that they’re stressed ... And if I look at the reasons they’re giving for leaving, very rarely does it come out around workload or whatever in the main...in a lot of cases. In some cases it’s ours, and that may be a stress indicator. And in the main, it’s personal reasons or, you know, hygiene factors like they’ve been headhunted and offered a lot more money.” [Employer 10]

Staff turnover itself was identified by some interviewees as a further cause of stress for the staff remaining and the financial cost to the business of staff turnover (and absenteeism) was also raised as an organisational effect of work stress.

“It just builds on and builds on to the stress, so eventually the person actually says, ‘Oh, I’ve had enough,’ and leaves. And then that adds further stress to the people who are already there, because then new people come in and it takes time to train others up. So it’s almost...before you know it you get into a spiral effect, where stress causes someone, for instance, to leave, and then it just escalates.” [Pharmacist 10]

4.4.2.4 Other organisational effects

A number of other organisational effects of work stress were mentioned by a small number of respondents. Both staff turnover and sickness absence from stress were cited as causes of breakdown in working relationships within the pharmacy. The impact on a pharmacy’s reputation was also mentioned by one interviewee, whilst another suggested that the diminishing reputation of pharmacists generally was itself a cause of stress. Lastly, one respondent suggested that relationships with other local health professionals could be tarnished by work-related stress.

“I think because we have fewer staff, and fewer resources, we’re struggling to cope with the workload and we’re told time and time again by the patients that this is affecting their opinion of the organisation.” [Pharmacist 11]

4.4.3 The impact of stress on the quality and safety of patient care

4.4.3.1 Patient safety

Nearly every pharmacist we spoke to indicated that at times of stress at work – particularly due to high workloads, insufficient staffing levels and/or fatigue through a lack of rest breaks – they were more likely to make an error in the dispensing and checking process. Most gave specific instances of a dispensing error they had made, or near misses they were involved in, in such circumstances.

“There has been once or twice when errors have gone out when we’ve been really busy or short staffed and it’s just been really stressful. The odd one has been made, luckily it’s not been anything too serious, but no errors that reach the patients are good really. And when you’re in that sort of environment more errors are likely to occur when you’re stressed, you tend to find that during busier periods or when you’re trying to do a 100 things at once that’s the times when things start to slip through.” [Pharmacist 12]
Rarely had such incidents risked harm to the patient in the opinion of the pharmacists. However, the increased risk of error at times of heightened workplace stress was often cited as an additional source of stress for these interviewees, as mentioned earlier.

Many pharmacy employers were also aware that there might be a risk to patient safety from increasing workplace stress. Some knew of examples of errors that had been made as a result of pharmacists working in stressful situations or of increasing error rates as workloads had increased and staffing became stretched. Others reported that whilst they were aware of the risk, they had no firm evidence of this link between increasing workplace stress and errors made.

“So we’ve actually got a process where we try and learn from [errors]. And if we do start to see a trend, a senior manager will go out to look at branches to understand what the cause is. And they look at the whole operating process. They look at staffing levels, look at skills, look at layer of branch. They look at how they deliver the SOPs, what their processes are to see if we can find out what’s causing the errors. Because quite often it’s through stress. We know that. The errors are happening, there’s something causing it. So we look at it that way.” [Employer 11]

Conversely, a number of employers and stakeholder organisation representatives suggested that there was no link between increasing workplace stress and dispensing errors. A number of different explanations were given for this. In some cases, examination of dispensing error logs had not demonstrated any association between workload or stress and errors. Moreover, one organisation providing professional indemnity insurance for pharmacists reported that the number of claims against pharmacists had not been rising along with workloads. An alternative explanation given for why stress did not cause errors was the belief mentioned above that pharmacists were able to absorb the pressures placed on them at work and always made patient safety a priority. Others believed that whilst stress was sometimes reported as a cause of error, this was not in fact the principal cause which might actually be, for example, poor working practice.

“So have I got direct evidence of people who’ve made dispensing errors because of stress? No. I’ve got lots of examples of people who have made dispensing errors because they have fallen below the bar of acceptable professional performance. Now, when challenged about that, some of them, I suppose when backed into a corner, will say well, you know, it’s because I was stressed, rather than because fundamentally I was a poor practitioner. So it might sound slightly harsh actually, but it’s not meant to be. But yeah, sometimes people aren’t up to the mark really.” [Employer 8]

4.4.3.2 Other aspects of service quality

A number of pharmacists and, to a lesser extent, employers were concerned with the impact of workplace stress on other aspects of service quality. In particular, some felt that the amount of time that pharmacists were able to spend with patients/customers was being curtailed, affecting the quality of the consultation process. Moreover, pharmacists were sometimes aware of coming across as irritable or sometimes rude to customers when under stress.

“If you’re very, very busy and there’s a high stress level in the pharmacy and a customer wants a question answered, you might not have enough time to give an adequate answer, so you might just give a brief response or intervention and really, that customer could have
It is worrying, about the quality of service, definitely, that that could be influenced by the fact that you haven’t got time to give your time, if you know what I mean.” [Pharmacist 2]

4.5 Stress prevention and management strategies

A number of stress management and prevention strategies with some evidence of effectiveness had been identified from the literature review (Chapter 3) and were used to inform subsequent discussions during interviews. These were categorised as either interventions directed towards the individual employee, interventions at the interface between employee and organisation, and interventions at the organisational level, according to the framework first described by DeFrank and Cooper29 (see Table 3.1). Interviewees were asked about which stress prevention and management strategies were currently being implemented within community pharmacy organisations (and the perceived success of those), which might be transferable to a community pharmacy setting and which were deemed unsuitable in this context (and the opportunities and barriers to their implementation).

In addition, interviewees were asked specifically about the adoption of safe workload parameters within community pharmacy: whether any were currently implemented (and details of those), how they might be determined, and the opportunities and barriers for enforcing safe workload parameters in this setting, the findings from which will be reported first.

4.5.1 Safe workload parameters

4.5.1.1 Current practice

The majority of employers we spoke to used a workload/staffing model to help inform the allocation of staffing levels and skill-mix at different times in different branches. These models were invariably developed in-house, sometimes with the help of external consultants, but varied in their levels of complexity and the parameters taken account of.

The simplest or least developed models tended to be used by the smaller pharmacy chains. Here, rules of thumb, based predominantly on the number of prescription items dispensed, were generally adopted to give an indication on the number of pharmacists or staffing hours required for a particular branch. Most interviewees were unwilling to specify the number of items involved although one interviewee suggested that 600 items a day or more would require a second pharmacist. An added layer of complexity to this kind of model was used in another, larger, pharmacy chain which grouped branches according to dispensing volumes and tried to match them in terms of staffing.

“We have peer groups, so we match like, say, 15 shops against each other for equivalent volume of items, so they’ve got roughly the same workload. And we look at how they perform within those groups. And we look at staffing levels, you know, what worked and match it up. You know, we’ve got a rough idea of what level you need before you need more staff, you know, that sort of thing. So we do look at that, but I haven’t got any definitive, you know, numbers.” [Employer 1]
The most sophisticated workload/staffing models were generally described by the large multiples and supermarkets and often incorporated a number of different parameters in a formula or algorithm including items dispensed, over-the-counter sales, additional services offered, size of the pharmacy, and extended pharmacists’ roles. Two interviewees specified that time-and-motion studies had been conducted to determine the time it took to do every task within the pharmacy and that this was then added to the formula to calculate an allocation of staff hours.

“We have a workload planning tool […] that is based on time for various tasks to be completed, so how long it takes a pharmacist, a technician, an ACT, a supervisor to do every single task in a pharmacy. And, therefore, how many staff hours you need to cover those tasks. So, simply described, it’s a very sophisticated tool […] So that allows us to plot where workload is and where our available staffing hours are. And based upon some very hard data about how long various tasks take, and every single task has been timed, plotted, verified.” [Employer 8]

Few pharmacists were able to describe the workload models used by their employers. One (working for a large multiple) described a cut-off point of 700 items a day, above which a second pharmacist would be deployed. Another, who had previously worked for a supermarket pharmacy, believed that there the over-the-counter sales determined staffing hours. An independent pharmacist described the freedom they had to determine their own staffing levels, with other pharmacists being taken on as dispensing volumes and the business had grown allowing the pharmacy to be “overstaffed” compared with others.

“So we’ve got a business that we’ve grown. And at certain points during that business growth, stress, our stress has been the driver that’s taken us to take on more staff and has - we sit back and we look at, you know, I’m not enjoying work today and I’m not enjoying work because I can’t get through my to-do list, and it’s generally been that both of us have felt the same at about the same time, and then we’ve said hmmm, wonder if it’s because we are now doing maybe 3,000 items was the tipping point. Now look at what we’re doing. We’re doing 3,300. Maybe we need to be looking at an extra member of staff or changing the way that we work. But all those are controlled by me, so I’ve only got myself to blame if there’s not enough staff. So I can sit back and say can I afford somebody new? Yes, I can. And then that helps, and that’s helped us to continue delivering quality.” [Pharmacist 4]

In most cases, employers described their workload models as flexible and only a guide to the staffing levels required and that they were open to discussion with any pharmacist who felt that more staff were required to maintain safe practices. Many also believed, however, that their models worked well in the majority of cases when the number of hours was deployed correctly by the pharmacist. A small number suggested that pharmacists did not always have the expertise to know how many staff were needed and the model only fell down when pharmacists didn’t always allocate the hours given in the most optimal way or when there was a performance or competence issue. Therefore they could be reluctant to increase staffing levels when this was requested by the pharmacist.

“We have certainly had examples where...if a dispensing incident is made then clearly I have a duty to investigate that and put in place remedies and mitigating actions to try and prevent recurrence. And quite often one of the defences that a pharmacist may choose to use if they made more than one dispensing incident, there’s a pattern there, is that they’re struggling in
that environment to meet the workload that’s present. So I would never instantly say okay, let’s move that person out then. And I don’t think that would ever be the first reaction of the leadership team in pharmacy operations. I think what they would seek to do is understand why the pharmacist felt that was the case. And this is where our clinical governance team become very valuable. Because they see the operation across a number of stores they’re able to draw on their experience and identify whether or not this is a real issue in that store, there really is insufficient or adequate resource available to support the pharmacist or if this is around the individual pharmacist’s performance, and what steps may be most appropriate in those circumstances. So equally we would never rush in to try and move the pharmacist out. We’d never rush in and throw in more hours into the pharmacy because quite often that never actually really solves the issue anyway. If it’s around capability all that does is actually end up costing the organisation a lot more and actually can exacerbate the situation.” [Employer 7]

This was certainly reflected in the experience of some pharmacists who were not always convinced by the staffing levels computed by the employers’ models. Some felt that they were not listened to when they believed that workloads at current staffing levels were unsafe. Others, that the models were used to keep staffing to a minimum and reduce costs.

“It’s just been getting progressively worse, and I can’t see it...seeing it change. But it would be nice if we did get better staffing levels. But they have this model that says it’s all supposedly computerised and it tells you what staffing levels you need; and then that’s what they’re all being forced to work to – that the area managers are being forced to work to that – so they’re having to move staff around from one branch to another to reduce the staffing levels; and I think most branches have had to have their staff reduced.” [Pharmacist 14]

4.5.1.2 Should safe workload parameters be introduced?

The majority of pharmacists we spoke to and a small number of employers and stakeholder organisation representatives believed that, ideally, safe workload parameters should be introduced for pharmacists (i.e. a maximum number of items that could be dispensed by any one pharmacist per hour or per day). However, a number of objections were also raised about this possibility together with a variety of obstacles to implementing such parameters.

Firstly, some suggested that because pharmacists varied in terms of their capability, it would be impossible to determine a single ‘safe’ dispensing limit – what might be too great a volume to dispense safely for some, may be the optimum dispensing volume for others. Thus, by imposing a limit, you may be restricting the productivity of some pharmacists.

“You know, some people can only do...can do relatively low numbers, other people can do relatively high numbers. And I don't see a difference in the errors that those people make. So, you know, it depends on, to me, the individual. And if you were to try to impose a safe working limit on a community pharmacy...pharmacist, I’m not sure that that would be practical. You know, I think...I’m sorry, but I take a view that people have a responsibility to work within their limits and their capability, and their competence. And, you know, I’m quite prepared to help, support, do anything I can to help them, if they...you know, if they are prepared to talk to me about it. But I know, within my organisation, that I have people who...
have a huge capacity for great volumes of work, and people who don't. And we will support those people in different ways. But to tell the guy who's got a big capacity that he can only do this amount would be de-motivating for that person.” [Employer 10]

A second obstacle to determining safe workload parameters raised by interviewees was the number of other factors which could influence safe dispensing levels, including the complexity of prescription items involved, the number of other tasks a pharmacist was expected to perform, the availability and skill of other members of staff, and environmental factors such as the layout of the pharmacy and interruptions from customers, phone calls etc.

“I don’t think you, necessarily, can say what is a safe workload, for any individual, it varies from person to person, it depends on the circumstances they work in, it depends on the complexity of the prescriptions, it depends on their capability, you know, there’s a number of different factors, I think, we would all, probably, have an idea, in our minds, of what would be, necessarily, unsafe, but, I don’t know that you can, necessarily, say, that, if it’s this, it’s safe and if it’s that, it’s unsafe and, I think, that would be a very dangerous route to, you know, to go down. So, it is about competency and capability and the situation on the day.” [Employer 6]

There was also the perception held by some pharmacists and stakeholder organisation representatives that the employers would object to such a move on financial grounds as imposing a limit on dispensing volumes would necessarily eat into pharmacies’ profits at a time when they were already facing cut-backs in financial remuneration from the NHS. Objections could also be made on the grounds that setting staffing levels was the business of the employing organisations alone.

In relation to what levels of dispensing should be deemed safe, or which other parameters should be factored in to determine safe working limits, the complexity of the problem resulted in few specific suggestions being given. However, suggestions were made in relation to the mechanisms for implementing such a scheme, including obtaining buy-in from the employers, linking increases in remuneration to any subsequent increase in staffing requirements, the need for regulation to enforce such changes and, alternatively, producing guidelines for safe working practices rather than enforcing strict limits.

4.5.2 Current practice in stress management and prevention

4.5.2.1 Strategies with a focus on the individual

Table 4.3 summarises the interview findings in relation to strategies in stress management and prevention with a focus on the individual currently implemented by community pharmacy organisations (‘current’), with the potential to be adopted in the future (‘possible’) or ‘unlikely’ to be implemented in community pharmacies, according to the employers (E), pharmacists (P) and stakeholders (S) interviewed. They are listed in order of the prevalence of current strategies, as mentioned by employers.

Most employers we spoke to described a number of schemes or strategies they already had in place for preventing or managing stress which focused on the individual. These were generally secondary or tertiary preventative measures available for those already suffering from work stress. The most commonly mentioned were return-to-work schemes, for those who had taken time off from work
for stress-related illness, and counselling services (and/or employee assistance programmes or helplines), for those currently experiencing stress at work. Staff coaching or mentoring schemes, occupational health services, stress management training and support for drug or alcohol misuse were less commonly offered. Other strategies, such as those offering access to exercise or relaxation activities, were not offered by any of the organisations we spoke to although a small number positively encouraged pharmacists to participate in such activities or offered signposting to external provision, such as the counselling service offered by Pharmacist Support.

TABLE 4.3 Strategies in stress management and prevention with a focus on the individual, categorised as ‘current’, ‘possible’ or ‘unlikely’ within community pharmacy organisations by employers (E), pharmacists (P) and stakeholders (S).

<table>
<thead>
<tr>
<th>Intervention/target</th>
<th>Current strategy</th>
<th>Possible strategy</th>
<th>Unlikely strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>P</td>
<td>S</td>
</tr>
<tr>
<td>return to work scheme</td>
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<td>✓*</td>
<td>✓*</td>
</tr>
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<td>counselling</td>
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<td>✓✓*</td>
<td>✓</td>
</tr>
<tr>
<td>coaching</td>
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<td>✓</td>
<td>✓*</td>
</tr>
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<td>‘employee assistance programme’</td>
<td>✓</td>
<td>✓</td>
<td>✓*</td>
</tr>
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<td>helpline</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
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<td>✓</td>
<td>✓</td>
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<tr>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
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<td>signposting</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>stress management training</td>
<td>✓</td>
<td>✓</td>
<td>✓*</td>
</tr>
<tr>
<td>drug and alcohol support</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>encourage outside interests</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>health checks</td>
<td>✓</td>
<td>✓</td>
<td>✓*</td>
</tr>
<tr>
<td>exercise</td>
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<td>✓</td>
</tr>
<tr>
<td>CBT</td>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>relaxation/meditation</td>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>assertiveness training</td>
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<td>✓✓</td>
<td>✓✓*</td>
</tr>
<tr>
<td>none</td>
<td>✓✓</td>
<td>✓✓</td>
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</tr>
</tbody>
</table>

Key:  
* Intervention(s) most commonly mentioned by respondents in this category (column)  
✓✓ intervention mentioned by half or more respondents in this category  
✓ intervention mentioned but by fewer than half of the respondents in this category

Only a small number of the pharmacists that we spoke to were aware of or mentioned any stress management and prevention schemes focused on the individual that were offered by their employers, although that may be because they had not previously sought out any support for stress from their employers. However, a small number did mention that they were aware of return-to-work schemes and helplines or other counselling services.

Very few interviewees, either employers or pharmacists, commented specifically on the success of such interventions focused on the individual. One superintendent pharmacist believed that the take-up of their own helpline service and that provided by Pharmacist Support was good but did not have the information to be able to comment on the success or otherwise of individual cases, in part due
to confidentiality issues. A second employer had recently changed provider for their helpline service as take-up had not been good as a result of the previous service not being well marketed. None of the pharmacists we spoke to described having used any of these schemes themselves although some knew of others who had. A small number spoke of a reluctance to use counselling/helpline services: one because of a belief that it would not be able to help; another because they did not want to use a telephone service, preferring to speak to someone in person.

4.5.2.2 Strategies focussed on the individual-organisational interface

Table 4.4 summarises the interview findings in relation to strategies in stress management and prevention with a focus on the individual-organisational interface currently implemented by community pharmacy organisations (‘current’), with the potential to be adopted in the future (‘possible’) or ‘unlikely’ to be implemented in community pharmacies, according to the employers (E), pharmacists (P) and stakeholders (S) interviewed. They are listed in order of the prevalence of current strategies, as mentioned by employers.

TABLE 4.4 Strategies in stress management and prevention with a focus on the individual-organisational interface, categorised as ‘current’, ‘possible’ or ‘unlikely’ within community pharmacy organisations by employers (E), pharmacists (P) and stakeholders (S).

<table>
<thead>
<tr>
<th>Intervention/target</th>
<th>Current strategy</th>
<th>Possible strategy</th>
<th>Unlikely strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>P</td>
<td>S</td>
</tr>
<tr>
<td>appraisals</td>
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<td>✓✓✓</td>
<td>✓✓</td>
</tr>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
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<td>management training</td>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>skill training</td>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
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<td>✓✓</td>
</tr>
<tr>
<td>co-worker support</td>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>participation</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>delegation</td>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>role clarification</td>
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<tr>
<td>management support</td>
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</tr>
<tr>
<td>teamwork</td>
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</tr>
<tr>
<td>leadership training</td>
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</tr>
<tr>
<td>shared learning</td>
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</tr>
<tr>
<td>absence monitoring scheme</td>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>external training</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>re-location</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
</tr>
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<td>prioritising workload</td>
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<td>being a locum</td>
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<td>building patient relationships</td>
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<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td>Induction</td>
<td>✓✓</td>
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<td>✓✓</td>
</tr>
<tr>
<td>all</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
</tr>
</tbody>
</table>

Key: * Intervention(s) most commonly mentioned by respondents in this category (column)
✓✓ intervention mentioned by half or more respondents in this category
✓ intervention mentioned but by fewer than half of the respondents in this category
A wide range of strategies for stress prevention or management at the individual-organisational interface were described by employers, some more common than others. The majority of the employers we spoke to described appraisal systems they had in place, which were commonly conducted annually, sometimes with a six month review. One described an alternative system involving monthly review meetings and a six-monthly planning cycle. The extent to which appraisals were perceived to be used, or indeed useful, for stress management purposes varied however. The primary aim of appraisals or performance reviews in community pharmacies is commonly to assess performance against targets set at a previous appraisal. Additionally, they may be used to address personal or professional development issues. This is known from previous research (refs) and was re-iterated in these interviews. A number of the employers we spoke to believed that, in addition, appraisals could be a useful place to address problems associated with workplace stress.

