**Please ensure that this proposal is no longer than two A4 sides**. Thank you.

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| Host department: Keele |
| Project Title: Burnout - The tackling underlying factors intervention (TUF intervention) |
| * Proposed supervisory team\*: * Carolyn Chew-Graham, Professor of General Practice Research, Keele University : expertise in mental health and burnout research in primary care. * Barbara Hanratty, Professor of Primary Care and Public Health, Newcastle University: expertise in primary care research * Maria Panagioti, Senior Lecturer, The University of Manchester: expertise in Improving the well-being of health care providers, and workforce retention/engagement. |
| * Main supervisor: Carolyn Chew-Graham |
| Lead supervisor email (for the website advert): [c.a.chew-graham@keele.ac.uk](mailto:c.a.chew-graham@keele.ac.uk) |
| \*Second supervisor based in a different consortium member to lead supervisor: Maria Panagioti maria.panagioti@manchester.ac.uk |
| External expert advisory team: Clare Gerada, RCGP president, expertise in GP burnout; Cindy Scmidt, Kansas University, expertise in healthcare workers burnout and spiritual health, Alistair Appleby, Aberdeen University, expertise in spiritual health in primary care. |
| Potential for cross consortium networking and educational opportunities: |
| This topic lends itself to cross consortium networking as it is interdisciplinary, with burnout being a ‘hot topic’ well recognised by all researchers within primary care. It is anticipated that networks will be developed across and beyond the consortium, with a wider expert advisory team being developed from multiple disciplines, including, but not limited to, public health, primary care, mental health, spirituality and health, linguistics, and psychology. |
| Project description: |
| Aim:  This project will develop a complex intervention to reduce the impact of burnout on general practitioners (GPs).  Background:  Burnout is currently rife in UK GPs.1 A recent survey (2021) showed that 20% of UK GPs are in the highest risk group for burnout, with mean emotional exhaustion and depersonalisation scores above burnout ‘cut offs’.2 Burnout leads to retirement and resignation3 which adds to the workforce crisis. The Covid-19 pandemic has presented huge challenges to the primary health care workforce.4 There is limited evidence that the identification of burnout and available interventions actually mitigate the risks of burnout.  Burnout appears to have a malign effect on all aspects of health.5 Better personal and workplace spiritual health6 has been linked with reduced risk of burnout in doctors,7 nurses8 and other groups,9 and the survey reported above showed that GPs with low spiritual health scores were five times more likely to be in the highest risk group for burnout.2  A qualitative study, with in-depth interviews with GPs with lived experience of burnout, is currently being conducted.10 Initial analysis indicates common work-related stressors include financial and business, workload, interactions with the regulators, and accommodations for neurodiversity. Personal stressors included past trauma, neurodiversity, personality traits, lack of self care, use of gallows humour and questions about identity.  Early recognition of burnout, and responsive support, is critical.  Proposed Methods:  Phase 1: Systematic review and narrative synthesis  A systematic review/narrative synthesis will be conducted to investigate current interventions used to reduce and treat burnout in GPs in primary care.  A second systematic review/narrative synthesis will investigate current provisions for supporting GPs with personal challenges, for example neurodiversity (Autism, ADHD etc), adverse childhood experiences, or backgrounds of socioeconomic disadvantage.  Phase 2: Qualitative study  Qualitatative investigation of the user experience of current interventions for burnout, for those who returned to general practice after burnout, via a storytelling approach,11 12 allowing assessment of the personal and organisational behaviour changes that were beneficial, and harmful, as well as understanding in depth those interventions.  Development of a stakeholder advisory team.  Phase 3: Intervention development:  A person based approach13 will be taken to co-produce14 an organisational intervention to tackle the predisposing, precipitating, perpetuating factors in burnout, and enhance protective factors. The intervention will be co-produced with practicing GPs and other primary healthcare staff, with purposeful involvement of a diverse group of GPs for applicable areas of the intervention. The design of the intervention will take knowledge gained from phases 1 and 2. This will aim to help GPs identify early if they are at risk of burnout and ill health, support organisational and personal behaviour change to support wellbeing and reduce the risk of burnout, as well as providing underpinning for plans regarding a return to work for both organisations and GPs themselves. It is expected that the intervention will involve an online resource that will offer self directed help and support, as well as contacts for external support; the novelty in the intervention will be its approach to burnout from a spiritual and holistic health perspective, looking at personal and organisational spiritual health (as defined by GPs)6, and holistic health, utilising peer research. While there is current support for the mental health of individual GPs who reach crisis, this intervention aims to support full holistic health, via a systemic approach, before, during and after burnout, not just for GPs themselves, but to promote healthier organisations.  References:  1. Spiers J, Buszewicz M, Chew-Graham CA, et al. The experiences of general practitioner partners living with distress: An interpretative phenomenological analysis. *Journal of Health Psychology* 2018;25(10-11):1439-49. doi: 10.1177/1359105318758860  2. Whitehead IO, Moffatt S, Jagger C, et al. A National Study of Burnout and Spiritual Health in UK General Practitioners During the COVID-19 Pandemic. *PlosOne (in review)* 2022  3. Sheather J, Slattery D. The great resignation—how do we support and retain staff already stretched to their limit? BMJ Opinion, 2021.  4. Jefferson L, Golder S, Heathcote C, et al. GP wellbeing during the COVID-19 pandemic: a systematic review. *British Journal of General Practice* 2022;72(718):e325. doi: 10.3399/BJGP.2021.0680  5. Salvagioni DAJ, Melanda FN, Mesas AE, et al. Physical, psychological and occupational consequences of job burnout: A systematic review of prospective studies. *PLoS One* 2017;12(10):e0185781. doi: 10.1371/journal.pone.0185781 [published Online First: 2017/10/05]  6. Whitehead O, Jagger C, Hanratty B. What do doctors understand by spiritual health? A survey of UK general practitioners. *BMJ Open* 2021;11(8):e045110. doi: 10.1136/bmjopen-2020-045110  7. Ishbel Orla Whitehead SM, Stephanie Warwick, Gemma Frances Spiers, Tafadzwa Patience Kunonga, Eugene Yee Hing Tang, Barbara Hanratty. A systematic review of the relationship between burnout and spiritual health in doctors. *PlosOne (in review)* 2022  8. Wu X, Hayter M, Lee AJ, et al. Positive spiritual climate supports transformational leadership as means to reduce nursing burnout and intent to leave. *Journal of Nursing Management* 2020;28(4):804-13. doi: https://doi.org/10.1111/jonm.12994  9. Lizano EL, Godoy AJ, Allen N. Spirituality and worker well-being: Examining the relationship between spirituality, job burnout, and work engagement. *Journal of Religion & Spirituality in Social Work: Social Thought* 2019;38(2):197-216. doi: 10.1080/15426432.2019.1577787  10. Whitehead IO. Depth interviews with burned out GPs: In analysis, 2022.  11. McCall B, Shallcross L, Wilson M, et al. Storytelling as a Research Tool Used to Explore Insights and as an Intervention in Public Health: A Systematic Narrative Review. *International Journal of Public Health* 2021;66 doi: 10.3389/ijph.2021.1604262  12. Hebert LE, Bansal S, Lee SY, et al. Understanding young women’s experiences of gender inequality in Lucknow, Uttar Pradesh through story circles. *International Journal of Adolescence and Youth* 2020;25(1):1-11. doi: 10.1080/02673843.2019.1568888  13. Yardley L, Morrison L, Bradbury K, et al. The Person-Based Approach to Intervention Development: Application to Digital Health-Related Behavior Change Interventions. *J Med Internet Res* 2015;17(1):e30. doi: 10.2196/jmir.4055  14. Hawkins J, Madden K, Fletcher A, et al. Development of a framework for the co-production and prototyping of public health interventions. *BMC Public Health* 2017;17(1):689. doi: 10.1186/s12889-017-4695-8 |

