Time for a rebalance: psychological and emotional well-being in the healthcare workforce as the foundation for patient safety

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The COVID-19 pandemic shone a light on the work and needs of the healthcare workforce like never before, resulting in an increased focus of workforce well-being research, policy and within mainstream media. Despite this recent attention, the relevance of workforce well-being for healthcare delivery and efficiency is not a new phenomenon. The National Health Service (NHS) in England employs around 1.4 million people,[1] and as such provides a prominent case study for these issues. A landmark report in 2009 by Dr Steve Boorman (commissioned by the English Department of Health[2]) reviewed the health and well-being of the NHS workforce in England. The report highlighted issues with poor well-being, sickness and the likely relationship between workforce well-being and patient outcomes. Recommendations were outlined to reduce staff sickness and improve experiences of work, with cost savings predicted at £500 million per year if sickness was reduced by a third. Dr Boorman's report was one of the first calls for change and many have since followed.

Forward to 2024 and the NHS workforce is experiencing unprecedented demand with systemic stress, burnout and sickness alongside the psychological legacy of the pandemic.[3] Sickness rates in the NHS are higher than in the rest of the economy.[4] In 2023, around 42% of staff felt unwell in the last 12 months as a direct result of workplace stress and just under 55% had come to work in the last 3 months despite not feeling well enough to do their duties, known as 'presenteeism'. It is important to note that for this most recent round of the NHS Staff Survey,[5] 48% of staff completed the survey; some argue this in itself speaks loudly to how staff in the NHS feel, given that 52% did not complete it.[6] Recent analysis by the International Public Policy Observatory, via The University of East Anglia and RAND Europe, estimated the cost of poor mental health and well-being to NHS England might amount to £12.1 billion per year.[7]

Workforce well-being issues are fundamental for retention and the delivery of quality healthcare, yet can be labelled as 'soft' and easily overlooked compared with more technical aspects of healthcare management. This is regardless of the evidence showing that where staff well-being is prioritised, patients are safer. Despite these observations in the academic literature, the prioritisation and management of workforce well-being in practice are complex. In line with this complexity, in this issue of *BMJ Quality and Safety*, Taylor *et al*[8] used a fitting realist lens to synthesise literature on the causes of psychological ill-health and interventions designed to support the workforce. Their study focusses specifically on nurses, midwives and paramedics as these groups make up around 30% of the total NHS workforce and over half of the clinical workforce. The realist analyses drew on initial theory development from 8 key reports and 159 sources. The authors identified 26 context–mechanism–outcome configurations: 16 explaining causes of psychological ill-health and the other 10 helping to explain why well-being interventions have not worked to mitigate psychological ill-health. These were synthesised into five key findings:

1. A blame culture makes psychological well-being difficult to promote.

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2. System needs frequently over-ride staff psychological well-being.
3. Implementing and upholding values at work often have unintended personal consequences for staff.
4. Interventions designed to support well-being are usually focused on the individual and fail to recognise cumulative chronic stressors.
5. Identifying and implementing interventions is challenging.

Through their analysis, the authors identified several tensions between the realities of healthcare delivery that seem incompatible with and affect the psychological ill-health of the workforce. Therefore, they call for an urgent need to restore the balance in four key areas and prioritise multilevel systems approaches that consider the conflicting demands between meeting service delivery requirements, and protecting the workforce:

1. Psychological harm to frontline healthcare workers should be anticipated and planned for.
2. Listening and learning cultures should be balanced with the need for professional accountability.
3. Interventions that are reactive in nature (usually in response to traumatic events) must be balanced with proactive preventative interventions.
4. An individual focus where feeling blamed for their own psychological ill-health must be balanced with an organisational focus to address systematic issues—A systems approach to staff psychological well-being is needed, which balances individual responsibility for psychological ill-health with organisational responsibility, interventions and bundles of support.

The unique contribution of the study relates, in part, to the use of a realist methodology, which has facilitated insights into the complexity of healthcare environment context(s). As the authors note, previous studies have failed to explore this sufficiently and have often focused on individual professional groups. Studying across groups and subsequently across contexts stands to gain a deeper exploration of cross-disciplinary challenges.

EMOTIONAL 'COST' OF CARE AND MECHANISMS OFSUPPORT

Psychological ill-health is a product of cumulative stress as well as exposure to individual traumatic events. The emotional complexity of healthcare delivery is intensely stressful and rarely acknowledged or recognised,[9] even though heightened emotional experiences affect clinical decision-making and play an integral part in care delivery and patient safety.[10]

Emotional labour theorises how nurses and other healthcare staff manage their emotions to ensure their patients feel safe. This labour has been studied extensively since the 1990s when the likes of Smith[9] and James[11] applied Hochschild's[12] landmark emotional labour theoretical lens ('The Managed Heart') to nurses' practice. Over the last 30 years, the unwaning pressure on healthcare services in contemporary practice has increased the intensity of emotional work, as staff still strive to 'balance' meeting patient expectation, their own professional expectations of what 'good' care looks like and operational demands.