“It may well...yes, I would bring up stress. It’s not formally part of the appraisal but it’s something that sometimes comes out. But stress tends to rear its ugly head at other times, as an issue, actually. So I don’t think you can simply say well, I’ve got an annual appraisal, so that’s stress sorted out. It might be stress sorted out on that day. So I think you need to be alert to it all the time, you need to have a sensitivity to it.” [Employer 2]

The pharmacists we spoke to took a different view however. A commonly held opinion was that the emphasis was too heavily on performance with little opportunity to discuss personal development issues or, indeed, stress. Some perceived appraisals as a source of stress with their managers using it as an opportunity to identify shortcomings, set unrealistic targets and make financial savings.

“Appraisals – we do but I don’t know if it’s used as a form of stress management or stress prevention, I think it does the opposite it creates the stress. We have performance contract reviews which are carried out, or should be carried out by line managers. I think in the vast majority of cases it’s a time when you reflect on have you reached the targets so we’re back to the targets again, and I would prefer my appraisal to be “What direction would you like to see your career going in?” which it never is. Also appraisals they have a grading which means you’re not meeting your expectations, you are on the way to meeting them, you have met them or you are exceeding them and nobody ever exceeds them because then it means they would have to be paid more.” [Pharmacist 11]

Another existing strategy for managing workplace stress commonly mentioned by employers was good communication between managers (from line managers through to head office) and pharmacists and, related to this, management support. A number of employers particularly mentioned open lines of communication to the superintendent’s office, and subsequent support, for pharmacists facing difficulties in relation to workplace stress.

“In the professional services team, we see ourselves as being the supporter of the professional people within the business. And we try and build one to one relationships with as many people as we can. So that they feel that they can come to us with concerns if they do have any concerns with regards to delivering professional standards. [...] We also do pharmacy visits. So we try and have a lot of contact with pharmacists and professional people within the business. We get direct calls from people to say where they have got concerns. We do get that.” [Employer 11]
Interestingly, both of the pharmacists we interviewed from this particular organisation praised the support they received from managers in relation to stress and valued the open lines of communication to senior management; one put it down to the fact that there were pharmacists at all levels of the organisation. This contrasts to the instances mentioned above where poor relationships with managers were identified as a cause of workplace stress for some pharmacists.

A large number of employers also mentioned offering support and/or training with conflict resolution. In the larger organisations this could involve the human resources department. Training in conflict resolution was offered to pharmacists in at least two pharmacy chains: these employers recognised that pharmacists may not have the skills to deal with conflict, either with customers, managers or subordinates, and that this training could help to avoid such issues escalating or causing stress. One pharmacist also mentioned the training course in conflict resolution offered by CPPE.

Management training more generally, including training in leadership, time management and delegation, was offered by a large number of employers. This was often offered to pharmacists early in their careers, sometimes during their pre-registration placement (“pre-reg”), as it was recognised that this was one area not covered well in undergraduate MPharm programmes. One particular area of management training thought to be beneficial to pharmacists in relation to stress prevention was around teamwork and delegation.

“We run management development programmes. But it’s a skill and it’s a process, and you’ve got to, I think in any busy work environment now, whether you’re in pharmacy, medical practice, banking, whatever, if you’ve got a team of people, and whether you’re called “manager” or not, you have a team of people in a pharmacy, you’ve got to use them effectively and you’ve got to be able to delegate effectively and appropriately. So I think it’s a core skill but they don’t necessarily join us with that ability. We do work with them in the pre-reg year, but obviously that’s only with people who come through our pre-reg programme, which doesn’t include everybody who joins our organisation.” [Employer 8]

Also important to facilitating delegation to pharmacy technicians and other dispensing staff was skill training, and many of the employers we spoke to also offered this. Many of the pharmacists we spoke to also spoke about the importance of teamwork and delegation in managing workplace pressures. However, whilst some mentioned the training offered in support of this, others suggested that successful teamworking and delegation was as much to do with the inherent abilities and personalities of the pharmacist and other team members.

“We have absolutely fantastic staff here and I think that really, really probably helps. I know if I ask some of the girls to do something it’ll be done, maybe not today if they don’t get a chance, but I know tomorrow it’ll be done. I know if somebody’s on holiday they’ll support you and they’ll come and work overtime. [...] I know if at half past five I’ve got fifty people standing in the shop they’ll stay and they’ll help; they’re not just going to walk off and leave you. And I think that makes such a big difference to anywhere really. [...] I don’t think the organisation’s really done anything to encourage that. And obviously because I’ve been here for so long I’ve been a bit involved in employing all of these girls, even the ones that were taken on before I took over as manager. [...] I think what we tend to look for is a personality, you can teach people to do the job, you can’t teach people to... So that’s what we tend to
Co-worker support – by which we mean support from other pharmacists within the organisation as opposed to teamwork within a particular branch – was also encouraged by a number of employers. Whilst it was easier in the smaller chains for pharmacists to “meet together on a fairly regular basis”, some larger chains and multiples also facilitated this through away days (and other training activities) and professional peer support networks. Whilst many pharmacists had cited the professional isolation of working in community pharmacy as a source of stress, a small number did take advantage of these support networks of pharmacists within their own organisation in times of stress.

About half of the employers we interviewed purported to encourage autonomy amongst their pharmacists as a way of preventing workplace stress. However, the degree of autonomy permitted appeared to vary, with some making the distinction between professional autonomy (which was encouraged) and autonomy around the running of the business and standard operation procedures (which was not).

“You are the expert on pharmacy in your shop, it’s your shop, it’s your pharmacy and don’t expect anybody to know more about the pharmacy than you. It’s your business and we tend to say them do things, as long as it’s legal you can do whatever you want to do in your pharmacy. And you tend to don’t ask permission, you ask for forgiveness afterwards if it goes wrong. So we tell them that, and I know some of our guys are really, really focused on that and some of the guys don’t do anything with it. But we do encourage them to run it as their pharmacy and to own their pharmacy. We do tell them treat the money as if it’s your money, as if these are your sales, as if they’re your customers.” [Employer 9]

“I think there’s something about allowing a degree of latitude for the professional to be the professional and exercise their profession in a way which is beneficial to the patient. That’s not cart blanch then an opportunity to go and rip up all, whatever it may be, 60 or so standard operating procedures that I might have because they’ve been created for a reason. So there’s degrees of autonomy, but I’m fundamentally a supporter of the individual professional having a right to exercise their own professional discretion and autonomy.” [Employer 7]

Around a third of pharmacists described enjoying a degree of autonomy in their pharmacy, either because they were independent pharmacists or because this was something supported by their employer. In one case, the pharmacist was able to exert a degree of autonomy not necessarily offered to others in that organisation.

“I do, to a great extent – perhaps more than a lot of pharmacists – and probably because of the length of time I’ve been there and the approach we have with the other people at the shop. Yeah, I do do things my way and, like I say, everybody that works for me – even the manager of course has worked for me for 12 years, first as me being her manager and now with her being my manager – so we don’t have a problem like that in my particular case; although I know they do in other shops.” [Pharmacist 14]
Participation in decision making within the organisation was another related strategy which could be used to prevent stress in some community pharmacies, both smaller chains and large multiples and supermarkets. For example, in one small chain it was possible for the superintendent pharmacist to talk directly to all pharmacists to elicit views on, and thus be involved in, the development of new services. In one of the supermarket pharmacy chains, a web-based forum was used to elicit the views of a wide range of pharmacists on using existing SOPs. These were then used by a smaller group of pharmacists who volunteered to “look at the current SOPs, take them apart and rebuild them again” to encourage ownership and make them more relevant to front-line practitioners. In one of the multiples where participation in decision-making was encouraged, one pharmacist believed that, on balance, it helped to prevent stress:

“Do I think that [involvement in decision-making] would relieve stress? Yes, and no. That’s a difficult one. Because I actually think people just get stressed just thinking about what they were going to say. However, from my point of view, which I suppose is all I can tell you, yeah, I feel it does help me because I would hate to think that somebody was going to make a decision that I was going to have to live by and I’d had no input.” [Pharmacist 13]

Other strategies less commonly mentioned by employers included: re-location of a pharmacist struggling to cope with a high dispensing-volume environment to a quieter store (usually only possible in the larger chains); and absence monitoring schemes. A small number of pharmacists also mentioned building relationships with customers and or local GPs as ways of helping to manage workloads and prevent stress.

4.5.2.3 Strategies with a focus on the organisation

Table 4.5 summarises the interview findings in relation to strategies in stress management and prevention with a focus on the organisation currently implemented by community pharmacy organisations (‘current’), with the potential to be adopted in the future (‘possible’) or ‘unlikely’ to be implemented in community pharmacies, according to the employers (E), pharmacists (P) and stakeholders (S) interviewed. They are listed in order of the prevalence of current strategies, as mentioned by employers.

The importance of the prevailing organisational culture in stress prevention was mentioned by all employers interviewed for this study. A number described what could be described as a supportive culture, looking out for the welfare of the individual pharmacist. Others spoke of a pharmacist-led or bottom up approach, which relates to the degree of autonomy and participation offered by the organisation as described above. A third aspect of the organisational culture which some organisations tried to foster was openness and honesty. Finally, one of the smaller chains spoke about encouraging a community focus within their organisation.

“So I think, you know, one of the key aspects for me of workplace stress is being held accountable for things for which you’re not responsible. And we’ve tried to reverse that entirely, so it’s very much pharmacist led, the entire business. Instead of head office telling pharmacists how it’s going to be, we try and get head office to provide the resources the pharmacists need to do the job that we want them to do.” [Employer 2]
TABLE 4.5 Strategies in stress management and prevention with a focus on the organisation, categorised as ‘current’, ‘possible’ or ‘unlikely’ within community pharmacy organisations by employers (E), pharmacists (P) and stakeholders (S).

<table>
<thead>
<tr>
<th>Intervention/target</th>
<th>Current strategy</th>
<th>Possible strategy</th>
<th>Unlikely strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>P</td>
<td>S</td>
</tr>
<tr>
<td>organisational culture</td>
<td>✓✓*</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>rest breaks</td>
<td>✓✓</td>
<td>✓✓*</td>
<td></td>
</tr>
<tr>
<td>physical environment/ergonomics</td>
<td>✓✓</td>
<td></td>
<td>✓*</td>
</tr>
<tr>
<td>staffing/skill-mix</td>
<td>✓✓</td>
<td></td>
<td>✓*</td>
</tr>
<tr>
<td>IT/equipment</td>
<td>✓✓</td>
<td></td>
<td>✓*</td>
</tr>
<tr>
<td>flexible working</td>
<td>✓</td>
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<td></td>
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<tr>
<td>role of HR</td>
<td>✓</td>
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<tr>
<td>role of head office</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>recruitment initiatives</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>repeat prescription service</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>learning from errors/audit</td>
<td>✓✓</td>
<td></td>
<td>✓*</td>
</tr>
<tr>
<td>prescription collection service</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>turnover monitoring scheme</td>
<td>✓</td>
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<tr>
<td>whistle blowing policy</td>
<td>✓</td>
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<tr>
<td>improving systems</td>
<td>✓</td>
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<tr>
<td>job rotation</td>
<td>✓</td>
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<tr>
<td>workload</td>
<td>✓</td>
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<tr>
<td>working hours</td>
<td>✓</td>
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<td></td>
</tr>
<tr>
<td>all</td>
<td>✓</td>
<td></td>
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</tr>
</tbody>
</table>

Key: 
* Intervention(s) most commonly mentioned by respondents in this category (column)
✓✓ intervention mentioned by half or more respondents in this category
✓ intervention mentioned but by fewer than half of the respondents in this category

Two employers mentioned the necessity for having a match between the organisational culture and individual pharmacist’s values. In one instance, the interviewee spoke about the importance of providing tailored support to pharmacists struggling to cope as a result of a mismatch between a particular branch culture and individual capabilities. In another, the interview suggested that where there was a mis-match between the organisation’s culture and the pharmacist’s values, they should leave.

One of the employers spoke specifically about a purposive change in organisational culture following a merger:

“And organisational culture changes slowly over time, and the business, over the last five years, has made incredible changes to its organisational culture, from one which was very authoritarian and demanding, to one that is now much more supportive, still demanding, of course, because that’s what business is about, but very much more supportive. And, you know, much more focused on the individual rather than the result.” [Employer 10]
When asked how this was achieved, the interviewee described the pivotal role of the chief executive and his board, the contribution of a new staff survey and subsequent changes to a raft of policies around the terms and conditions of employment.

Far fewer pharmacists mentioned the culture of their organisation as currently contributing to stress prevention or management (compared to the number citing it as a cause of work-related stress, see above). However, those that did re-iterated what they perceived as a supportive and open culture within their organisation and the importance of the relationship between head office and the individual pharmacist.

One organisational strategy for preventing workplace stress commonly discussed by interviewees was the opportunity for rest breaks. All of the employers we spoke to were clearly aware of their responsibilities to provide a rest break for pharmacists under the European Working Time Directive although how that was facilitated differed from organisation to organisation. In some instances either some or all of the pharmacies in a chain were closed for lunch. However, this was not always possible in the view of the employer because of customer demand, proximity to a health centre or general practice, or volume of work. In other cases, cover for the pharmacist was provided either through a locum or second pharmacist at certain times of the day, giving the opportunity for a rest break. However, such structural facilitators for rest breaks were not always available. In some organisations, therefore, other strategies were employed to encourage pharmacists to take rest breaks. A 20 minute break was sometimes written into pharmacists’ contracts. Sometimes employers put pressure on pharmacists to take breaks when it became apparent that they were not doing so. In a small number of cases either the dispensary (as opposed to the pharmacy) closed for 20 minutes or more each day and/or the pharmacist’s rest break was advertised to customers. In one organisation, pharmacists were required to record their rest breaks in a log and this was monitored. However, in others, the decision to take a break was left entirely to the pharmacist’s discretion.

“Well, they have a daily log, it’s got down what time the break was, and we do that for a couple of reasons, one, to make sure we’re recording that they are taking a break, and should there be a problem they can demonstrate that people were. But also if there’s a locum comes along hopefully they read it and realise that that’s the appropriate time to take a break at that pharmacy and they will follow suit, because we’ve probably trained the patients to partly expect the pharmacists to be unavailable during that 20 minutes or so. [...] I think when I first took on the superintendency ten or eleven years ago we’d gone past the stage of when we acquired a business, if it happened to close at lunchtime we opened it, felt that it needed to be open, I think we’d even got to that stage then of realising that actually we were lucky enough to have a business that’s closed at lunchtime, that’s a benefit because we can get everybody to rest at the same time if you like and you’ve got your maximum staff on at all points when you’re open. [...]So we’re flexible I think around the lunch strategy. But where branches do open we occasionally have a second pharmacist, so that’s not difficult, because they’ll take that time. But we do monitor, it’s part of the area support pharmacist’s job to monitor the daily log in sheet and make sure that pharmacists are taking an appropriate break.” [Employer 4]
Conversely, few pharmacists described any organisational strategies implemented to facilitate the taking of rest breaks. Rather, they more commonly described the many barriers to being able to take adequate breaks (see below). A small number worked in pharmacies which closed for lunch. Otherwise, pharmacists were more likely to describe their personal strategies for ensuring that they took a break during the day including devising their own rest break schedule or leaving the shop for a 15 minute walk.

Many employers also implemented strategies around staffing and skill-mix to help support pharmacists in the face of mounting workplace pressures. In most cases this involved deploying a suitable team of support staff to the pharmacist (dispensers, pharmacy technicians, ACTs) and training them to the appropriate level to facilitate the delegation of, mainly, dispensing (but also some cognitive services) tasks.

“And there’s a point where you’re going to have to look at whether you need second cover or extra checkers, you know, things to take the pressure off the pharmacist from the dispensing side. And that’s when people bring it to us, you know, there’s that sort of...from a business point of view, you’ve got to have a look at the financial implications of the second pharmacist or second cover, you know. And when you’re getting to that point, that’s the tipping point really, and we do have to make decisions, you know. And so yeah, that’s a tension between the pharmacist, and also, the financial side. But we’d always help the pharmacist. You know, if any pharmacist says that they were stressed in any way, we would look at that and act on it, you know, straightaway.” [Employer 1]

As this employer also suggests, in a smaller number of cases organisations also stated that they would consider deploying a second pharmacist to help manage the workload. A third, related, strategy implemented by some organisations was to employ store managers in the pharmacy to allow pharmacists to relinquish some of their business management responsibilities.

Again, the pharmacists we spoke to rarely mentioned any existing staffing and skill-mix strategies for preventing or managing work stress.

A number of employers and one independent pharmacy owner stressed the importance of improving the physical working environment of community pharmacies to prevent workplace stress. In particular, a number of instances of ergonomic developments were described to improve work flow, minimise interruptions to pharmacists’ work and/or provide adequate surrounding-s for patient counselling.

“We’ve done things like refit branches because we’ve seen that the pharmacists where they were standing were getting interruptions by customers. That was causing them to stress and they couldn’t work effectively. So we’ve actually re-fitted the pharmacies - quite a substantial refit. And moved the checking area away from interruptions from the customers.” [Employer 11]

“When we actually designed the pharmacy, we designed it so that the layout would reduce stress a certain amount, even down to the simple thing of, as I’m looking around, to the surface of the workbench. For example, the shop fitters offered us a certain type of finish and they said well you’ll find that if you actually try to write or overwrite, as I say, on a
prescription or something on that surface, it's actually - it's not clear. It can be slightly roughened. So I specified that they have a shiny, flat work surface so that isn't a problem. The general layout, the size of the dispensary so things can be accessed and picked off quite easily. That certainly reduces stress. Working in a tight space, so first of all the design of the place I think we put something into.” [Pharmacist 6]

In addition, efforts had been made by employers to improve the comfort of the working environment through better lighting and air conditioning. Moreover, many employers had also made improvements to IT and equipment, including upgrading computer equipment, introducing robotic dispensing, and service improvements such as repeat prescription services and prescription collection services, all in an effort to manage workloads and working conditions for pharmacists.

Improvements in ergonomics and work systems were also mentioned by a number of pharmacists although to a lesser extent than employers. However, whilst these interviewees recognised these as attempts to prevent workplace stress, they were sometimes seen as having the opposite effect.

“One of the things we do now is we collect loads and loads of prescriptions and we’ve got them in hand and the people aren’t coming back for a week, and in the olden days you picked up prescriptions, you did them all, and then they were just sat waiting, and when I go to a place where they pick up like 100 prescriptions from the surgery I’m looking at this pile thinking oh my god, we’ve not done all those yet, and you’ve always got this feeling of you’ve never finished, whereas you used to have a feeling of going home and thinking I’ve done everything and I’ve done a good day’s work.” [Pharmacist 7]

4.5.3 Opportunities for further development of stress prevention and management practice

Interviewees from each category—employers, pharmacists and stakeholder organisations—were asked which additional interventions or strategies community pharmacy organisations could or should implement to prevent or manage workplace stress. In contrast to the discussions about existing strategies, however, employers made far fewer suggestions overall for further developments in this area than pharmacists. This was unsurprising given the dissonance described above between the number of current strategies described by employers and those about which the pharmacists we spoke to were aware.

4.5.3.1 Strategies with a focus on the individual

Table 4.3 (above) summarises the interview findings in relation to strategies in stress management and prevention with a focus on the individual with the potential to be adopted in the future (‘possible’) in community pharmacies, according to the employers (E), pharmacists (P) and stakeholders (S) interviewed. For pharmacists and stakeholder organisations, this category of stress management intervention was mention less frequently than the others in relation to strategies that could or should be implemented by community pharmacy organisations. For the employers, however, it was mentioned more frequently.

For pharmacists, the types of intervention most commonly suggested in this category related to counselling services (counselling, CBT and/or a helpline for those suffering from workplace stress). This was closely followed by stress management training. Other individual strategies mentioned by
only one or two pharmacists included return-to-work schemes, and opportunities for exercise and relaxation.

For employers, encouraging exercise amongst pharmacists, e.g. through providing gym membership, was most commonly mentioned as a possibility here, closely followed by CBT and/or counselling services and stress management training.

Interviewees from stakeholder organisations rarely suggested individual approaches to stress management although assertiveness training for pharmacists was one suggestion made that didn’t get a mention elsewhere.