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| Training and development provision by host: |
| *Formal training:*  Training in co-production  Training in the Person Based Approach to intervention development  Training in storytelling research, and use in behaviour change theory  Other training based on existing skills and needs of student |
| *Informal training:*  Throughout the PhD, the student will have opportunities to attend university training courses and departmental seminars which offer training in planning a PhD, time management, presentations, viva preparation, writing up, publications, and career development. The student will also receive career advice mentoring throughout the three years. |
| *PPIE:*  Public and patient involvement has been key to the development of this topic, and further involvement will be sought. A considerable amount of Public and Patient Involvement and Engagement (PPIE) takes place at Keele University with a number of supportive resources developed (<https://www.keele.ac.uk/pcsc/research/ppie/>). Crucial to this topic is involvement of stakeholders (GPs themselves, and other primary care clinicians and managers) through co-production of the intervention, especially recruitment of marginalised GPs such as those from diverse backgrounds, including neurodiverse GPs and those from childhoods in a lower socio-economic position, or experiencing adverse childhood experiences. |

N.B. No more than 2 pages to this part of the form please

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| Indicative project costs:  The indicative research budget for each fellow is £20-25k.  This information will not form part of the web advert |
| Estimated costs include:  Conference attendance and travel £1500  PPIE and stakeholder reimbursement £2000  Training costs**:** NatCen training: Focus group training- designing and moderating focus groups £440, other training as needed £2000  Open access publishing £4000  Inter-library loans and translation for non-english papers £200  Focus group costs, including digital transcription costs £5000  Development and hosting of the intervention £8000 |

\* **Who will be the supervisors and where will students be based for their doctoral studies?**

Across the consortium there are currently approximately 340 potential supervisors. Students will typically be based in the institution of their primary supervisor

Wherever possible a students' second supervisor will be based in a different consortium member organisation or in a non-member organisation. The programme will provide supervision that crosses institutional boundaries to provide a supervisory team that fits the needs of the student and expands the diversity of the students and their research.

The programme will always pair less experienced supervisors with more experienced ones and, in some cases, students can have up to four supervisors to increase the diversity and inclusiveness of our supervisory pool.