4.5.3.2 Strategies focused on the individual-organisational interface

Table 4.4 (above) summarises the interview findings in relation to strategies in stress management and prevention with a focus on the individual-organisational interface with the potential to be adopted in the future (‘possible’) in community pharmacies, according to the employers (E), pharmacists (P) and stakeholders (S) interviewed. The interventions in this category most commonly cited by pharmacists as a possible means to manage or prevent workplace stress included appraisals, time management training, management training, improving communication and increasing pharmacists’ autonomy.

Whilst most of the community pharmacy employers we spoke to already operated systems of appraisal for their pharmacists, some of the pharmacists we spoke to, particularly those working for smaller chains and independents or locum pharmacists, did not benefit from such schemes. Some of these could envisage that regular appraisals might be beneficial in managing or preventing workplace stress. Others, who did already have regular appraisals, perceived either that more frequent appraisals would be beneficial for highlighting concerns about workplace stress or else that current appraisal systems did not leave room for such discussions, focusing primarily on business performance targets.

Time management training, and management training more generally, was also cited by a number of pharmacists as something that could potentially be useful for managing or preventing stress in community pharmacy.

“Time management training, I think, in pharmacy is a big…there’s a need for that. And sometimes I think time’s just wasted on … prioritising is a problem, so I think that should … Because I think if you’re able to prioritise, you wouldn’t get rid of the stress but at least you will … because sometimes I see pharmacists on the phone trying to order a product, when they could have asked the dispenser to do it. I’m thinking well, really you don’t have to…you could write it down for the person if they’re going to struggle with it or whatever, but some things we don’t … we should be able to delegate necessarily.” [Pharmacist 8]

Management training was also a possible strategy mentioned by a number of employers and stakeholder organisation representatives. However, stakeholders in particular also mentioned the need for training middle managers in recognising and managing stress in their employees.

Whilst employers had few other suggestions for future strategies in this area, stakeholder organisation representatives made a number of other suggestions including: increasing pharmacists’
autonomy, training in conflict resolution for pharmacists, and improving co-worker support, role clarity and, again, delegation.

“It is the hardest job I’ve ever come across to use time management strategies in. Delegation strategies are better to be used rather than time management [...] so there is no need for a pharmacist to answer the phone, and whoever answers the phone when the patient says, “Can I speak to the pharmacist?” they can qualify what it’s about and see if anybody else can deal with it. So you can delegate this to the staff, these sorts of functions and roles, but it takes a bit of time, it takes thinking and they’ve got to be capable.” [Stakeholder 3]

4.5.3.3 Strategies with a focus on the organisation

Table 4.5 (above) summarises the interview findings in relation to strategies in stress management and prevention with a focus on the organisation with the potential to be adopted in the future (‘possible’) in community pharmacies, according to the employers (E), pharmacists (P) and stakeholders (S) interviewed. Whilst employers had very little to suggest in this category, pharmacists and stakeholder organisation representatives mentioned a number of organisational strategies that they perceived might be beneficial in preventing or managing stress in community pharmacy.

Unlike the employers we interviewed many of whom cited their organisational culture as supportive to pharmacists and conducive to preventing workplace stress, many pharmacists believed that changes to existing organisational cultures were still necessary to help prevent or manage stress for pharmacists. Reflecting earlier descriptions of the causes of workplace stress, some pharmacists perceived that there needed to be a shift away from a profit-focussed culture towards a patient-focussed culture which took more account of the professional (as opposed to the business) aspects of a pharmacist’s role. A small number of suggestions were made as to how this could be achieved, including non-pharmacist middle and senior managers spending more time in store to gain a better understanding of what pharmacists do, and reducing the emphasis on meeting targets (or reducing the targets themselves).

“Not having such a big workload and maybe not so much pressure on you must do X, Y, Z. Or maybe that they say right, this week the focus is MURs, push for MURs, and this week it’s such and such, rather than no, we expect you to do all that plus blah, blah, blah, and that’s all your standard job. Because I think the worry is that in ten, five years time it’s not just going to be two MURs, it’s going to be twelve, and then it’s going to be twelve hundred items, and it’s just going to keep going up and up and up, and there’s going to be nobody saying well actually enough’s enough, nobody can do this. So that’s what I think would help me.” [Pharmacist 7]

A number of stakeholder organisation representatives concurred, suggesting that community pharmacies should learn lessons from the aviation industry where companies prioritise safety above profit, supporting and encouraging employees to report unsafe practise, and that pharmacies should foster a “culture of concern”, engaging staff in reaching organisational goals as opposed to the “organisational bullying” perceived to be endemic in some organisations.

The facilitation of rest breaks was another organisational strategy commonly mentioned by pharmacists as something still needing to be implemented for the prevention or management of
work stress in community pharmacy. Whilst many employers had stated (above) that they encouraged breaks, pharmacists perceived that the barriers to taking breaks (described below) were such that, unless structurally facilitated, they were unlikely to be taken. Suggestions given for how this might be achieved included paying pharmacists though rest breaks, providing somewhere to take breaks away from the dispensary (or allowing pharmacists to leave the premises), scheduling specific times for rest breaks and advertising these to staff and customers alike, closing the dispensary or pharmacy during breaks, and providing pharmacist cover.

“So the other thing that the company won’t commit to, and I know it’s for financial reasons, is to specify definitely what they would class as a break, they always say they encourage you to take a break but they leave the onus on you, so if you make a dispensing error and say, “It’s because I’ve not had a break,” they’ll say, “Yes but we encourage you to have a break.” [...] So there’s nothing that is, they won’t commit to saying, you know, “After you’ve had four hours of work, have ten to fifteen …” they don’t even specify a period of time, “... have ten to fifteen minutes, make sure it’s outside of the dispensary.”” [Pharmacist 11]

Similarly, some of the stakeholder organisation representatives strongly believed that implementing an effective rest break strategy was essential for preventing workplace stress having a negative impact upon patient safety. Similar to the suggestions made by pharmacists, these interviewees maintained that by training support staff and educating customers, including rest breaks in pharmacists contracts of employment, encouragement to take breaks off the premises, closure over lunch or pharmacist cover, effective rest breaks for pharmacist could be facilitated.

“So I think one of the key things that can happen there is the training of the support staff around the pharmacist to enable that sensible taking of a break. And I think having a sign up in the pharmacy which explains what the delay is on prescriptions saying that the pharmacist is temporarily unavailable, the prescription waiting time is now 15 minutes instead of five, if that’s explained well then I think that’s not a problem. And in reality, no matter what some pharmacy organisations say, I do not think that local PCTs would threaten to withdraw the contract if that were the case.” [Stakeholder 1]

Whereas employers emphasised the deployment of support staff and encouraging delegation of duties by pharmacists in existing strategies for managing workloads and preventing work stress, pharmacists were more likely to suggest that a second pharmacist was required, particularly to enable both core dispensing and extended services, such as MURs, to be provided by the pharmacy.

“I think it’s that they need more pharmacists. I feel that the amount of things they want us to do, that it would be so much easier with two of us. And at one time there would have been two of us, but they’ve cut it back now where they’re trying to get just...for the hours that a shop is open there will be only be one pharmacist ever in the dispensary, unless you go over that threshold, and then you get one extra day” [Pharmacist 14]

“There should have been some funding for it somewhere along the line; because there hangs the difference between having a good service and a high quality one. You’re having more people to deliver the service and give better quality of information and care. We haven’t got the funding for that, have we, that’s the problem.” [Pharmacist 16]
In addition to managing the workload and enhancing the quality and safety of service provision, pharmacists perceived that having a second pharmacist would also facilitate other stress management strategies, such as providing cover for rest breaks, and opportunities for relaxation, counselling or training.

Some pharmacists and stakeholders perceived that more could still be done to improve the physical working conditions and ergonomics of community pharmacies as a way of preventing workplace stress. In particular, having more space to create better workflow in the dispensary, situating checking areas away from counter areas to avoid interruptions, better lighting, less noise and increased cleanliness were all mentioned.

“As a pharmacist I would feel much more comfortable, especially where a prescription is larger than three items, to check it where I am not surrounded by customers and that feeling of pressure because the person you’re checking it for is stood there pointing things out, asking you what you’re checking in the middle of checking. And, you know, saying “I’m in a rush, I’m in a rush can you hurry up” so just changing that because they don’t actually allow us to do that, they want you to check everything on the front.” [Pharmacist 11]

In addition, improvements in technology and IT for pharmacies were seen as a way of reducing stress and increasing patient safety.

“I think there are investments that could be made, and investment is a challenging word at the moment in the financial climate we’re in, but we don’t optimise IT as much as we could, and the actual systems that are available don’t necessarily optimise it either. And so if you’re using a challenging or poor quality IT system to manage the dispensing process, then that adds to inefficiencies and inefficiencies add to stress. So if we got better systems in place, IT systems, then that will help.” [Stakeholder 4]

4.5.4 Strategies in stress management and prevention less likely to be adopted by community pharmacy organisations

Tables 4.3 to 4.5 (above) also summarise the interview findings in relation to strategies in stress management and prevention unlikely to be adopted by community pharmacies, according to the employers (E), pharmacists (P) and stakeholders (S) interviewed. Few stress management and prevention strategies were pinpointed by interviewees as being non-transferrable to a community pharmacy setting. However, there was more scepticism voiced against strategies focussed on the individual than any other category of intervention, primarily (although not exclusively) from employers, and most commonly mentioning exercise and/or relaxation/meditation approaches.

“Exercise, again, I mean, I don’t think...I think, you know, the pharmacists are pretty well aware of what to do to help yourself. But it’s not...you know, it might come up in a conversation, but it’s not something that we’d actually say go off and do that. And the same with relaxation and meditation, you know. You can give people advice...I mean, I’m sure within the counselling session, they mention these things anyway, you know, but it’s not an active thing we would look at.” [Employer 1]

A small number of employers also raised doubts over the applicability to their organisation of CBT (individual), increasing autonomy and improving role clarity (individual-organisational), and culture
change, ergonomics and technological (organisational) strategies. A small number of pharmacists perceived that their organisations would be highly unlikely to implement strategies to increase participation (individual-organisational), improve the physical working environment or facilitate rest breaks (organisational strategies).

4.5.5 Barriers to implementing stress management and prevention strategies in community pharmacy

A number of barriers to implementing different strategies in stress prevention and management, and to the success of those strategies implemented, were raised by interviewees. These could generally be categorised as barriers pertaining to the pharmacist, organisational barriers and external barriers.

4.5.5.1 Pharmacist-related barriers

Most employers and a small number of pharmacists and stakeholder representatives mentioned the difficulties that some pharmacists had in delegating duties to pharmacy support staff (technicians, ACTS, etc.) as a key barrier to the success of existing strategies to prevent workplace stress. Often this was put down to a lack of trust in the ability of support staff or an inherent difficulty some pharmacists had in relinquishing responsibilities to others. Also mentioned were the lack of management training received by pharmacists at university, the responsible pharmacist regulations leaving the pharmacist responsible for any errors made by those delegated to, insufficient numbers of adequately trained support staff to delegate to, resistance to change, and pharmacists sometimes feeling threatened by the increasing professionalisation of pharmacy technicians.

“We do use ACTs in our business and in certain settings they’re an absolute godsend. But some pharmacists, because they have this idea that they’re accountable for everything, and in law they are – it doesn’t mean they have to do everything though – but they’re unwilling to trust ACTs.” [Employer 8]

Similarly, some employers felt that pharmacists were resistant to following guidelines or procedures which had been designed to help manage workloads and prevent stress.

A second pharmacist-related barrier commonly mentioned by pharmacists, stakeholder organisation representatives and employers alike was that pharmacists often didn’t come forward with problems relating to workplace stress or take advantage of the support available to them. This could be for a number of reasons but the most often mentioned was the stigma associated with stress, that pharmacists thought it could be seen as a sign of weakness or failure and perceived that it could put their job or career at risk.

“There’s so many people unhappy about things but they don’t know where to go. And also, they don’t want to be scapegoated because then if you’re the only one, you won’t get locum work because you’ve complained, you know, so you’re a troublemaker.” [Pharmacist 8]

It was also suggested that pharmacists didn’t always recognise that they had a problem in the first place or, if they did, chose not to use the support services available either because they did not believe they would help or else because of time pressures.
4.5.5.2 Organisational barriers

The most commonly mentioned organisational barrier to implementing stress prevention or management strategies was financial. From the perspective of many employee pharmacists, community pharmacy organisations’ prioritisation of profit over people made them reluctant to invest in stress management strategies, even if it had the potential to save money in the long term.

“I’m not too sure how it could be to be honest with you, because I think basically when you’ve got a managing director sitting there then I don’t think they’re really bothered about people down at the grassroots level to be brutally honest. I think that they’re just looking at graphs on a sheet and numbers on a bit of paper. So whether the pharmacists are stressed or not I don’t think they really care, they just want to see the right numbers basically.” [Pharmacist 12]

Employers, however, highlighted the fact that profit margins within community pharmacy had been eroded over recent years, with changes to the general pharmaceutical services contract and the global recession, leaving little left to invest in such measures.

“But if you keep paring back the profit, and paring back the profit and paring down the profit, where is the profit? I mean, I know that’s what the Department of Health will say, “Well, they’re all making big profits, let them just invest the bloody profits.” We just aren’t any longer. [...] So the cultural things and so on, yes, I think they can be addressed, but if there’s a fundamental lack of resource, what do you do about that? And that’s the elephant in the room for me in all of this. [...] You know, I think we’re having a pretty good go at this but, you know, when I look at the resources available, I’m having to say no to people now. Whereas previously, I could always say yes, because it was more important to keep people happy. Now, I have to say look, you know, if you want that resource, you know, where’s it going to come from? There isn’t any spare now.” [Employer 2]

Financial pressures were perceived to be obstructing developments in stress management and prevention in a number of ways, for example by leading to cuts in staffing (or staffing levels not keeping abreast with increases in workload), pharmacists not being paid for (and therefore being reluctant to take) rest breaks, preventing the deployment of second pharmacists to provide cover for rest breaks or training or to share the workload, and a lack of investment in the physical environment or technology within the pharmacy.

The extant culture within community pharmacy organisations was also often cited as preventing developments in this area. This was not only around the ‘quest for profit above all else’ focus perceived by many pharmacists and already described, but also a shared understanding that pharmacy had become a high workload, high stress occupation with expectations that pharmacists would work long hours with no breaks, always putting the patient first.

“But I think it’s difficult to see how things can change really, because I think it’s the nature of the beast really. And you do tend to speak to a lot of people who feel the same, that because of the job it’s just intrinsically stressful” [Pharmacist 12]

“But I’m certainly far from happy with it, because I think we’re just making impossible and unreasonable demands on pharmacists and pharmacy teams. It’s become environmental
and endemic, it’s almost...you know, we’ve almost got used to the level of stress, we don’t even notice it anymore. ” [Employer 2]

The increasing size of community pharmacy organisations was also implicated as a barrier to the successful implementation of stress management strategies and this was linked both to the culture of larger organisations and the key role of middle managers in the (mis-)translation of stress management policies from senior managers to the front line and the influence of whether or not they were pharmacists themselves.

“So for an organisation with 2,000 something pharmacies or 1,600 pharmacies their...I know the people at the top. As a superintendent I meet with them at the society, they’re good people, they’ve generally got pharmacy at heart, they’re finding a tough battle in a boardroom for a shareholder organisation that wants results. It’s not for what they do necessarily at the leadership level, it’s how that culture can be spread right down to the shop level, isn’t it? And I think their biggest mistake is not employing pharmacists in the middle management positions. That’s one thing I would change, and I would never work for a pharmacy organisation that didn’t have pharmacists as area managers. Because I could not see myself seeing eye-to-eye with people who didn’t really understand the needs of the professional.” [Employer 4]

Larger organisations were seen as less likely to be able to offer autonomy to pharmacists and made it harder to implement effective communication strategies. They were also perceived as being more targets-focussed. Two employers whose pharmacy chains had grown over recent years both recognised that this had changed the culture of their organisations making it more difficult to manage the well-being of their pharmacists. Similarly, pharmacists with experience of working in both smaller and larger pharmacy chains could identify differences in these aspects of the working environment.

“Because it’s such a big company you do feel like you work for an absolutely massive company that you don’t really count because it’s so big. Whereas I know that when I worked for [name of pharmacy], that was quite a small multiple, and I quite like having contact with managers because I feel like they care about you then, and there was more opportunity to see somebody from, not necessarily head office, but somebody that was there if you just had a quick query to just talk about face-to-face rather than having to email somebody that you don’t know or ring somebody up that you don’t know. Because you know this problem that I was talking to you about, I’m thinking of contacting this guy that I don’t even know if I’m supposed to speak to him personally. I think I’m supposed to go through my line manager. Because being such a big company you end up thinking shall I bother, is he too important for me to talk to.” [Pharmacist 7]

Conversely, it was perceived by some smaller organisations that they lacked the infrastructure and resources to be able to offer many of the support services available to the larger multiples.

Finally, a number of pharmacists and stakeholder organisation representatives believed that there was little recognition amongst community pharmacy employers that stress was a problem. Sometimes it was perceived that when stress-related problems were raised with managers, they were not taken seriously. Others felt that senior managers were completely unaware of the
problem, either because they were ‘in denial’ or else because pharmacists weren’t raising it as a problem and the organisations were not making any endeavours to find out, for example through staff surveys.

Q: Do you think at head office level there’s a reluctance to tackle stress in community pharmacy?

A: I don’t mean this to sound as callous as it does, but are they even aware of it? Because if we’re not telling them how are they going to know? So I don't think it's maybe a reluctance, I think it might be complete ignorance. [Pharmacist 13]

4.5.5.3 External barriers

External barriers to managing or preventing stress in community pharmacy were also identified by interviewees. The most common of these was the regulatory and contractual framework – in particular the responsible pharmacist legislation – which, together with patient expectations, predicated the presence of the pharmacist at all times. This particularly affected pharmacists’ ability to take a rest break but also made attending stress management activities such as training or counselling sessions difficult without pharmacist cover.

“But you have to stay in the premises, if you’re leaving the premises, clearly, if you’re leaving, you’re not the responsible pharmacist and if you haven’t got a responsible pharmacist, the branch has to close, therefore, if you’re closed, we wouldn’t pay people to be in the pharmacies while we’re closed.” [Employer 6]

“I think the main problem is it’s linked in with the job itself. I think you have a lot of expectations from everybody, the public, other health professionals, that you’re going to be there all the time. So if a patient comes in with a prescription and somebody says to them, ‘oh, the pharmacist’s on their break,’ they sometimes get quite upset about it, because they expect you to be there all of the time.” [Pharmacist 12]

Cuts to the community pharmacy contract and the current financial climate were also cited as adding to the financial constraints to implementing stress management or prevention strategies, as described above.

“What I’ve heard is a lot of independents are closing or being sold because of clawbacks by the NHS; the remuneration alteration by the NHS. So I suppose if...yes, I can only think that that’s, if for example, more regulation regarding numbers of staff, then presumably businesses would, you know, it would be more expense for them, and if the NHS is paying less, remunerating less and less, then I suppose it’s numbers, isn’t it really? [Pharmacist 15]

“The challenge in the current economic environment is finding the money to fund that, both in terms of numbers of people and the training costs associated with that, and giving them the time, protected time, to conduct that training so that their capability is up.” [Stakeholder 4]

An additional barrier to the implementation of stress management strategies by community pharmacies occasionally mentioned was the perceived oversupply of newly qualified pharmacists making it easier for employers to replace anyone seen to be struggling with their workload.
“I almost get the impression that in a sense, that the schools of pharmacy have added to that problem, and will add to that problem, because the numbers coming out now will mean that there will be a continual replenishment.” [Pharmacist 10]

4.5.6 Facilitators for implementing stress management and prevention strategies in community pharmacy

Interviewees were also asked about what they thought might help to facilitate developments on stress management and prevention within community pharmacy organisations.

4.5.6.1 Evidence

One of the most commonly cited facilitators was the availability of evidence: evidence of the scale of the problem; evidence of the costs to organisations of, for example, stress-related sickness absence; evidence of the risk to patients; evidence of what works; and evidence of the potential cost savings from investing in stress management.

For some employers, whilst they may have been aware that stress could be a problem for pharmacists, they did not have the evidence that stress was a problem in their own organisation nor that it was a major cause of sickness absence in the community pharmacy sector. They remained to be convinced by the business case for managing or preventing stress generally. A number of pharmacists suggested that employers should conduct regular staff surveys or 'stress audits' to assess the scale of the problem. Other suggestions from stakeholder organisation representatives to raise awareness of the scale of the problem amongst employers were the dissemination of research findings demonstrating the extent and causes of workplace stress amongst community pharmacists and also case studies illustrating the impact of workplace stress on individual pharmacists.

“Well, I think maybe if you put something along the lines of that people aren’t being honest and they’re actually off because they’re stressed. And I don’t know how you’d word that. Maybe if somebody could do like an anonymous questionnaire and have one of the questions being something like have you ever said you were ill because of such and such and it was actually because of stress, because then it would maybe make the company a bit more aware that it is actually a problem.” [Pharmacist 7]

Many pharmacists and stakeholder organisation representatives perceived that community pharmacies would only act to prevent or manage workplace stress if they had robust evidence of sector-specific organisational costs of stress-related absence.

“Because everything seems to be so financially-driven, I think by hammering it home about this is how much it is costing you as a business, or you as an employer, is definitely probably one of the better business cases. The legal and ethical considerations, then most big companies, they know that, they get hauled over the coals if they step out of line or they don’t show duty of care and things like that. But a lot of them could easily argue and say, ‘Well, we didn’t know there was a problem, we thought it was just upset stomachs,’ that’s all they kept reporting back to us, till somebody goes completely, like, flips. Financially, I would say, is probably the strongest business case, the financial aspect.” [Pharmacist 1]

Some believed that evidence of the link between pharmacists’ stress and dispensing errors and the increasing risk to patient safety would help to convince pharmacies to address workplace stress in
their organisations. Others, however, thought that it would take experience of a patient being harmed and the potential threat to an organisation’s reputation before pharmacies would act.

“It sounds awful but the only time when they really do sit up and take notice is when something goes wrong. On one occasion, and this was a pharmacist that came in to cover a day off and they said “it’s very busy in here this is a dangerous working environment and I need a second pharmacist” and he was told “Well the pharmacist that works there every other day manages and you’re a locum and you’re being lazy, so you should manage.” And then a dispensing error happened which involved methadone controlled drug and the area manager came in straight away. So it seems as though when something goes catastrophically wrong then maybe there’s more of a willingness to address the issues, which it shouldn’t be like that but…” [Pharmacist 11]

Others suggested that strong evidence of ‘what works’ in community pharmacy and the potential for cost savings from investing in such initiatives were what was required.

“I think some clarity around what the return on that investment is. I mean it’s fine talking about, ‘In an ideal world we would do this, this, and this’, whether it’s in IT, whether it’s in premises, whether it’s in the additional interventions that might support reducing stress in the individual pharmacist employee, we need to know what works, how you can apply it effectively, and cost effectively. So some evidence, some case studies and some robust research that says, ‘Do this, get that’. ” [Stakeholder 4]

4.5.6.2 Engaging staff and managers

Interviewees also stressed the importance of engaging all levels of staff within community pharmacy organisations: senior managers/directors/owners in to help facilitate the initiation of stress management strategies; buy-in from middle managers to ensure the successful implementation of such initiatives; and the engagement of pharmacists to actually participate in stress management schemes.

“My point is, unless the key stakeholders are engaged, then the message won't have landed. By producing a paper or producing something in the PJ, doesn't make it so, does it? The owners of companies. The people who hold the purse strings, I would say. They’re the people that you have to try and persuade, for example, when you’re talking about your training budget. So it’s not just sufficient to be talking to the registered professionals, I don't think, because they’re already there really. And we fight ... not a losing battle, but we fight a battle for investment, like everybody else. [...] I don’t think it's the superintendent's role. I mean, obviously I’m aware of it because I see probably more about the practice reality than many in the organisation. But I don't think it’s necessarily solely a superintendent’s responsibility. You know, thinking about our own organisation, I think the operations line has a huge responsibility there, right from our directors of regions through area managers, cluster managers, operations director. So I think the message really needs to go right to the top really, and throughout.” [Employer 8]
4.5.6.3 Facilitating rest breaks

A number of operational suggestions were also made for the facilitation of stress management strategies that of necessity involved the temporary absence of the pharmacist, for example rest breaks or training. The availability of a second pharmacist is one which had already been mentioned above but which has significant cost implications for the company. However, another suggestion which may be more attractive to community pharmacies was around managing the expectations of customers by, for example, advertising times when the pharmacist would not be available. This strategy had already been used by some pharmacies with some success.

“Advertising a break that, you know, maybe all Sainsbury’s pharmacies or all Lloyds or whatever, are always closed from 12 to 12.30. I know some independents do that. But if you’re not closed but you just put a sign up that the pharmacist is on their break, that irritates people. It’s not advertised on the doors or anywhere, they come in and then you say, oh. [...] So a bit of consistency and advertising the breaks. Maybe in a particular PCT decide if Lloyds or whatever, they break from 12 ‘til 12.30, another one does, I don’t know, 12.30 ‘til one.” [Pharmacist 8]

4.5.6.4 External levers for change

Additionally, some interviewees pointed out the role of external levers for change in this area including the role of the Royal Pharmaceutical Society, additional funding through the pharmacy contract, ring-fenced funding specifically for investing in stress management strategies, and regulation or legislation around, for example, rest breaks or safe workload parameters.

“I think there should be some more rules about time work and proper breaks. For example, the Australian rule about how many prescriptions you can dispense, so that there is less pressure and you are thinking about what you’re doing and not just automatically doing it.” [Pharmacist 2]

Employers were also keen to stress the role of universities in providing training in management skills to undergraduate pharmacists.

4.6 Best practice in stress management and prevention

If there was time towards the end of the interview, Interviewees were asked about the extent to which their own organisation (or community pharmacies more generally) took an approach to stress management and prevention that met each of the criteria identified from the literature review and presented in Chapter 3 of this report. Six employers, three stakeholders and four pharmacists provided data here.

4.6.1 Sustained top management support

Some examples of sustained top level management support were given by both pharmacists and employer representatives. For example, in one large multiple the managing director, himself a pharmacist, was described as good at engaging with employees by one pharmacist and supportive of stress management initiatives by the superintendent.
“I think we’ve got a lot of top level management support, so I think we’ve got good working relations across the superintendent and the operations team. Partly because I think we’re all pharmacists, we’ve all worked in community pharmacy and we all know exactly what it’s like. So I think there is a recognition within that that stress can happen and we need to support and manage that within the pharmacies.” [Employer 11]

In one of the supermarket chains, after a company merger, the chief executive and his board were credited with turning around the organisational culture to one that was far more supportive of its employees.

“The business, over the last five years, has made incredible changes to its organisational culture, from one which was very authoritarian and demanding, to one that is now much more supportive, still demanding, of course, because that’s what business is about, but very much more supportive. And, you know, much more focused on the individual rather than the result. [...] And that...to be honest, that is down to the senior executive, that is down to the chief executive and his Board. And, you know, in effect, it’s around what they do and how they do it. So there’s been lots more focus, for instance, on what we call a climate survey, you know, where all 120,000 employees are invited to share their views about the business, you know, and what makes a difference to them, and so on and so forth. Five years ago, we would never have done that; never have done that. You know, much more focus on communicating with people, much more focus on caring about people. You know, recently changed a whole pile of policies on maternity and paternity leave, on bereavement leave, on, you know, all sorts of things that were clearly causing difficulty and frustration to people out in the shops.” [Employer 10]

In other organisations, however, top level management was seen as a potential barrier to making progress with managing or preventing stress amongst pharmacists. Particular difficulties were expressed around the nature of national and multinational corporate ownership of some pharmacies where investment in things such as stress management required a strong business case to be made to a board of directors who may be quite remote from issues affecting frontline pharmacists.

“The benefit, the financial benefit, they would need to see. And it’s very hard putting a financial benefit, I think, on employee happiness, if you see what I mean. [...] It’s something that hasn’t existed in the past [...] I think people in senior roles in companies have to truly believe that’s part of the ethos that they wish to follow. And I think [name of large multiple], as it is today, has lost some of that way. And I think [names of two supermarket chains], I don’t think have had it there in the first place. So, if you haven’t had it, it’s quite difficult to implement it and see the benefit. Because it’s not something that gives you instant return.” [Pharmacist 10]

In other instances, whilst it was perceived that top level management support was there and part of the culture of the organisation, this did not always filter down through the organisation (see ‘buy-in from middle management’ below).

4.6.2 Context specific

To implement context-specific stress management and prevention strategies usually requires organisations to undertake a tailored risk assessment or “stress audit”. Staff surveys were only
conducted in a minority of the community pharmacy organisations involved in this scoping study. In a small number of cases, surveys were undertaken and were perceived to have led to some positive changes in working conditions.

“I don’t think they do stress particularly, but they do have an employee satisfaction that they do once a year, so stress is linked in with that. And I know that based on it they do sometimes make changes to things to make life a little bit easier. Well, I think when people make suggestions, say paperwork’s been doubled up in some area for instance, then they’ll look at how they can change that to make life easier in the pharmacy. So I think they are quite willing to take on suggestions and look at the results of the survey, and actually act on them.” [Pharmacist 12]

However in one large multiple, although regular staff surveys were conducted, questions were perceived by pharmacists as being leading and strong encouragement was given to submit positive responses. The findings were not thought to be a true reflection of pharmacists’ views of the organisation as a whole.

“They do this survey once a year by this external company. But on that we’re told to give [name of large multiple] a positive...we’re told what to write in it, so it’s not really coming from what you actually think. [...] You’re encouraged to...your boss sends you an email saying you need to be writing all good things basically, so I just thought, well, what’s the point in doing it when it’s not actually wanting proper feedback? [...] But the first thing I had to do is say who my boss was and then all the questions seemed to be about the boss, not about the organisation or things what was going...there was no question like, “Do you feel under stress?” or “Have you got too much to do in your job?” or “Do you feel that [name of large multiple] always does the right things?”, “Do you think that we listen to you?” [...] I thought it was quite a manipulative survey which was going to end up that everybody says, “Yes, it’s a great place to work.”” [Pharmacist 7]

In another large multiple, where an annual staff survey was conducted which included questions about stress and workload, the findings suggested that, “stress wasn’t particularly a problem” [Employer 8].

4.6.3 Combined individual and organisational interventions

None of the interviewees reflected specifically on this aspect of the model of best practice. However much of the preceding discussion had been about the range of interventions currently implemented by community pharmacy organisations and these findings are presented in detail above.

4.6.4 Participative approach

There was some support for taking a participative approach to developing a stress management and prevention strategy within community pharmacy organisations and some examples given of how this was being achieved. The staff surveys already mentioned were cited as one way of garnering pharmacists views about aspects of the working environment that required change. Some organisations also tried to engage pharmacists through staff conferences and or recruiting working groups of employee pharmacists to help to develop SOPs, for example. One stakeholder organisation
also mentioned the role of appraisals in one community pharmacy to gather feedback on the working environment.

However, many were also cautious about the extent to which a participative approach was practicable. One pharmacist thought that involving pharmacists too soon in the process could be counter-productive, adding to existing stress levels. Some employers and stakeholders felt that a balance had to be struck between meeting the needs of the organisation and the needs of the individual, and that too much emphasis on a bottom up approach could inhibit progress.

“What we need to do is make sure that people understand the context in which organisations have to operate to be sustainable otherwise they won’t have a job. And balancing that with the motivations, the personal motivations of the individual, and aligning those two things so that organisational requirements measures against that personal agenda, and getting that aligned is absolutely critical, otherwise it’s just not going to work.” [Stakeholder 4]

Others perceived that there was “strong resistance” from some of the larger organisations to taking a participative approach.

“I think that’s quite a crucial one, this idea of a participative approach. And then you think about the issue of standard operating procedures in approach to that. There is very strong resistance from larger employers for a participative approach in developing the standard operating procedures, despite the evidence that a participative approach makes them better or accepted. And this is the central issue, I’m a large organisation, I’m the superintendent, how the hell am I going to make sure all of my shops do the same thing? I’m going to write an SOP, bosh, and anyone who doesn’t follow it gets whipped. And that’s a natural reaction. It’s a command economy.” [Stakeholder 1]

4.6.5 Buy-in from middle management

Middle managers (store managers, area managers and regional managers) were perceived as crucial to implementing successful stress management and prevention strategies. More often than not, they were viewed by employers, pharmacists and stakeholder organisation representatives as a potential source of mis-communication of policies to frontline pharmacists, preventing the translation of a supportive head office culture to the shop floor.

“Middle management is often left flailing; you may have some really good clarity at the top end about what we’re supposed to be doing, and you might have some communication to the bottom – and I don’t mean that in a negative way, but to the workforce at the coalface, you might have some communication that goes down and says, ‘This is what our culture is, this is what our values are, this is the way we want to work, this is what we’re trying to achieve’, but actually if the middle management don’t consistently apply that and practice that, then that’s where it usually fails, in my observations. So I think that’s probably one of the critical ones.” [Stakeholder 4]

It was recognised that this was dependent upon the individual and that not all middle managers obstructed developments but a number of contributory factors were identified to this problem. The fact that many of the larger organisations employed non-pharmacists in middle management positions was thought to inhibit their understanding of the professional role of pharmacists. It was
suggested that non-pharmacists were employed in these roles as they were more likely to have the management skills required by their employers and also because they would be less costly. However, their business orientation and the pressures placed upon them to achieve targets were seen as a cause of the pressures consequently placed on pharmacists to achieve their targets with, for example MURs. Two examples of this miscommunication between head office and pharmacists were provided by one pharmacist in relation to targets for MURs and rest breaks and the implementation of the European Working Time Directive:

“But the middle management ones, they’re all competing against each other to get the best results, to get the most profit; I think that it’s coming from them; and 40 years ago they used to be all pharmacists, but now they’re almost none of them are pharmacists. And they’re probably getting pressure – they’re all getting pressure on them – to do the targets; so it just works its way down. And I think the message does change; the ones at the top will say, ‘Oh, no, you’ve got to do them [MURs] right’, but the ones at the bottom say, ‘You’ve got to do them.’ It’s a bit like that lunchtime thing where the ones at the top are saying, ‘Oh, we must give our pharmacists at least 20 minutes’, but by the time it gets down to the area manager level and the branch manager level, it’s not, ‘At least 20 minutes’, it’s, ‘At most 20 minutes, we must give them the 20-minute break’, and that’s all we will get.” [Pharmacist 14]

4.6.6 Change management

None of the interviewees reflected specifically on this aspect of the model of best practice.

4.6.7 Organisational culture

Many interviewees acknowledged the importance to effective stress management and prevention strategies of having a supportive organisational culture or one that was focussed on the wellbeing of its employees. Some stakeholders and employers purported that this was the espoused view of the senior managers of most community pharmacy organisations.

“But I’m sure if you took all of our companies, and they’re all big companies, some of them global companies, they will have their processes and systems and even their culture, certainly their outward culture would be all about looking after their people.” [Stakeholder 5]

However, it was clear from the findings reported above that many pharmacists perceived that this was far from the case in their experience and that targets-driven cultures prioritising profits over patients and pharmacists were common.

Although, as described above, one supermarket chain had seen a recent positive change in organisational culture following a takeover, others suggested that eliciting such a change in culture was difficult and required strong leadership and engagement throughout all levels of an organisation.

“And then that’s a cultural thing and I think, you know, that cannot change overnight. If a company’s not doing that currently, if it’s a ‘tell and do’ organisation it would find it very difficult to change to being a more participative type organisation, they would take a long time I think.” [Stakeholder 5]
It has been suggested that for any changes to be enduring, stress must be recognised as an important issue in strategy and policy documents. When asked about the existence of a policy on work-related stress, only two employers and one pharmacist interviewed were aware of one within their own organisation. Indeed, for a small number of employers there appeared to be a reluctance to mention stress explicitly in policy documents for fear of pigeon-holing wider concerns.

“I don’t think you can have a policy that, necessarily, says...we have some things about how to raise concerns, what to do if there’s various things there, you know, that happen, but, I think, there’s, also...I think, if you’re going to badge something, there’s a danger that if you badge things, certain things, then, you, actually, put that idea into people’s minds, so, that’s why we’ve called it raising concerns, of which, you might have a concern about some things that might indicate a workplace pressure. I think, actually, it’s about, I want people to flag up a concern about anything, not just about that, that can be just one of a number of things I want to know about.” [Employer 6]
5 Summary and conclusions

5.1 Study strengths and limitations

Drawing on evidence from the organisational literature and a series of in depth interviews, this scoping study has provided evidence to support the development of evidence-based organisational strategies to prevent or manage workplace stress in community pharmacy.

A secondary synthesis of existing reviews of the literature on organisational stress management interventions has not only identified those interventions for which there exists evidence of effectiveness (including cost effectiveness) but it has also produced a model of best practice in stress management and prevention which may be suitable for adoption by community pharmacy organisations seeking to implement strategies in this area.

Semi-structured qualitative interviews with frontline pharmacists and senior representatives of community pharmacy provider and stakeholder organisations have provided evidence of existing awareness of workplace stress in community pharmacy, its perceived causes and the effects on individual pharmacists, community pharmacy organisations and the quality and safety of patient care. Furthermore, these interviews have for the first time produced evidence of the range of stress management and prevention interventions currently implemented by community pharmacies, including any safe workload parameters, and views of which interventions might be suitable for or adaptable to the community pharmacy context.

Whilst generating important new evidence, a small number of methodological limitations should be considered alongside the findings of this scoping study. Firstly, the literature review conducted was not systematic (on the direction of the research funders to limit the resources devoted to this aspect of the study). By electing to draw information about the effectiveness of stress management interventions only from existing reviews, and not from the original published source, the retrieved data were limited to those already extracted by these reviews’ authors and varied greatly in terms of the amount of detail presented. The reviews also varied widely in terms of their scope, coverage and methodologies with the result that the current review cannot necessarily be seen to be inclusive of all interventions. However, given the number of reviews included, a number of which were themselves systematic, and the degree of overlap in terms of the studies identified and reviewed therein, we can be fairly confident that the majority of existing, good quality evaluations of organisational stress management and prevention interventions were covered.

Secondly, the interview findings are derived from qualitative data obtained from a purposive sample of key informants. These findings therefore cannot be seen to be statistically representative of or generalisable to all community pharmacy organisations or pharmacists. Rather, as with most qualitative research, we have sought to identify the range and breadth of existing views and experiences which may be transferable to other pharmacies or pharmacists. In this respect, the findings are again limited by the number and range of pharmacists from whom interviews were obtained. Due to restrictions in the time and resources available to the researchers, together with difficulties in recruiting volunteers, we were not able to secure a large number of interviews from each of the different organisational types that exist in community pharmacy (independents, small/medium chains, multiples, supermarkets). Given the range of experiences of pharmacists...
working for different types of organisation identified by this study, indeed for pharmacists working for different organisations within each type, it is difficult to say with any certainty that data saturation was reached. Nevertheless, as a scoping study, the sample was sufficient to produce findings of sufficient breadth and depth to meet the aims of the study and to identify areas requiring further investigation.

5.2 Helping to build the business case for tackling workplace stress in community pharmacy

In addition to generating findings which address the four key objectives of this study (to identify and synthesise existing evidence for the effectiveness of organisational interventions designed to prevent or manage workplace stress; to identify and appraise current developments in stress prevention and management in UK community pharmacy organisations; to identify any safe parameters of workload being used or proposed by community pharmacy organisations; and to gauge stakeholders’ views of what is needed, and what might be possible, in relation to stress prevention and management in the community pharmacy context), these interviews have also provided further evidence of the causes and effects of workplace stress in community pharmacy and have highlighted a dissonance in the perceptions of pharmacists and employers regarding their awareness of the extent of the problem of stress in the workplace and its impact on pharmacists, community pharmacies and patient safety. These findings therefore provide added value to this study, and will help to build the business case for developing strategies to prevent or manage workplace stress in this sector.

5.2.1 Is stress a problem in community pharmacy?

The findings of this study suggest that pharmacists and employers do not necessarily agree about the extent of the problem of workplace stress in the community pharmacy sector or within their own organisations. The pharmacists we spoke to all recognised stress as a growing problem, whether or not they had personal experience of it, whereas community pharmacy employers were more ambivalent. Whilst some were in agreement with pharmacists and spoke openly about the increasing problem of workplace stress, others suggested that it might be a problem but not in their own organisation and a small number appeared reluctant to label problems associated with increasing workplace pressures as ‘stress’. A commonly held view amongst some employers was that when pharmacists experienced stress it was as much to do with individual personality, performance/competence or personal issues as workplace pressures per se.

A number of reasons for this apparent divergence of views may be possible. Firstly, those pharmacists responding to the request for study participants may have done so on the basis that they perceived that stress was a growing problem in community pharmacy and we may not have captured the views of those who held the opposing view. However, our recent survey has already provided strong evidence for the scale of the problem in community pharmacy, with a statistically representative sample of pharmacists expressing significantly higher levels of workplace stress than a normative sample of NHS employees. These findings lend further support to the existing body of research evidence indicative of the growing problem of workplace stress for community pharmacists. Secondly, employers are somewhat dependent on what they are told by their employees and managers about stress levels within their own organisation. We have provided
evidence here that there is sometimes a reticence by pharmacists to admit to suffering from stress, either through stigma or for fear of losing their jobs, and that the mechanisms do not always exist for such problems to be raised with managers or that managers do not always take them seriously. Where staff attitude surveys are being conducted by community pharmacy organisations, they do not appear to be identifying stress as a problem but there is a perception held by some pharmacists that the tools used are not designed for this purpose, may ask leading questions and are not confidential. Therefore employers may indeed lack any firm evidence of the extent of any stress-related problems being experienced by their own pharmacists. Lastly, it is possible that employers may be reluctant to admit that workplace pressures are adversely affecting their pharmacists as to do so would accept responsibility for any adverse effects on those pharmacists or the service they provide to customers/patients.

Thus, the mounting evidence from this and other studies is strongly indicative of increasing levels of workplace stress in community pharmacy however some employers still require further evidence of the implications of this for their own organisations to help develop the business case for investment in stress prevention and management strategies. The costing tool developed by NICE may be useful here to help employers estimate the cost of mental ill health to their own organisation and the potential cost savings of implementing a strategy for preventing and managing workplace stress. That tool is available online at [http://guidance.nice.org.uk/PH22/CostingTemplate/xls/English](http://guidance.nice.org.uk/PH22/CostingTemplate/xls/English).

### 5.2.2 Sources of workplace stress for community pharmacists

This study has provided further qualitative evidence describing the major sources of workplace stress for community pharmacists:

- **As expected, increasing workloads** (both the increase in dispensing volumes and the additional cognitive services now provided by community pharmacies) was one of the main causes of workplace stress mentioned, although often in the context of **insufficient staffing** levels.
- **Many pharmacists cited long working hours with no opportunities for rest breaks.**
- **The unique position of community pharmacists who offer open access to patients can often lead to constant interruptions** and, less often, leaves them open to abusive or even violent behaviour. The **physical layout** of the pharmacy can often add to the levels of stress experienced in this regard.
- **Management responsibilities**, both for other staff and for aspects of the business, often taken on without adequate prior training, were also a major source of stress for these pharmacists, as was their responsibility for **patient safety**.
- **Interpersonal relationships**, with co-workers and managers, could be key to whether increasing workplace pressures were manageable or constituted a source of stress for pharmacists.
- **The importance of organisational culture** to pharmacists’ experiences of workplace stress manifest itself in a number of ways in these interviews. Cultures perceived to value profit over patient care were sometimes associated with larger community pharmacy organisations which offered little in the way of **participation or autonomy** to pharmacists and employed **non-pharmacist middle managers** who could place excessive **pressure to meet targets** on pharmacists. Conversely, some of the smaller chains were perceived as having a more supportive culture, employed middle managers who were pharmacists and offered more autonomy to pharmacists.
The individual characteristics of pharmacists were seen to be important too, particularly by pharmacy employers, with some pharmacists thriving on workplace pressures and others struggling to cope. A number of interviewees suggested that pharmacists as a group tended to be self-sacrificing and could ‘soak up’ any increases in workplace pressures although there was a feeling that there was a limit to this above which pharmacists’ well-being or patient safety would be compromised.

External factors perceived as important sources of workplace pressures included the current economic recession, changes to contractual remuneration for pharmacies and the regulatory burden placed on pharmacies.

The findings suggest that different groups of pharmacists may be subject to different work stressors to a greater or lesser extent. For example, for employee pharmacists working for the large multiples, pressure to reach targets and stress from a lack of participation in decision making and autonomy within the job appeared to be more problematic. Stress in relation to working patterns (shift work) and from a lack of recognition of the specialist nature of pharmacy by non pharmacist managers was a particular issue for those working in supermarket pharmacies. For independent pharmacy owners, the pressure relating to taking work home and maintaining profit levels was a major source of stress. And locum and relief pharmacists often experienced stress from working in unfamiliar surroundings and poor working relationships with support staff. Other stressors such as burgeoning workloads, difficulties taking rest breaks and demanding patients were common to all groups of pharmacists.

Together with qualitative and quantitative findings from previous studies, these findings not only strengthen the evidence for the organisational causes of workplace stress but also identify a number of potential targets for work stress interventions in community pharmacy.

5.2.3 The impact of workplace stress in community pharmacy

Supportive of the business case for tackling workplace stress in community pharmacy, this study has provided qualitative evidence of its impact upon pharmacists, community pharmacy organisations and the quality and safety of service provision:

- Many pharmacist interviewees had experienced psychological ill health as a result of workplace stress including anxiety, depression, insomnia, irritability, low self esteem and difficulty concentrating.
- A similar number reported having had physical ailments as a result of workplace stress including fatigue, headaches, musculoskeletal problems and gastrointestinal symptoms.
- A widely described effect of workplace stress for pharmacists was the impact on job satisfaction, with many feeling demotivated or lacking commitment to their job and/or profession. Workplace stress had led some to change job roles, change jobs or leave the profession entirely.
- Sickness absence was seen by most pharmacists as an important organisational consequence of workplace stress. However, the link between stress and absenteeism was not always recognised by employers.
- Both pharmacists and employers perceived a decrease in both individual and organisational performance and productivity as a result of workplace stress. This could be as a result of the lack of motivation and organisational commitments however presenteeism was also seen to be a problem amongst pharmacists.
• The effect of workplace stress upon staff turnover was also more widely acknowledged by pharmacists than employers.
• Other organisational effects mentioned by interviewees included the damaged reputation of companies and the profession and the impact on interpersonal relationships.
• All of the pharmacists we spoke to believed that workplace stress increased their risk of making a dispensing error and most could give examples of a near miss or dispensing error they had made when stressed. Again, pharmacy employers were more ambivalent about the link between workplace stress and patient safety.
• The impact of workplace stress on the quality of service they provided to customers was of particular concern to pharmacists, for example the time spent providing advice and information could be curtailed and their manner brusque or even rude.

From the pharmacists’ perspective, workplace stress is clearly having a detrimental effect not only on the workforce but also on community pharmacy organisations, in terms of performance, absenteeism and turnover. In this way, community pharmacy is no different to any other sector of employment. As described in Chapter 1 of this report, the financial costs of workplace stress to organisations can be substantial, with the potential for considerable cost savings for organisations investing in effective strategies to prevent or manage workplace stress. Yet there appears to be a reluctance on the part of some of the community pharmacy employers in this study not only to recognise the scale of the problem, as described above, but also to take on board the potential costs to their organisations. The findings of this study should go some way towards expanding the evidence base in this area but more research is still required in the context of community pharmacy. In particular, quantitative evidence of the relationships between workplace stress and organisational costs is still needed for the sector as a whole and within individual organisations to help to persuade the employers to make the investment in stress prevention strategies. This is particularly important in this time of economic recession and financial constraint.

Of particular importance to healthcare organisations such as community pharmacies is the potential impact of workplace stress on patient safety. There is already mounting evidence of the risk of dispensing errors being made by pharmacists under pressure and the organisational factors which contribute towards this. The findings of this study provide further support of this increasing risk and suggest that many believe that the sector may be near breaking point, where any further increases in workload without the necessary organisational support may lead to a significant rise in dispensing errors. However, some employers in this study did not believe that there was a clear relationship between stress and dispensing errors in their organisations. We have recently produced some tentative quantitative evidence of the link between perceived overload and dispensing errors (Johnson et al., unpublished manuscript) and work is ongoing in another PTECO-funded study examining the effects of mental workload on pharmacists’ ability to detect dispensing errors. However, there is still a need for further research in this area to examine the objective relationships between workload, stress and error.
5.3 Organisational solutions to workplace stress in community pharmacy

5.3.1 What works in other organisations?

The literature review has provided a synthesis of existing evidence of the effectiveness of organisational interventions for the prevention and management of workplace stress. Whilst no evidence exists derived from studies conducted in the community pharmacy sector, a number of the studies covered by the reviews included in the current review were conducted within healthcare organisations. Moreover, although not every intervention is directly transferable to other organisational settings, the list of effective interventions generated provides a good starting point for those looking to develop evidence-based strategies in stress management and prevention.

Using the framework first described by DeFrank and Cooper, we categorised those interventions with existing evidence for their effectiveness as either being focused on the individual employee, at the interface between the individual and their organisation, or else focused on the organisation itself.

- The individual-level interventions with the greatest volume of supporting evidence in this review included stress management training, cognitive behavioural approaches and counselling although evidence also existed for the effectiveness of exercise, relaxation/meditation, employee assistance programmes and return-to-work schemes.
- The interventions focused on the interface between the individual and their organisation with the greatest volume of supporting evidence in this review included interventions to increase employee participation, to improve communication and those involving skill training. Evidence also existed for the effectiveness of interventions aiming to improve co-worker and management support and teamwork, those aiming to increase employee autonomy, the introduction of appraisals, interventions increasing role-clarity, and introducing training in conflict resolution and time management training.
- At the organisational level, the greatest volume of evidence was found for the effectiveness of interventions modifying task or job characteristics, targeting ergonomics or other aspects of the physical working environment and those involving changes to work scheduling (including flexitime, rest breaks and shift patterns). However there was also evidence for the effectiveness of management training, the introduction of new technology or equipment, changes to organisational culture and skill-mix, the introduction of company policies or strategies and workload modifications.

The potential benefits of implementing such interventions in community pharmacy are also suggested by the findings of this review. We categorised the demonstrated benefits of stress management interventions identified in the literature according to whether they applied to the individual or to the organisation.

- The most commonly measured benefits to the individual employee demonstrated in this review were reductions in perceived stress or strain, increases in job satisfaction and improved psychological well-being.
- The benefits to the organisation most commonly demonstrated in this review were reduced sickness absence, improvements in the perceived organisational culture or climate and increased performance or productivity.
The review findings also suggested that there was more evidence for the effectiveness of individual level interventions in stress management but that these tended to benefit the individual rather than the organisation and could be short-lived. Methodological difficulties hampered efforts to evaluate the effectiveness of organisational-level interventions but these were more likely to benefit the organisation and the effects could be longer lasting.

Finally, from the findings of this literature review we have developed a model of best practice in organisational stress management and prevention which may be suitable for adoption by community pharmacy organisations seeking solutions to workplace stress which is summarised again here:

- Sustained **top management support** is a pre-requisite to success. This includes access to necessary resources when needed. Requires a strong business case.
- Interventions should be **context specific**. This requires organisations to undertake a tailored risk assessment (“stress audit”), involving sub-group analyses of different sections and levels of employee.
- The strategy implemented should **combine individual and organisational interventions** designed on the basis of the risk assessment.
- Success requires a **participative approach**. Employees should be involved in all stages of implementation, from design through to evaluation. Cooperation and open communication between management and employees is needed and employees should be recognised as experts.
- Action planning is vital with **clear tasks and responsibilities** laid out.
- **Buy-in from middle management** is also required. Without this, sustained progress will flounder.
- If external **change agents** are recruited, they need to act as facilitators rather than dictators of the necessary approach.
- For any changes to be enduring, stress management needs to be incorporated into the **organisational culture** – “how things get done around here”. It must be recognised as an important issue in strategy and policy documents and not sidelined. It should acknowledge the role of the organisation as well as the individual.

The findings from the literature review were used as the basis for discussion in the interviews to explore what was already happening in community pharmacy organisations to prevent or manage workplace stress, and what else might be suitable, acceptable and/or adaptable in the community pharmacy context.

### 5.3.2 What is already happening in community pharmacy?

Interviews with community pharmacy employers suggested that a wide range of strategies capable of preventing or managing workplace stress were already being implemented:

- Return-to-work schemes, counselling services, and coaching were the most frequently mentioned existing strategies which were aimed at individual pharmacists.
- Those directed at the employer-organisation interface included: appraisals, communication strategies, management support, conflict resolution, management training, and encouraging autonomy and participation.
Ensuring there was a supportive organisational culture, encouraging rest breaks, appropriate staffing levels and skill-mix, and improving the physical environment, technology and equipment, were among the existing organisational-level strategies most often described by employers.

However, interviews with the pharmacists themselves suggest that they were either unaware of the efforts made by their employers in this regard or else that they believed that the strategies implemented were ineffectual or, sometimes, having the opposite effect and contributing to workplace stress.

There are a number of possible reasons for these divergent views between employers and pharmacists. Firstly, given the reluctance of some employers to accept that stress is a problem for pharmacists and the nature of these strategies, it seems likely that many have been implemented primarily for other reasons, either to meet statutory or regulatory requirements, for business reasons or to support pharmacists in other ways. For example, we already know from previous research that appraisals in community pharmacy focus predominantly on setting and reviewing business targets and do not necessarily provide an appropriate forum to discuss professional or personal issues. Whilst the literature review provided evidence that appraisals could be effective in managing or preventing stress, it seems less likely that that they currently have utility for this purpose in community pharmacy. The findings of the interviews are supportive of this supposition suggesting that some pharmacists may view them as a source of stress rather than an opportunity to discuss and address workplace pressures.

Another pertinent example of this is around rest breaks. The employers interviewed were keen to stress that they encouraged pharmacists to take the minimum statutory requirement of a 20 minute rest break. However, only a small number appeared to be taking any steps to facilitate this or ensure that it happened. Supportive of the findings of previous research, it was clear from this study that, unless the pharmacy closes for lunch, pharmacists find it extremely difficult to take a meaningful break during the working day. This lack of rest breaks was identified as a major cause of stress for pharmacists in the current study.

A second possible reason for the divergent views of pharmacists and employers was that whilst many of these strategies may have been devised with good intent by senior managers, their translation into practice may have resulted in them not meeting their original aims. There is good evidence from the interviews that indeed this may be the case, particularly in some of the larger organisations. Here, middle managers appear to play a pivotal role. Often viewed as a source of miscommunication of policies to frontline pharmacists, when effective, middle managers could also be an important source of support to pharmacists experiencing workplace stress. The role of middle managers in shaping and communicating organisational strategies and supporting the well-being of employees is increasingly being recognised in both the healthcare and wider organisational literature. In this study they were often viewed as a cause of stress, being an important source of pharmacist’s perceptions of their organisation’s culture, particularly when they placed undue pressures on pharmacists to meet business targets, and could be seen to disregard pleas for help with managing workplace pressures and blocking communication of such problems to senior management. These interviews also suggest that these problems could be worse in organisations employing non-pharmacists in middle management positions.
Finally, it could be that pharmacists were simply unaware of the strategies implemented by employers to combat workplace stress. This could be because they had not previously sought their employers’ support with problems encountered in relation to workplace stress, or because employers did not widely advertise the schemes or strategies they had implemented. Given that few community pharmacy organisations appeared to have a written policy on workplace stress, a potentially important source of information for pharmacists seeking support stress-related problems, it is unsurprising that pharmacists may be unaware of the support or strategies available to them. Having an explicit policy on workplace stress (as an identified risk to health and safety) is not only a legal requirement for organisations but is also one way to help engender a supportive organisational culture as described in the model of best practice derived from the literature review.

5.3.3 Is there a need to implement safe workload parameters?

These interviews explored current practice in relation to workload/staffing models implemented by community pharmacy organisations and highlighted some of the opportunities and barriers to setting safe workload parameters for community pharmacists. In other industries where excessive workplace pressures can endanger the safety of individuals, e.g. aviation and haulage, legislation exists to limit workloads and working hours to protect both industry employees and members of the public.

Most employers we spoke to used workload/staffing models with varying degrees of complexity to inform the allocation of staff to branch pharmacies. A number of different variables could be accounted for in these models in addition to dispensing volume: over-the-counter sales, other services provided, size of the pharmacy, and the average time taken to complete individual tasks. Whilst few were willing to divulge the parameters used, figures of between 600 and 700 items per day were suggested as cut-off points for dispensing volume over which a second pharmacist would be deployed. Currently in England there are no national guidelines or regulations for safe dispensing volumes. However, this figure is significantly higher than guidelines published by the Pharmacy Board of Australia which suggest that “If the workload exceeds 200 scripts a day, additional pharmacists or dispensary assistants may be required to ensure adequate time is allowed to dispense properly every prescription.” Moreover, only a very small proportion of pharmacists currently dispense these volumes of prescriptions daily (Jacobs et al., unpublished data) yet the evidence from this study and others suggests that many feel that current dispensing volumes are already dangerously high and staffing levels inadequate putting both the wellbeing of pharmacists and the safety of patients at risk. Therefore, there would appear to be an argument for setting nationally agreed limits or at the very least guidelines of what volume of dispensing would require additional staff or a second pharmacist.

Whilst there was some support, particularly amongst pharmacists, for setting safe workload parameters for community pharmacists, a number of important barriers were raised including natural variation in the capability of different pharmacists, the complexity of the pharmacists’ role, the number of other variables contributing to safe levels of dispensing, and the financial consequences to community pharmacies of imposing safe dispensing limits without commensurate changes in contractual remuneration. The difficulty in determining a single ‘safe’ limit to dispensing volumes has previously been described by Grasha who examines the objective and subjective components of workload and their relationship to dispensing errors concluding that this relationship is complex and that “… pharmacists have different thresholds for workload and how much they can
do safely and without burning out.” These findings suggest that it may not be possible to set an agreed objective limit to dispensing volumes above which a second pharmacist should be deployed. However, there is an argument for further research in this area to develop a common workload/staffing model which could be used to benchmark safe working practices for community pharmacies. It may also be of benefit to pharmacists to require employers to share the details of any existing workload/staffing models for regulatory or contract monitoring purposes, as suggested previously by the Pharmacists’ Defence Association.95

5.3.4 What are the options for further development?

Regarding which stress management and prevention interventions might be suitable for adoption or adapting to community pharmacies, organisational level interventions and those focused on the interface between the pharmacist and organisation received more support generally than those focused on the individual.

- The interventions focused on the interface between the pharmacist and organisation most commonly cited by pharmacist as a means to prevent or manage workplace stress in community pharmacy included appraisals, time management training, management training, improved communication and increased autonomy.
- The organisational level interventions most commonly cited by pharmacists included changes to the organisational culture, rest breaks and modifications to staffing and skill-mix.

Employers, however, who made fewer suggestions overall for further development in stress management, were more likely to support the implementation of individual level interventions, particularly stress management training and exercise schemes.

Whilst these suggestions do not necessarily correspond to those interventions with the greatest volume of supporting evidence in the literature, they have all been shown to have been effective elements of organisational stress management and prevention strategies in a number of studies. Crucially, however, the model of best practice derived from the literature review suggests that for such strategies to be successful, a range of individual and organisational interventions should be implemented which are context-specific. Thus, this list constitutes a good starting point for community pharmacies seeking to identify potential evidence-based solutions to workplace stress in their own organisations. It is important, however, that organisations first undertake a tailored risk assessment or “stress audit”. This was not only suggested by a number of review authors captured in the current study, and an important feature of the model of best practice described above, but is something that organisations are required to do as part of their obligations under the Management of Health and Safety at Work Regulations 1999.
6 Recommendations for future research

The findings of this scoping study have highlighted a number of areas where further research is needed, the evidence from which will support the endeavour to find organisational solutions to workplace stress in community pharmacy.

1. It was clear from this study that more work is still required to build the business case for tackling workplace stress in community pharmacy. To provide employers with context-specific evidence of the costs to community pharmacy organisations of workplace stress, an economic analysis of rates of sickness absence, staff turnover and reduced productivity (presenteeism) as a result of stress-related illness is recommended.

2. There is also a need to generate further systematic evidence of the relationships between workload (both subjective and objective), stress and errors. This would not only help to further build the business case for tackling workplace stress but could also help to inform the development of a workload/staffing model of safe practice on community pharmacy. Ongoing research funded by PTECO includes a study of the relationship between mental workload and pharmacists’ ability to detect dispensing errors being conducted in a laboratory setting. We would recommend the funding of a prospective observational study of the relationships between workload (both objective and subjective) and dispensing errors in vivo.

3. The value of secondary analysis of existing administrative data cannot be underestimated. We recommend that longitudinal analysis of employers’ records of sickness absence, turnover and error reports together with insurers’ records of indemnity insurance claims over the past ten years is conducted to investigate the relationships of these outcomes to rising workloads and changes in staffing and skill-mix.

4. The findings of this study suggest that some community pharmacies are better at preventing and managing workplace stress than others. However, this scoping study was not designed to generate enough detailed information about any individual organisation to provide any examples of best practice from which other community pharmacies could learn. We therefore recommend that a series of case studies is conducted with a small purposive sample of organisations and organisational types for this purpose.

5. There is currently no published evidence of the effectiveness or cost effectiveness of stress management and prevention interventions implemented in community pharmacy organisations. We therefore recommend that well designed intervention studies (or natural experiments) are conducted to evaluate such strategies. In particular, the findings of this study suggest that there is a need to evaluate the cost-effectiveness of:
   a. Rest break interventions for pharmacists
   b. Management training for pharmacists, particularly in delegation skills
   c. Different skill mix interventions, including the deployment of a second pharmacist
   d. Training for middle managers in identifying and supporting pharmacists adversely affected by stress

6. Additionally, we would recommend that action research is conducted in partnership with one or more community pharmacy organisations to evaluate the effectiveness of implementing the model of best practice in stress management and prevention identified from the literature review.
Many of the above recommendations will require buy-in from community pharmacy organisations for access to data, research sites and research participants. Whilst undertaking the current study, we started to scope interest amongst community pharmacy employers and stakeholder organisations in future research involvement and, whilst some organisations appeared more reticent than others, there was an encouraging amount of support amongst study respondents. Clearly, concrete research proposals would be required before being able to recruit these organisations as research partners but we would also like to recommend that PTECO (soon to become Pharmacy Research UK) engage with community pharmacy representative bodies such as the RPS, Pharmacy Voice (CCA, AIMP and the NPA) and the IPF to encourage future research participation.

Finally, we recognise that with limited resources, PTECO/Pharmacy Research UK might be unable to fund some of the more costly research projects being proposed here. However, community pharmacy is not often recognised as a priority area by the larger research funders such as the NIHR and research councils. We would therefore like to recommend that PTECO/Pharmacy Research UK work together with the RPS to lobby these funders for the establishment of future research calls suited to funding the types of research proposals listed above.
References

9. Willis S, Hassell K. Pharmacists' occupational well-being needs to be improved in order to avoid dispensing errors. *The Pharmaceutical Journal* 2010; **285**: 371


29. DeFrank RS, Cooper CL. Worksite stress management interventions: Their effectiveness and conceptualisation. Journal of Managerial Psychology 1987; 2: 4-10


### Appendix 1  Data extraction proforma

<table>
<thead>
<tr>
<th>1. RefMan ID</th>
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<tbody>
<tr>
<td>2. Authors</td>
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<td>4. Title</td>
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<td>5. Journal/Publisher</td>
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6. Theoretical framework

7. Review method

8. Interventions described
   - Citation
   - Setting (participants, sample size)
   - Intervention
   - Evaluation (design/outcome measures/period of evaluation)
   - Effectiveness

9. Conclusions
   a. Success factors
   b. Barriers
   c. Methodological issues

10. Other comments
Appendix 2  Table of reviews included in literature review
<table>
<thead>
<tr>
<th>Review</th>
<th>Theoretical framework</th>
<th>Method</th>
<th>Intervention studies described</th>
<th>Conclusions</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Citations</td>
<td>Settings</td>
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<tr>
<td>Giga et al. (2003)</td>
<td>DeFrank and Cooper’s typology of job stress interventions: Individual (relaxation, meditation, CBT, Exercise, time management, employee assistance programmes etc.) individual-organisational interface (co-worker support groups, person environment fit, role issues, participation and autonomy, etc.) Organisational (selection and placement, training and education, physical and environmental, communication, job redesign/restructuring, etc.)</td>
<td>comprehensive literature review, UK only. Only 3 studies looked specifically at organisational interventions (others were individual and/or individual/organisational)</td>
<td>Bond &amp; Bunce (2001)</td>
<td>97 administrative employees</td>
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<td></td>
<td></td>
<td></td>
<td>Cartwright, Cooper, Whatmore (2000)</td>
<td>343 government department employees</td>
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<td></td>
<td></td>
<td></td>
<td>Parkes (1995)</td>
<td>49 driving test examiners</td>
</tr>
<tr>
<td>Review</td>
<td>Theoretical framework</td>
<td>Review method</td>
<td>Intervention studies described</td>
<td>Conclusions</td>
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<tr>
<td>Graveling et al. (2008)</td>
<td>Included both organisational level interventions and stress management interventions. Organisational interventions: changing working practices; training supervisors and managers; altering shift or work patterns; support or training to improve skills or job role</td>
<td>Systematic review with quality assessment</td>
<td>Dahl-Jorgenson et al. (2005)</td>
<td>Shop and municipal workers in a shopping mall in Norway (n=282 in final evaluation)</td>
</tr>
<tr>
<td>Theorell et al. (2001)</td>
<td>Swedish insurance company</td>
<td>Training supervisors and managers – psychosocial training for managers; job stress training for managers</td>
<td>Quasi-experimental</td>
<td>No significant effects on psychological demands on managers or employees, significant reduction in cortisol, serum lipids for employees</td>
</tr>
<tr>
<td>Takao et al. (2006)</td>
<td>Office and manual workers in a Japanese brewery</td>
<td>Training supervisors and managers – psychosocial training for managers; job stress training for managers</td>
<td>Quasi-experimental</td>
<td>Sub-group analysis identified a significantly positive effect for younger male white collar workers on psychological distress (other studies of web-based training showed no effect)</td>
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<tr>
<td>Study</td>
<td>Population</td>
<td>Intervention</td>
<td>Study Design</td>
<td>Findings</td>
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<tr>
<td>Etzion (2003)</td>
<td>Individuals employed in industry in Israel</td>
<td>Taking an annual vacation</td>
<td>matched case-control study</td>
<td>Burnout dropped after vacation and stayed down, stress fell and then returned by 3 weeks</td>
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<tr>
<td>Totterdell and Smith (1992)</td>
<td>UK police officers</td>
<td>Changing a shift rotation system</td>
<td>Quasi-experimental with control group</td>
<td>Significant decrease in GHQ after 6 months</td>
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<tr>
<td>Three quality studies showing positive effects; one weaker study</td>
<td>Support/training to improve skills/job role e.g. psychosocial intervention courses,</td>
<td>Most of these were quite specific training activities and tended to show improvements only in role clarification and/or personal accomplishment (burnout) in the short term</td>
<td></td>
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<tr>
<td>Review</td>
<td>Theoretical framework</td>
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<tr>
<td>Jordan et al. (2003)</td>
<td>SMIs were classified as organisational level (selection and placement, training and education, physical and environmental, communication, job redesign and restructuring), individual/organisational level (co-worker support groups, person environment fit, role issues, participation and autonomy) or individual level (relaxation, meditation, biofeedback, CBT, exercise, time management employee assistance programmes).</td>
<td>Systematic review (reported in Giga et al., 2003) followed by development of a model of best practice identified from the literature (listed here) and then 18 beacons of excellence identified from real life examples.</td>
<td>Louijjesen et al. (1999) Netherlands hospital employees, Ergonomic improvements and equipment; management training; co-worker support; job rotation; stress management training; communication; return-to-work scheme</td>
<td>Action research project, Significant improvements in absenteeism levels and the work environment post intervention. Perceived improvements in how sick colleagues were dealt with, working conditions in the hospital, participation in improving their work situation, atmosphere at work, health and safety, and the quality of care provided to patients. Model of best practice developed with 5 requirements: 1. senior management commitment 2. participative approach 3. stress prevention strategy 4. risk assessment and task analysis 5. work-related and worker-related prevention and management (not addressed)</td>
</tr>
<tr>
<td>Authors</td>
<td>Setting</td>
<td>Description</td>
<td>Intervention</td>
<td>Outcome</td>
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<td>Elo et al. (1998)</td>
<td>Finish paper factory</td>
<td>multifaceted intervention, specific to different departments, developed on the basis of stress questionnaire findings</td>
<td>Action research project</td>
<td>increased discussion of stress and improved stress management techniques, improved work control, reduced physical and mental stress</td>
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<tr>
<td>Greco (1992)</td>
<td>Canadian government ministry</td>
<td>management training, employee training in stress management techniques, improved communication, improved teamwork</td>
<td>Action research</td>
<td>improved management style, wellbeing</td>
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<td>Munz et al. (2001)</td>
<td>Large telecoms company</td>
<td>stress management training, CBT, exercise, relaxation, risk survey, participation</td>
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<td>improved wellbeing, reduced stress, reduced absenteeism, increased sales</td>
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<tr>
<td>Nijhuis et al. (1996)</td>
<td>Dutch construction industry</td>
<td>management training (time management, planning, relationships, communication)</td>
<td>Pre-post-test survey</td>
<td>increased job satisfaction, reduced stress, reduced absenteeism</td>
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<td>Poelmans et al. (1999)</td>
<td>Belgian pharmaceutical company</td>
<td>stress survey, management training, stress management training, ergonomic changes</td>
<td>Participative action research</td>
<td>changes in organisational culture, decreased sickness absence</td>
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<td>Wynne and Rafferty (1999)</td>
<td>Irish airport management company</td>
<td>staff and management training, career development, appraisals, improved communication, stress management training, shift patterns</td>
<td>No formal evaluation</td>
<td>anecdotal improvements in shift patterns, training and communication</td>
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<tr>
<td>Review</td>
<td>Theoretical framework</td>
<td>Review method</td>
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<td>Karasek (2004)^1</td>
<td>Applies job demand-control model and also uses a variation in the model of the Michigan stress development process to identify different approaches to stress prevention targeted at different stages: person-based (e.g. counselling, relaxation, CBT), communication pattern (person-environment interactions e.g. conflict resolution, trust building), microenvironment (task structure interventions e.g. job enrichment, job enlargement, autonomous groups collective coping and decision-making), macroenvironment (work organisation and production process interventions e.g. management)</td>
<td>19 international case studies selected</td>
<td></td>
<td>Participation, workers viewed as experts by management (openness without fear of reprisal), top management support including access to necessary resources, stress reactions seen as ‘normal’, development of worker groups producing action plans; awareness of the causes of stress; communication; action planning with management support for implementation</td>
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<td>Citations: various Settings: various Interventions: legislation; worker participatory work environment changes e.g. stress committees, job reorganisation, engagement around family/work conflicts; work reorganisation e.g. shift work, discussion platform then technological changes, ergonomic and organisational redesign; participatory task and work restructuring e.g. stress training then self-initiated work reorganisation, communication, health circles; expert guided task and work restructuring e.g. job enrichment, IT improvements; person-based e.g. counselling, trauma stress program, stress management program</td>
<td>Evaluation designs: various Effectiveness: 90% successful in reducing stress symptoms or making other improvements in problems identified, many achieved organisational change identified as stressors, few reported changes in stress-related ill health. Gains in productivity in 6 of the 12 cases where this is discussed.</td>
<td>Success factors: participatory, workers viewed as experts by management (openness without fear of reprisal), top management support including access to necessary resources, stress reactions seen as ‘normal’, development of worker groups producing action plans; awareness of the causes of stress; communication; action planning with management support for implementation</td>
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<td>Barriers: symptoms-only interventions (not addressing difficult working environments), technical solutions imposed from the top, management control of process</td>
<td>Methodological issues: (not addressed)</td>
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<td>Review</td>
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<td>Intervention studies described</td>
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<tr>
<td>Kompier et al. (1998)</td>
<td>Stress management can be primary (reducing stressors – prevention of stress), secondary (reducing stress in those already suffering – prevention of illness) or tertiary (treatment of those with stress-related illness e.g. rehabilitation). The majority of effort is on secondary/tertiary stress prevention – less in primary prevention. Target of stress management can be individual (improving skills to manage stress) or workplace context (improving job content) – most interventions are targeted at the individual.</td>
<td>10 Dutch projects selected (through being involved or through network approach) as potential exemplars of good preventative practice. Needed to have a primary preventative element; a stress audit; an evaluative element; and look at individual and organisational outcomes.</td>
<td>10 interventions are described. Most used a combination of work-directed and person-directed measures. Work directed: ergonomics technology; work organisation and planning; job enrichment; work time schedules; team work; organisational structure; communication Person directed: sickness absenteeism management; training and development; health promotion; inductions; anger management</td>
<td>Most reduced sickness absence and benefits outweighed costs e.g. Intervention in a hospital (n=850): changes in interior climate, work/rest schedule, technical devices, reduced physical workload, work organisation, job enrichment, sickness absenteeism management, health promotion activities and individual stress management training activities – led to improvements in working conditions, better climate, less sickness absence, benefits exceeded costs</td>
</tr>
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</table>

- **Citations**
- **Settings**
- **Interventions**
- **Evaluation designs**
- **Effectiveness**
- **Success factors**
- **Barriers**
- **Methodological issues**
### Intervention studies described

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<th>Success factors</th>
<th>Conclusions</th>
<th>Methodological issues</th>
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</thead>
<tbody>
<tr>
<td>Kompier et al. (2000)</td>
<td>focuses on stress prevention i.e. organisational interventions – work stress prevention programmes are predominantly reactive (fire-fighting) and directed towards the individual</td>
<td>Multiple case study approach – cases identified through national experts from all EU member states. All cases had to have a published evaluation but it didn’t need to have a control group or involve randomization.</td>
<td>reorganisation of work (inc. reorganisation of monotonous tasks, integration of maintenance/support with production), management training, training and development of foremen, office personnel, occupational health, personnel</td>
<td>comprehensive surveys and process evaluation</td>
<td>positive subjective evaluation but time pressure had increased – costs and benefits hard to assess – no change in health complaints</td>
<td>stepwise and systematic approach; clear tasks and responsibilities; participative approach; cooperation between management and employees; recognition of employees as experts; emphasizing the responsibility of management; combining monitoring and intervention; proper risk assessment using validated instruments and for whole company/subsection; assessment of employees/management; clear facts and figures to convince top management</td>
<td>time constraints; differences between practical and scientific aims; difficulties keeping employees and middle management involved</td>
<td>evaluation of organisational interventions limited by context (e.g. hard to randomise, pace of change, complexity)</td>
</tr>
<tr>
<td>Kalimo &amp; Toppinen (1999)</td>
<td>Finland Forest industry (n=19,000)</td>
<td>reorganisation of work (inc. reorganisation of monotonous tasks, integration of maintenance/support with production), management training, training and development of foremen, office personnel, occupational health, personnel</td>
<td>comprehensive surveys and process evaluation</td>
<td>positive subjective evaluation but time pressure had increased – costs and benefits hard to assess – no change in health complaints</td>
<td>stepwise and systematic approach; clear tasks and responsibilities; participative approach; cooperation between management and employees; recognition of employees as experts; emphasizing the responsibility of management; combining monitoring and intervention; proper risk assessment using validated instruments and for whole company/subsection; assessment of employees/management; clear facts and figures to convince top management</td>
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<td>evaluation of organisational interventions limited by context (e.g. hard to randomise, pace of change, complexity)</td>
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<tr>
<td>Lourijsen et al. (1999)</td>
<td>Netherlands hospital (n=850)</td>
<td>climate changes, work/rest time schedules, technical devices, reduced physical workload, work organisation, job enrichment, new procedures around sickness absence, managers training, individual training</td>
<td>comparing pre-post-test; control hospital</td>
<td>improvements in working conditions, climate, absenteeism, cost benefits outweighed costs</td>
<td>time constraints; differences between practical and scientific aims; difficulties keeping employees and middle management involved</td>
<td>time constraints; differences between practical and scientific aims; difficulties keeping employees and middle management involved</td>
<td>evaluation of organisational interventions limited by context (e.g. hard to randomise, pace of change, complexity)</td>
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<tr>
<td>Poelmans et al. (1999)</td>
<td>Belgian pharmaceutic al company (n=3261)</td>
<td>ergonomic interventions, information session for senior management, stress coping training, training for management in people management, stress and ergonomics</td>
<td>questionnaire study of 324 employees</td>
<td>reduction in sickness absence, stress no longer taboo subject and on company agenda, benefits from decreased absenteeism outweighed costs</td>
<td>time constraints; differences between practical and scientific aims; difficulties keeping employees and middle management involved</td>
<td>time constraints; differences between practical and scientific aims; difficulties keeping employees and middle management involved</td>
<td>evaluation of organisational interventions limited by context (e.g. hard to randomise, pace of change, complexity)</td>
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<tr>
<td>Whatmore et al. (1999)</td>
<td>UK public sector</td>
<td>three training programmes:</td>
<td>pre-post-test comparisons</td>
<td>individual health variables improved</td>
<td>time constraints; differences between practical and scientific aims; difficulties keeping employees and middle management involved</td>
<td>time constraints; differences between practical and scientific aims; difficulties keeping employees and middle management involved</td>
<td>evaluation of organisational interventions limited by context (e.g. hard to randomise, pace of change, complexity)</td>
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<td>Study</td>
<td>Setting</td>
<td>Intervention</td>
<td>Control Group</td>
<td>Improvements</td>
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<td>Netterstrom (1999)</td>
<td>Danish bus company (n=29)</td>
<td>Self-regulating (autonomous) teams; drivers free to organise themselves</td>
<td>None</td>
<td>Decreased sickness absence, decreased passenger complaints, high job satisfaction.</td>
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<td>Theorell &amp; Wahlstedt (1999)</td>
<td>Swedish mail sorting office (n=136)</td>
<td>Smaller more autonomous production units; small increase in staffing;</td>
<td>Pre-post-questionnaires</td>
<td>Skill discretion and decision authority had improved after 12 months;</td>
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<td>small working groups; improved information systems; changed shift patterns;</td>
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<td>Reduction in sickness absence leading to financial gains</td>
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<td>new food vending machines, microwaves</td>
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<tr>
<td>Beermann, Kuhn &amp; Kompier (1999)</td>
<td>German hospital (n=230)</td>
<td>“Health circle”; changes in information flow and communication; better</td>
<td>Questionnaire, observations, discussions and interviews</td>
<td>Subjective improvements in stress reduction, communication and social support</td>
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<td></td>
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<td>coordination; ergonomic and technical improvements; personnel training</td>
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<tr>
<td>Wynne &amp; Irish airport</td>
<td>OD and health</td>
<td>Not formally</td>
<td>Improvements in</td>
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<tr>
<td>Rafferty (1999)</td>
<td>management company (n=953)</td>
<td>promotion: redesign of shift rosters; improved communications; appraisals for all staff; career development; health promotion programme</td>
<td>evaluated</td>
<td>many policies and procedures which are likely to produce positive outcomes</td>
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<td>Bagnara et al. (1999)</td>
<td>Italian School of nursing (n=128 student nurses)</td>
<td>controlled programme of support and supervision involving group discussions and support</td>
<td>validated questionnaires on work and health; control group</td>
<td>decreased anxiety, better psychological condition, high self esteem, better exam performance</td>
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<td>Review</td>
<td>Theoretical framework</td>
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| LaMontagne et al. (2007)      | Uses public health definitions of primary, secondary and tertiary prevention. | Systematic review of 90 papers – interventions rated as high, medium and low dependent upon preventative level, participative approach and context-specificity. Also categorised according to target of intervention (work, individual or work-individual interface). Used a 1-5 star rating of quality of evaluation. | There is an appendix to the paper with a lot of info about the 90 studies reviewed and their outcomes but only a categorisation of the intervention implemented (rather than a description of what it was). However, findings are presented regarding the relative effectiveness of different categories of intervention:  
  - Studies of interventions using high and moderate systems approaches represent a growing proportion of the job stress intervention evaluation literature  
  - Individual-focused, low-rated systems approaches are effective at the individual level, favourably affecting a range of individual-level outcomes  
  - Individual-focused, low-rated systems approach job-stress interventions tend not to have favourable impacts at the organisational level  
  - Organisationally-focused high- and moderate-rated systems approach job stress interventions have favourable impacts at both the individual and organisational level  
Sickness absence is a commonly used outcome measure and is often significantly improved by high-rated interventions.                                                                                                                                                                           | Systems approaches are more effective than other approaches – these emphasise primary prevention but integrate primary, secondary and tertiary prevention interventions, are participative in their approach and are context-sensitive. Also, in occupational health (as in public health), the further upstream one is from an adverse health outcome, the greater the prevention effectiveness. Therefore primary prevention is more effective than secondary, and secondary prevention more effective than tertiary. However, these approaches are optimally used in combination.                                      |
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<tr>
<td>Michie and Williams (2003)</td>
<td>Did not discriminate between organisational (primary) and stress management (secondary) interventions – will describe only the former here (only 2)</td>
<td>Systematic review including observational studies as well as interventional studies to look at associations between work factors and ill-health in healthcare and non-healthcare workers.</td>
<td>Heaney et al. (1995) Setting: 1375 residential care workers, Intervention: training to enhance social support and problem solving skills, Evaluation design: cluster RCT, Effectiveness: increased supportive feedback, ability to cope, better team function and climate; for those most at risk of leaving, reduced depression.</td>
<td>The findings from the observational studies reviewed suggested that the most common factors associated with psychological ill health were work demand (long hours, workload, work pressure), lack of control over work, and poor support from managers. These were also associated with sickness absence. Consistent with demand-control model of job strain. Therefore interventions aimed at changing these factors should reduce psychological ill health.</td>
<td>Intervention studies have focussed mainly on training staff – evaluation studies required looking at employment practices and management style. Economic studies also required to convince managers to adopt interventions. More rigorous evaluation designs required.</td>
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<td>Murphy (1999)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Discriminates organisational (primary) interventions from individual (secondary) interventions or tertiary interventions. Organisational interventions are far less common in the literature – not an exact science (prescriptive approach not possible); difficult to implement.</td>
<td>Not described. Uses exemplars of different types of intervention in healthcare settings as case studies</td>
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<tr>
<td>Jones et al. (1988)</td>
<td>Hospitals</td>
<td>Multi-component intervention: stress survey; small group sessions with top management/employees; policy/procedural changes to improve communication; education of employees about nature and sources of stress at work; employee assistance programme</td>
<td>Frequency of medication errors reduced by 50% in one study. Malpractice claims 70% lower in another study</td>
<td>Staff involvement and participation in decision-making (from planning to evaluation); sustained commitment by top management; buy-in of middle management; supportive OC management commitment can be measured through policies, procedures, decisions, actions, prominence of stress prevention in strategic planning and business strategy. A health-enhancing OC treats stress-prevention not as an isolated programme but as an integrated part of the business strategy – encourages innovation and involvement in employees</td>
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<td>series of articles by West (1989) and Bunce &amp; West (1994, 1996)</td>
<td>Health care workers</td>
<td>Innovative coping: new strategies or tactics devised and applied by workers as a means of reducing excessive demands at work – only possible if workers have the discretion and authority to implement changes</td>
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<td>Murphy et al. (1994); Abts et al. (1994); Molleman &amp; van Knippenberg (1995)</td>
<td>Nurses in a rural hospital; nurses in surgical unit</td>
<td>Work redesign: redesigned patient care delivery system (teams, shifts); team-based care delivery, physical environment, improved communication, regular update sessions; changes in patient allocation and nursing process for</td>
<td>Improved worker satisfaction, reduced stress, better handover between shifts, reduced (11%) turnover, reduced (66%) sickness absence; improved staff and patient satisfaction, reduced stress; final</td>
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<sup>14</sup> Not addressed.
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<th>Study</th>
<th>Setting</th>
<th>Interventions</th>
<th>Outcomes</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Heaney et al. (1995)</td>
<td>Caregivers in homes for learning disabled and mentally ill</td>
<td>Caregiver support programme: training in importance of support at work, participatory problem-solving approaches to work-related problems, skills to implement this approach</td>
<td>Before-after study (with control group?)</td>
<td>Improvements in perceived social support, group problem solving, job satisfaction, employee mental health</td>
</tr>
<tr>
<td>Hecker (1997)</td>
<td>Australian aboriginal health worker</td>
<td>Worker empowerment through participatory action research: focus groups and interviews leading to increased training and inclusion of these workers</td>
<td>None described</td>
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<tr>
<td>Hanlon (1986)</td>
<td>Hospital</td>
<td>Increased worker involvement to reduce costs e.g. quality circles leading to changing work practices, job descriptions, work flow, staffing patterns</td>
<td>Positive cost-benefit results but short-lived</td>
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<tr>
<td>Parsons &amp; Murdaugh (1994)</td>
<td>Hospital</td>
<td>Restructured care delivery, interdisciplinary team management, high staff involvement, change in OC (emphasis on excellence)</td>
<td>Increases in satisfaction, meaningfulness of work, internal motivation, feedback, task significance (suggestive of lower stress although this not measured)</td>
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<tr>
<td>Murphy and Sauter (2004)</td>
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<td>none given though all in US context</td>
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<td>“work organization intervention” = changes in job design, organizational practices, social policy that influences job design. Includes interventions at the individual/job interface. Includes primary, secondary and tertiary interventions.</td>
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<td>Legislative/policy level e.g. Family and Medical Leave Act (provision for unpaid leave for carers); Fair Labor Standards Act (overtime)</td>
<td>Empirical studies are rare</td>
<td>risk analysis, participative approach, top management support, combined approach</td>
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<td>Employer/organization level e.g. work-family programmes (flexible working schedules); changing OC or safety climate (e.g. training in management skills, leadership practices, communication, multiskilling, customer service based on risk analysis and participatory approach)</td>
<td>Evidence has accumulated that work-family programs improve job satisfaction and attitudes toward employer – but evaluation studies inconsistent (e.g. Saltzstein et al, 2001) changing OC / safety climate may produce large scale beneficial effects (e.g. Gershon et al, 2000; Parsons &amp; Murdaugh, 1994; Collins &amp; Porras, 1994; Lindstrom et al, 2000)</td>
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<td>Job/task level (e.g. workload reduction; participation in decision-making; improved job control; job enrichment)</td>
<td>Improvements in employee and patient satisfaction (Abts et al, 1994); increased task significance, meaningfulness at work, internal motivation, job satisfaction</td>
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<td>interventions to reduce stress = change and change in itself is stressful – may prevent positive findings Subgroup analysis required to show who benefits most. More evidence at individual level – more research needed at other levels. Need to measure both individual and organisational benefits and costs. Start with qualitative and quasi-experimental designs and save RCTs for most promising interventions. Intervention research should be theory-driven. Process evaluation/ethnographic study of implementation also needed.</td>
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Evidence has accumulated that work-family programs improve job satisfaction and attitudes toward employer – but evaluation studies inconsistent (e.g. Saltzstein et al, 2001) changing OC / safety climate may produce large scale beneficial effects (e.g. Gershon et al, 2000; Parsons & Murdaugh, 1994; Collins & Porras, 1994; Lindstrom et al, 2000)
(Parsons and Murdaugh, 1994); improved sickness absence (Kompier et al, 1998) – however effectiveness not always demonstrated in research

<p>| Individual worker level (e.g. stress management (CBT, meditation, relaxation), time management, conflict resolution training) | benefits to individual (decreased stress, somatic symptoms) though not job satisfaction or benefits for organisation. Effects short-term only. |</p>
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<tr>
<td>Parkes and Sparkes (1998)</td>
<td>2 main approaches to stress reduction: stress management directed at the individual; reduction in job-related/environmental stressors. The former may work but should not be the initial focus of concern for employers and could be seen as unethical. Organisational interventions can be either socio-technical (e.g. staffing levels, work schedules, company mergers, work patterns, staff meetings, ergonomics, technology) or psychosocial (increasing participation, communication, social support, autonomy and control, reducing role ambiguity and conflict). A specific type of</td>
<td>Not stated. Uses case studies to illustrate different types of intervention.</td>
<td>demonstrated differences between experimental and control groups after 3 months, greater after 6 months. Changes in role stress predicted tension and emotional strain but not job satisfaction or turnover rate. Increasing frequency of meetings increased perceived influence which in turn predicted satisfaction and staff turnover intentions.</td>
<td>focus on one or a few important stressors; adopt an established theoretical framework; employ sub-group analyses; identify the most rigorous research design possible; use both subjective and objective measures of outcome; use organisational as well as individual measures of outcome; use established validated measures of outcome; consider windows of opportunity; design data collection to maximise response rates; have more than one post-test follow up; ensure independence of researchers (i.e. independent from change agent)</td>
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<tr>
<td>Jackson (1983, 1984)</td>
<td>evaluated increased opportunities to participate in decision-making by increasing the number of scheduled staff meetings from 1 to 2 per month.</td>
<td>(not addressed)</td>
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<tr>
<td>Meijman et al (1992) and Parkes et al (1986, 1995)</td>
<td>both evaluated workload reduction in driving examiners</td>
<td>(not addressed)</td>
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Psychosocial intervention involves participatory action research (PAR) where employees actively participate in identifying stressors and proposing and implementing suitable interventions.

- **e.g. Kawakami et al (1997)**
  - Evaluated a programme of workplace improvements to reduce stress: supervisors were asked to list work stressors and make plans to reduce them. Improvements included enhancement of machine speed and performance, reduction in checks needed, increased training, standardisation of processes, increased supervisor support (sub-leaders).
  - Demonstrated decreased depressive symptoms (esp for males), decreased sick leave.

  - Psychosocial interventions: participatory action research; improved communication; autonomous working methods; increasing co-worker cooperation and support;
  - Demonstrated mixed success with some improving co-worker support, depressive symptoms, participative climate, job satisfaction, absenteeism, skill discretion and decision authority, and others showing no change or a deterioration in some outcome variables. Very difficult type of intervention to evaluate. The few
studies that employed strong designs, focussed on significant work stress problems and used a range of outcome measures, tended to produce the most encouraging results.
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<tbody>
<tr>
<td>Ruotsalainen et al. (2008)</td>
<td>Categorised interventions into person-directed (CBT, relaxation, music, massage), person-work interface (participatory problem solving and decision making training) and organizational (psychological training to improve attitudes, communication skills, stress; changes in work organisation, knowledge skills; support and advice from supervisors) – including latter 2 categories here (3 studies included in meta-analysis)</td>
<td>systematic review and meta-analysis</td>
<td>Delvaux et al. (2004) 115 oncology nurses in Belgium psychological training to improve attitudes and communication RCT</td>
<td>reduced stress but difference from control group became non-significant after 6 months (not addressed)</td>
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<td>organisational intervention evaluations were good quality studies with good randomisation processes problems of attrition Mostly in nursing – due to nursing-biased search strategy Limited evidence of effectiveness for both individual and organisational-level interventions. Not clear if results can be generalisable to other health professions.</td>
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<td>Melchior et al (1996)</td>
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<td>Melchior et al (1996) 161 psychiatric nurse in long stay settings in the Netherlands support and advice about nursing given by nurse managers or quality care coordinators RCT</td>
<td>reduced symptoms on one subscale of the MBI (depersonalization)</td>
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<tr>
<td>Review</td>
<td>Theoretical framework</td>
<td>Review method</td>
<td>Intervention studies described</td>
<td>Conclusions</td>
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<tr>
<td>Semmer (2003)</td>
<td>Looked solely at work focussed interventions (as opposed to individual focussed).</td>
<td>No method stated</td>
<td>Wall &amp; Clegg (1981) — Confectionary company: Task identity (removing physical barriers to make whole task visible) and autonomy (group decides on allocation of tasks, rest breaks, production speed etc.). Evaluation designs: Longitudinal design – no control group. Measures taken before, 18 months, 28 months: perceived identity, autonomy, motivation, job satisfaction, performance, GHQ. Effectiveness: Improvements in all these measures, especially over long term. Success factors: • Combining individual and organisational interventions • Experts as facilitators not dictators • Tailored risk assessment and diagnosis • Management support – requires business case</td>
<td>Changes can produce good outcomes but sometimes at a price Methodological issues: • Qualitative data on process issues very important in evaluations • Be aware of differential effects of interventions on different groups/types of people • Attrition • Timescale of evaluation • Case studies still valuable alongside quasi-experimental approaches • Hawthorn effect – good or bad?</td>
<td></td>
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<tr>
<td>Parker et al. (1998)</td>
<td>Various: e.g. improving communication, broadening job scope, changes to appraisal systems and pay, introducing teamwork – many using a participative approach. Evaluation designs: Longitudinal studies. Effectiveness: Improvements in job satisfaction, sense of fairness, mental health, absenteeism, job strain – each case led to improvement in those factors targeted and not in others. Some group differences. Success factors: • Participative approach.</td>
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<tr>
<td>Study reference</td>
<td>Setting</td>
<td>Intervention</td>
<td>Effect size</td>
<td>Findings</td>
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<tr>
<td>Smith and Zehel (1992)</td>
<td>Meat processing plant workers</td>
<td>Job rotation</td>
<td>unclear</td>
<td>Reduced musculoskeletal and psychosomatic complaints, improved perceived working conditions especially for those who originally had the least skilled jobs.</td>
<td></td>
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<tr>
<td>Landsbergis &amp; Vivona-Vaughn (1995)</td>
<td>Public health agencies</td>
<td>Establishment of problem-solving committees who then introduced changes e.g. policy manual, phone answering system, task variety, regular staff meetings, improved filing, quiet hours</td>
<td>Matched case-control</td>
<td>Not effective – some negative effects – not well implemented</td>
<td></td>
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<tr>
<td>Meijman et al (1992) and Parkes (1986)</td>
<td>Driving examiners</td>
<td>Reduced workload (number of exams/day)</td>
<td></td>
<td>Tension and adrenaline reduced, failure rate improved, reduced perceived demands and anxiety.</td>
<td></td>
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<tr>
<td>Study</td>
<td>Group/Setting</td>
<td>Intervention/Change</td>
<td>Outcomes/Results</td>
<td></td>
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<tr>
<td>Poelmans et al (1999)</td>
<td>Pharmaceutic al company</td>
<td>Ergonomic improvements, stress management and supervisor training</td>
<td>Reduced sickness absence after one year</td>
<td></td>
<td></td>
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<tr>
<td>Vink &amp; Kompier (1997)</td>
<td>VDU users</td>
<td>Participatory ergonomic experiment – furniture, NDU adjustment</td>
<td>Improved musculoskeletal outcomes, absenteeism</td>
<td></td>
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<td></td>
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<tr>
<td>Cahill (1992)</td>
<td>Child protection agency</td>
<td>Labour-management stress committee – introduced changes inc. quick data access, better IT aids</td>
<td>After 6 months, better skill discretion, decision latitude, job satisfaction. No change in strain.</td>
<td></td>
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<tr>
<td>various</td>
<td>various</td>
<td>Flexi-time</td>
<td>Decreased absenteeism, stress, increased job satisfaction</td>
<td></td>
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<tr>
<td>Quick (1979) (see also Schaubroec k et al. (1993))</td>
<td>Goal-setting by supervisor-employee interaction</td>
<td>Reduced role conflict and role ambiguity – participatory approach required (not replicated in other studies)</td>
<td></td>
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<tr>
<td>Kompier, Aust et al. (2000)</td>
<td>Bus drivers</td>
<td>Communication, performance review and feedback</td>
<td>Reduced absenteeism</td>
<td></td>
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<tr>
<td>Bagnara et al. (1999)</td>
<td>Student nurses</td>
<td>Peer support groups and expert mentors</td>
<td>Improved anxiety, GHQ, self esteem</td>
<td></td>
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<tr>
<td>Jackson (1983, 1984)</td>
<td>Increased participation in decision making</td>
<td>Controlled experiment</td>
<td>Increased perceived influence, reduced role conflict and</td>
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<tr>
<td>Review</td>
<td>Theoretical framework</td>
<td>Review method</td>
<td>Intervention studies described</td>
<td>Conclusions</td>
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<tr>
<td>Semmer (2006)</td>
<td>More evidence for person-focused than organization-focused interventions categorized into 3 themes: task characteristics; work conditions; social conditions</td>
<td>Not a comprehensive review</td>
<td>Wall &amp; Clegg (1981) Confectionary company employees Increased task identity by removing physical barriers to make whole process visible; increased autonomy given to workers for deciding on allocation of tasks, rest breaks, production speed etc. Increased task identity by removing physical barriers to make whole process visible; increased autonomy given to workers for deciding on allocation of tasks, rest breaks, production speed etc.</td>
<td>No control group but measures taken before, at 18 and at 28 months No control group but measures taken before, at 18 and at 28 months Improvements in intrinsic motivation, job satisfaction, performance, mental health esp over long term Improvements in intrinsic motivation, job satisfaction, performance, mental health esp over long term</td>
<td>● Management support ● Participative approach ● Change agents ● Comprehensive approaches ● Management support ● Participative approach ● Change agents ● Comprehensive approaches</td>
<td>(not addressed)</td>
<td></td>
</tr>
<tr>
<td>Smith &amp; Zehel (1991)</td>
<td>Meat processing plant</td>
<td>Job rotation recommended by focus groups</td>
<td>Reduced musculoskeletal problems and psychosomatic complaints; improved appraisal of work conditions – most marked for those workers with worst conditions at outset. Reduced musculoskeletal problems and psychosomatic complaints; improved appraisal of work conditions – most marked for those workers with worst conditions at outset.</td>
<td></td>
<td></td>
<td>(not addressed)</td>
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</tr>
<tr>
<td>Evans et al. (1999)</td>
<td>Bus drivers</td>
<td>Variety of ergonomic changes</td>
<td>Controlled experiment Decrease in observer-reported hassles, heart rate at work, distress after work. No long term changes Decrease in observer-reported hassles, heart rate at work, distress after work. No long term changes</td>
<td></td>
<td></td>
<td>(not addressed)</td>
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</table>

- Increased absenteeism is main consistent finding.
- Decreased absenteeism is main consistent finding.
- Harder to demonstrate success with organisational focussed interventions than individual level interventions – higher risk of failure – between 50 and 80% of OD projects fail in general.
- Differential improvements in measured outcomes.
- Job satisfaction and absenteeism show the most consistent results.
- Differential effects on subgroups.
<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Design</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kompier et al. (2000)</td>
<td>Bus drivers</td>
<td>Reduced hours and workshop on health promotion</td>
<td>Controlled experiment, small numbers (only 26 in control group)</td>
<td>Reduction in back pain and other, non-significant changes</td>
</tr>
<tr>
<td>Heaney et al (1995)</td>
<td>Mental health care workers (n=1200)</td>
<td>Peer training</td>
<td>Randomised, controlled</td>
<td>Improvements in supportive feedback from supervisors, self-appraisal of coping, team climate. No effect on supervisor support or depressive symptoms. Sub-group analysis indicates differential effects</td>
</tr>
</tbody>
</table>

Good things may come at a price – trade-offs necessary. Need for rigorous process evaluation.
<table>
<thead>
<tr>
<th>Review</th>
<th>Theoretical framework</th>
<th>Review method</th>
<th>Intervention studies described</th>
<th>Conclusions</th>
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<tbody>
<tr>
<td></td>
<td></td>
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<td>Citations</td>
<td>Settings</td>
</tr>
<tr>
<td>Semmer (2008)</td>
<td>Stress management training (individual level) vs. work environment approach. SMT: relaxation, CBT, specific approaches. Organisation-focused: tasks, working conditions, social relationships, combined approaches.</td>
<td>None described</td>
<td>this report summarises the findings of a number of reviews</td>
<td>various</td>
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</table>

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<table>
<thead>
<tr>
<th>Review</th>
<th>Theoretical framework</th>
<th>Review method</th>
<th>Intervention studies described</th>
<th>Conclusions</th>
<th>Success factors</th>
<th>Barriers</th>
<th>Methodological issues</th>
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</thead>
</table>
| Tucker (2003)          | Looks mainly at the effects of rest breaks on fatigue rather than stress (although the two are related and there is some evidence of links between rest breaks and stress and rest breaks are an issue for pharmacists hence the inclusion of this review.) Also looks at links between rest breaks and accident risk and performance | • rest breaks have been shown to reduce driving fatigue  
• variable evidence that the total time of rest breaks taken inversely associated with accident risk in drivers  
• in industrial settings, accidents more likely to occur the longer that had elapsed since the last break taken  
• Fatigue and productivity can benefit from frequent short breaks (evidence from a range of industrial settings)  
• More autonomy over the timing of breaks reduces stress and fatigue although workers often work beyond the point where performance is impaired  
• No evidence for optimum length of rest breaks which are often determined by nature of work | taking breaks at optimal times; eating/caffeine intake during breaks, more short breaks | nature of work; not recognising when tired; no autonomy to take breaks | (not addressed)                                                              |
<table>
<thead>
<tr>
<th>Review</th>
<th>Theoretical framework</th>
<th>Review method</th>
<th>Intervention studies described</th>
<th>Conclusions</th>
<th>Success factors</th>
<th>Barriers</th>
<th>Methodological issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>van der Hek and Plomp (1997)&lt;sup&gt;105&lt;/sup&gt;</td>
<td>Uses DeFrank and Cooper framework for categorising interventions (individual, individual-organisational, organisational)</td>
<td>comprehensive review yielding 24 studies, 4 of which were I-O or O interventions (listed here)</td>
<td>Cecil (1990) teachers stress inoculation training and co-worker support group no control group, 1 month follow up</td>
<td>SIT effective in reducing self-reported stress, co-worker support group not</td>
<td>organisation-wide approaches may show best results at all outcome levels; interventions targeted to the needs and demands of individuals; participation of the workers at the design stage</td>
<td>if participation is voluntary, those who need it most may not volunteer; not tackling the sources of stress</td>
<td>no long term effects measured, no control groups; cost-effectiveness analyses needed</td>
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<td></td>
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<td>Grossman (1993) hospital staff support groups no control group</td>
<td>effective in alleviating stress but high drop-out rates (for people needing it most)</td>
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<td>Jones (1988) hospital staff “organisation-wide stress management programme” – stress survey, reported to senior management, suggestions for reducing stressors, managers worked out series of policy/procedural changes concerning interdepartmental communication, organisation and personnel policies, discussions with employees, employee training in stress management, employee assistance programme matched control group, 1 year follow-up</td>
<td>significantly fewer medical malpractice claims in experimental group compared to matched controls</td>
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<td>Golembiewski (1987) management team OD programme aiming to develop socio-emotional infrastructure to generate and support changes – to create an OC to meet</td>
<td>no control group or follow up</td>
<td>levels of burnout diminished and remained reduced for 4 months, improvement in turnover</td>
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<tr>
<td>Review</td>
<td>Theoretical framework</td>
<td>Review method</td>
<td>Intervention studies described</td>
<td>Conclusions</td>
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<td></td>
<td>covers all stress interventions (organisational, cognitive-behavioural, relaxation, multimodal) – only one organizational intervention paper reviewed had a significant effect size (described here)</td>
<td>systematic review with meta-analysis</td>
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<tr>
<td>van der Klink et al. (2001)</td>
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<tr>
<td>Jones et al (1988)</td>
<td>hospitals</td>
<td>not described here</td>
<td>not described here</td>
<td>meta-analysis suggested that CBT and relaxation (and multimodal) individual interventions were more effective than organisational interventions – but this does not take into account the targeted nature of many individual interventions and the possible of differential effects of subgroups in organisational interventions.</td>
<td>(not addressed)</td>
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<td></td>
<td></td>
<td>not described here</td>
<td>not described here</td>
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Managing work-related stress

The aim of this paper is to provide background material for individuals who have agreed to participate in the University of Manchester research study ‘Managing workplace pressures to enhance safer practice in community pharmacy: a scoping study’.

It is based upon a review of the research evidence and guidance literature supporting the management and prevention of stress at work.

It is divided into four sections:
1. What is work-related stress?
2. The business case – why tackle work-related stress in community pharmacy?
3. What works? – the evidence from other organisations
4. How it’s done – factors for success

Please take a moment to read this information before the interview – it will help guide the subsequent discussion.

What is work-related stress?
Stress has been defined by the Health and Safety Executive as “the adverse reaction a person has to excessive pressure or other types of demand placed upon them”.

Work-related stress can come from a number of different sources relating to both work content and work context. It often reflects an imbalance between work pressures, the control a person has over their work, and the support received from others.

Work-related stress affects different people in different ways but can lead to physical and/or psychological ill-health and problems with job motivation and commitment.

Work-related stress in employees is also bad for the health of the organisation, adversely affecting performance, safety and reputation.
The business case: why tackle work-related stress in community pharmacy?

Costs of psychological ill health:
- Psychological ill health within the working age population costs UK employers £28 billion per year.
- Work-related stress is now the most common cause of long-term absence from work and one of the top five causes of short-term absence.
- The average employee takes 7.7 days sickness absence per year, costing (on average) £673 per employee per year. Those suffering from work-related stress take, on average, 22.6 days off per year.
- It has been estimated that the effective management of psychological well-being could save an organisation with 100 employees £250,000 per year.

Legal and ethical considerations:
- Employers have a legal ‘duty of care’ to ensure that employees are not made ill by work including tackling the causes of work-related stress.
- Employees suffering psychological ill health through stress at work have a legal right to redress in the civil courts.
- As part of an employer’s corporate social responsibility there is a strong argument that they have a moral duty towards their employees to prevent ill health through work.

Stress is a problem in community pharmacy:
We recently conducted a cross-sectional survey of community pharmacists. We found that:
- Community pharmacists feel significantly more troubled by most sources of work-related stress than a range of NHS employees.
- Community pharmacists working in large multiples or supermarket pharmacies feel significantly more troubled by many sources of work-related stress than those working in independent or small chain pharmacies.
- Pharmacy owners, managers, employees and locums differ in their experiences of work-related stress.
- Work-related stress is associated with poorer physical and mental health, reduced organisational commitment and more days off work.
- Poor health is also associated with reduced productivity.

Organisations can make a difference:
- There is now strong evidence that organisations can be effective in tackling work-related stress.
- Stress management and prevention measures can be directed towards the individual or can target the causes of stress: work context and work content.
- These measures have been shown to benefit individual employees and/or the organisation itself.
What works? The evidence from other organisations

The research literature evaluating different strategies for the prevention and management of work-related stress provides evidence for what works.

The table below lists the types of stress management and prevention measures for which there exists some evidence of effectiveness.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Individual-organisational</th>
<th>Organisational</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Cognitive-behavioural</td>
<td>● Autonomy</td>
<td>● Task/ job characteristics</td>
</tr>
<tr>
<td>approaches</td>
<td>● Co-worker support</td>
<td>● Ergonomics/ physical</td>
</tr>
<tr>
<td>● Counselling</td>
<td>● Appraisals</td>
<td>environment</td>
</tr>
<tr>
<td>● Stress management</td>
<td>● Role-clarity</td>
<td>● Technology/ equipment</td>
</tr>
<tr>
<td>training</td>
<td>● Conflict resolution</td>
<td>● Work scheduling (flexi, rest</td>
</tr>
<tr>
<td>● Exercise</td>
<td>● Teamwork</td>
<td>breaks, shifts)</td>
</tr>
<tr>
<td>● Relaxation/meditation</td>
<td>● Communication</td>
<td>● Skill mix, job rotation</td>
</tr>
<tr>
<td>● Employee assistance</td>
<td>● Participation</td>
<td>● Management training</td>
</tr>
<tr>
<td>programmes</td>
<td>● Time management training</td>
<td>● Company policy/ strategy</td>
</tr>
<tr>
<td>● Return-to-work schemes</td>
<td>● Skill training</td>
<td>● Organisational culture</td>
</tr>
</tbody>
</table>

Historically, strategies have focussed predominantly on the individual (e.g. counselling, cognitive-behavioural approaches, relaxation, etc.), providing support to those already suffering from the effects of work-related stress or giving them the tools or resilience to cope when it arises.

Individual-level approaches also include measures to assist those whose health has already been damaged by chronic stress (e.g. employee assistance programmes, return-to work schemes).

Over recent years however, efforts have increasingly been focussed on strategies to reduce the organisational causes of stress, targeting those aspects of work at either the individual-organisational interface (e.g. role clarity, co-worker support autonomy etc.) or in relation to the organisational context (e.g. ergonomics, management style, work schedules).

The reported benefits of these measures are varied:

- More evidence exists for the effectiveness of individual-level interventions – however, they tend to benefit the individual rather than the organisation and benefits can be short lived.
- The effectiveness of organisational-level interventions is harder to demonstrate – but they are more likely to benefit both the organisation and the individual and the effects can be longer lasting.
How it’s done: factors for successfully implementing stress prevention and management strategies

Whilst evidence exists for the effectiveness of different stress prevention strategies, it is also clear from the research literature that there is no one-size fits all, off-the-peg solution for an organisation seeking to reduce work stress and improve the well-being of its workforce. However, the evidence points to a number of criteria necessary for the success of such endeavours:

1. Sustained top level management support is a pre-requisite to success. This includes ensuring availability of necessary resources when needed.
2. Measures should be context specific. To achieve this, organisations need to undertake a tailored risk assessment (“stress audit”) of different sections and levels of employee.
3. The strategy implemented should combine individual and organisational measures designed on the basis of the risk assessment.
4. Success requires a participative approach. Employees should be involved in all stages of implementation, from design through to evaluation. Cooperation and open communication between management and employees is needed and employees should be recognised as experts.
5. Action planning is vital with clear tasks and responsibilities laid out.
6. Buy-in from middle management is also required. Without this, sustained progress will flounder.
7. Those responsible for the implementation, whether internal or recruited externally for the purpose, should act as facilitators, not enforcers.
8. For any changes to be enduring, stress management needs to be incorporated into the organisational culture – “how things get done around here”. It must be recognised as an important issue in strategy and policy documents and not sidelined. It should acknowledge the role of the organisation as well as the individual.

Further information

If you are interested in finding out more about work-related stress and what organisations can do to tackle it, the following resources can be helpful:

Appendix 4  Interview guide – pharmacists

Background info

First of all, I just need to get a bit of background information about yourself …

How long have you been a registered pharmacist? Have you always worked in the community? How long have you worked in your current pharmacy? Are you the owner/pharmacy manager/other employee pharmacist/locum? Do you work part time or full time? What hours do you generally work? Is this your only job?

Could you also please briefly tell me something about your pharmacy?

Characteristics of organisation:
- Type and size [multiple, supermarket, small/medium chain, independent? How many stores?]
- Management structure [Are pharmacists store managers? Who manages pharmacists? Are they themselves pharmacists?]

Characteristics of own store: location, staffing, volume of work

Could you also please describe your own role and responsibilities?
- Role in dispensing, other responsibilities, staff management, admin duties etc.

Workplace pressures

Are you aware if stress is a problem for pharmacists working in your pharmacy/organisation?

Are you currently, or have you ever been, affected by stress at work? In what way?

On the first page of the briefing paper I sent you, there is a description of the various causes and effects of work stress known from the literature …

What, for you, are/have been the main causes of stress at work? (content/context)

What, for you, are/have been the main effects of stress at work? (individual/ organisational/ patient safety)
- To what extent do you think stress affects your wellbeing?
- What aspects of stress in particular (e.g. dispensing workload, advanced/enhance services/pressure to meet targets/conflicting workloads/pressure from managers/pressure from customers)?
- Do you think this is affecting the quality or safety of the service you provide for your customers?
- In what way?
- Are you aware of ever having made mistakes at work because of workplace stress? If so can you please expand on this?

Is responsibility for patient safety itself a source of stress to you?
Interventions for community pharmacy

Who within your organisation has responsibility for managing or preventing work stress for community pharmacists?

What is your organisation currently doing (or what is currently being planned) to prevent or manage stress at work for community pharmacists?

- How successful do you think it is being?
- What do you think works well?
- What doesn’t work so well?

In relation to workload in particular, do you think there is a need to implement safe workload parameters for community pharmacists?

Is this something you are already doing in your pharmacy?

If yes - What are those parameters? How were they determined?

If no - What do you think those parameters should be? How do you think they should be determined?

Do you think there might be difficulties in implementing safe workload parameters in your pharmacy?

How might these difficulties be overcome?

What (else) do you think that your organisation could or should be doing (instead) to support pharmacists experiencing increasing workloads?

If we could look now at the types of stress management intervention which have been shown to be effective in other organisations (briefing paper, page 3) ...

Which of these interventions do you think might or might not be possible to implement in your pharmacy or organisation to prevent or combat the effects of stress at work for community pharmacists?

- Individual-level interventions
- Individual-organisational level interventions
- Organisational-level interventions

Do you know if your pharmacy/organisation is doing any of these things already? (If yes, success, works, doesn’t work)

What do you think are the main barriers to any of these changes being implemented in your pharmacy?
What do you think might help to facilitate any of these changes?

What evidence or information do you think might help to persuade pharmacies to tackle work stress in pharmacists? Do you think that the business case we make in the information sheet we gave you (p2) is persuasive? How do you think it could be improved?

If we could look now at the standards for best practice in stress prevention and management suggested in the literature (briefing paper, page 4) ...

To what extent do you think it might be possible to implement ‘best practice’ in stress prevention and management within your organisation?

Is any of this happening already, that you’re aware of?

What do you think are the main barriers to this?

What do you think would help facilitate this type of strategy in your pharmacy/organisation?

Future research [if relevant]

From the findings of this study we are hoping to undertake more research in this area, for example to investigate further the links between workload, stress and performance in community pharmacies and to evaluate interventions for stress management in community pharmacy organisations.

Is this something that you/your organisation might be interested in becoming involved in?

In what capacity? (research partner/advisory group/participant/access to participants)

Do you know if your pharmacy/organisation currently holds/collects any data which might help us to investigate the link between workplace pressures, community pharmacists’ well-being and patient safety/other outcomes?

Is this something they might be willing to share for research purposes/or might be looking to obtain help with analysing?

Is the pharmacy/organisation doing anything to evaluate the (cost-) effectiveness of the efforts you are already making to combat workplace pressures for community pharmacists?

Do you know if it is looking for/might be interested in engaging an academic research partner to help with this?
Appendix 5 Interview guide – employers

Background info
First of all, I just need to get a bit of background information about your organisation (Type? Number of employees/stores? Management structure)

Could you also please describe your own role and responsibilities?

Would you say that you personally had a role in managing or preventing work stress for community pharmacists in your organisation?

Could you describe that role?

Who (else) in the organisation has responsibility for this?

Workplace pressures
Are you aware if stress is a problem for pharmacists working in your pharmacy/organisation?

On the first page of the briefing paper I sent you, there is a description of the various causes and effects of work stress known from the literature ...

From your own experience, what do you think are the main causes of stress at work for community pharmacists within your organisation? (content/context)

From your own experience, what do you think are the main effects of stress at work for community pharmacists within your organisation? (individual/organisational/patient safety)

- To what extent do you think stress affects pharmacists’ wellbeing?
- What aspects of stress in particular (e.g. dispensing workload, advanced/enhance services/pressure to meet targets/conflicting workloads/pressure from managers/pressure from customers)?
- Do you think this is affecting the quality or safety of the service you provide for your customers?
- In what way?
- Are you aware of any of your pharmacists ever having made mistakes in the dispensing process because of stress or the volume of work they have had to do?
Interventions for community pharmacy

What is your organisation currently doing (or what is currently being planned) to prevent or manage stress at work for community pharmacists?

- How successful do you think it is being?
- What do you think works well?
- What doesn’t work so well?
- What problems are you facing with implementation?

In relation to workload in particular, do you think there is a need to implement safe workload parameters for community pharmacists?

Is this something you are already doing in your organisation?

If yes - What are those parameters? How were they determined?

If no - What do you think those parameters should be? How do you think they should be determined?

Do you think there might be difficulties in implementing safe workload parameters in your organisation?

How might these difficulties be overcome?

What (else) do you think that your organisation could or should be doing (instead) to support pharmacists experiencing increasing workload pressures?

If we could look now at the types of stress management intervention which have been shown to be effective in other organisations (briefing paper, page 3) ...

Which of these interventions do you think might or might not be possible to implement in your organisation to prevent or combat the effects of stress at work for community pharmacists?

- Individual-level interventions
- Individual-organisational level interventions
- Organisational-level interventions

Is your organisation is doing any of these things already? (If yes, success, works, doesn’t work)

What do you think are the main barriers to your organisation implementing any of these changes?

What do you think might help to facilitate any of these changes?

What evidence or information do you think might help to persuade your organisation or others to tackle work stress in pharmacists? Do you think that the business case we make in the information sheet we gave you (p2) is persuasive? How do you think it could be improved?
If we could look now at the standards for best practice in stress prevention and management suggested in the literature (briefing paper, page 4)...

To what extent do you think it might be possible to implement ‘best practice’ in stress prevention and management within your organisation?

Are you doing any of this already?

What do you think are the main barriers to this?

What do you think would help facilitate this type of strategy in your organisation?

Future research

From the findings of this study we are hoping to undertake more research in this area, for example to investigate further the links between workload, stress and performance in community pharmacies and to evaluate interventions for stress management in community pharmacy organisations.

Is this something that you/your organisation might be interested in becoming involved in?

In what capacity? (research partner/funder/advisory group/participant/access to participants)

Do you currently hold/collection any data which might help us to investigate the link between workplace pressures, community pharmacists’ well-being and patient safety/other outcomes?

Is this something you might be willing to share for research purposes/or might be interested in obtaining help with analysing?

How are/how might you evaluate the (cost-) effectiveness of the efforts you are already making to combat workplace pressures for community pharmacists?

Are you looking for/might you be interested in engaging an academic research partner to help you with this?
Appendix 6    Interview guide – stakeholder organisations

Background info

First of all, could you please briefly describe the role of your organisation?

Could you also please describe your own role and responsibilities?

Does your organisation have a role in relation to supporting community pharmacists affected by stress at work?

- What is your organisation currently doing in this regard?
- Is this something you are directly involved in?
- How successful do you think it is being?
- What do you think works well?
- What doesn’t work so well?

Workplace pressures

Are you aware if stress is a problem for pharmacists working in community pharmacies?

On the first page of the briefing paper I sent you, there is a description of the various causes and effects of work stress known from the literature ...

From your own knowledge and experience, what do you think are the main causes of stress at work for community pharmacists? (content/context)

From your own knowledge and experience, what do you think are the main effects of stress at work for community pharmacists? (individual/organisational/patient safety)

- To what extent do you think stress affects pharmacists’ wellbeing?
- What aspects of stress in particular (e.g. dispensing workload, advanced/enhance services/pressure to meet targets/conflicting workloads/ pressure from managers/pressure from customers)?
- Do you think this is affecting the quality or safety of the service provided for customers?
- In what way?
Interventions for community pharmacy

In relation to workload in particular, do you think there is a need to implement safe workload parameters for community pharmacists?

What do you think those parameters should be? How do you think they should be determined?

Do you think there might be difficulties in implementing safe workload parameters in community pharmacies?

How might these difficulties be overcome?

What (else) do you think that community pharmacies could or should be doing (instead) to support pharmacists experiencing increasing workload pressures?

If we could look now at the types of stress management intervention which have been shown to be effective in other organisations (briefing paper, page 3) ...

Which of these interventions do you think might or might not be possible to implement in community pharmacies to prevent or combat the effects of stress at work for community pharmacists?

- Individual-level interventions
- Individual-organisational level interventions
- Organisational-level interventions

What do you think are the main barriers to community pharmacy organisations implementing any of these changes?

What do you think might help to facilitate any of these changes?

What evidence or information do you think might help to persuade community pharmacies to tackle work stress in pharmacists? Do you think that the business case we make in the information sheet we gave you (p2) is persuasive? How do you think it could be improved?
If we could look now at the standards for best practice in stress prevention and management suggested in the literature (briefing paper, page 4) ...

To what extent do you think it might be possible to implement ‘best practice’ in stress prevention and management within community pharmacy organisations?

What do you think are the main barriers to this?

What do you think would help facilitate this type of strategy in community pharmacy?

Do you know of any examples of good practice in stress management or prevention in community pharmacies? – please describe

**Future research**

From the findings of this study we are hoping to undertake more research in this area, for example to investigate further the links between workload, stress and performance in community pharmacies and to evaluate interventions for stress management in community pharmacy organisations.

Is this something that you/your organisation might be interested in becoming involved in?

In what capacity? (research partner/funder/advisory group/participant/access to participants)

Does your organisation currently hold/collect any data which might help us to investigate the link between workplace pressures, community pharmacists’ well-being and patient safety/other outcomes?

Is this something you might be willing to share for research purposes/or might be interested in obtaining help with analysing?