This labour is not without cost to the individual, one of many unintended personal costs of upholding and implementing values as shown by Taylor *et al*. Certain types of emotional labour (namely 'deep acting', where staff try to manipulate true feelings to conform to the 'expected' emotional display) are related to burnout, poor well-being and intention to leave.[13] This can result in secondary trauma, 'moral injury', suppressing guilt, frustration and grief as staff are unable to deliver care which aligns with their professional values.[14] In a study undertaken during the COVID-19 pandemic, healthcare workers were twice as likely as the general population to experience post-traumatic stress disorder, and one in five met the threshold for conditions such as anxiety and depression.[15]

In practice though, strategies to address psychological well-being often focus on strengthening an individual's resilience and are usually designed to respond to acute trauma (eg, trauma-focused peer support known as 'TRiM') rather than considering cumulative stress and moral injury. Many argue that placing the emphasis on individual resilience as an inherent quality is further damaging to staff and ignores organisational responsibility,[16] particularly at a time when the workforce is already showing great resilience. Concurrently, as shown by Taylor *et al*, the absence of a structured approach to workforce well-being means implementation is challenging. Front-line staff often struggle to access interventions in a meaningful way. Organisational challenges and culture prevent staff, particularly more junior staff, from accessing support.[17] Taylor *et al* call for whole-system approaches to improving well-being, with organisation-wide interventions and bundles of support, which are preventative as well as reactive; a request echoed in the wider literature.[3]

STAFF WELL-BEING AS THE FOUNDATION TO IMPROVE PATIENT SAFETY

We know that over time, as staff suppress their true emotion (deep acting), they experience compassion fatigue and can become numb to the suffering of others, described by Taylor *et al* as a 'buffer' against secondary trauma. Ultimately and unsurprisingly, staff with better well-being are more likely to deliver compassionate care.[4 18]

Psychological well-being is also intrinsic to clinical safety outcomes. This is evident in two ways. First, staff who are well deliver safer care and are less likely to make clinical errors.[19 20] Second, when staff are well, they are less likely to be absent. Staff who are off sick from work contribute to depleted staffing which is fundamental for patient safety. In nursing, for example, when staffing is reduced and/or skill mix is

poor, patients are more likely to die[21] and any resulting care left 'undone' results in poor patient experience. Patients in hospitals with highest patient to lowest nurse ratios have 26% higher mortality (95% CI: 12% to 49%)[22] with more recent research echoing the same. In addition, the nurses left behind are twice as likely to be dissatisfied with their jobs, to show high burnout levels, and to report low or deteriorating quality of care in their hospitals,[21] continuing the cycle.

Although the impact of the experience of the workforce, their emotion and psychological well-being on patient safety is evident, these issues are often considered separately in healthcare management. Taylor *et al* highlight the lack of attention by regulatory bodies and NHS organisations to consider wider workforce issues when managing clinical error with catastrophic outcomes for those staff involved (secondary trauma and suicidal ideation). Similarly, wider 'solutions' to patient safety culture in academic literature can also fail to (explicitly) acknowledge, how critical an adequate and well workforce is to their likely success. The same considerations can be applied to many initiatives that stand to improve care. For example, most attempts to improve patient experience, care quality and increase efficiency in healthcare practice all require the workforce at their core but this acknowledgement is not always obvious. Based on growing evidence showing the relevance of psychological well-being for patient safety, it seems unlikely that safety culture and other initiatives that begin without an adequate and psychological well workforce will produce the desired results or ability to sustain them.

WHERE NEXT?

There is a growing body of literature confirming the relationship between workforce well-being and patient experience and outcomes. Economic evaluations have outlined potential cost savings into the billions.[7] Concurrently, there are a range of interventions shown to improve the well-being of the workforce and staff's experiences of delivering care. Yet poor well-being, sickness and retention issues persist and are significantly impacting the NHS's ability to deliver safe care, and similarly in other countries. Psychological ill-health is, as Taylor *et al* argue, highly prevalent across the workforce. Although their paper draws attention to the challenges faced by nurses, midwives and paramedics due to their dominance in the clinical field, there is likely to be transferability to other staff groups. This opens up future research opportunities which include other allied health professionals alongside 'non-qualified'/registered staff. Their study shows the causative explanations of tension, created as organisations juggle between healthcare delivery and the needs of the workforce and how some of these tensions are incompatible.

The call for an urgent rebalance in healthcare working environments to enable healthcare staff to recover and, ultimately, thrive is therefore timely and requires action. A shift to the needs of the workforce as a priority is supported widely in the academic literature and is welcome, but needs to be translated into concrete initiatives in practice. This calls for an open conversation that balances the current risk to patient safety posed by a depleted and unwell workforce versus the likely gains of prioritising the needs of the workforce going forward. Practical measures could be the inclusion of workforce well-being metrics from health and professional regulators. However, caution should be taken that mandating elements of well-being does not become a 'tick box' exercise when actualised at a local level.

Ultimately, in support of this rebalance, it is of paramount importance that a fully-staffed, psychologically well workforce is seen as 'the' foundational patient safety intervention across practice, policy and research going forward. For example, as researchers, we have a responsibility to make these links obvious when planning, undertaking and publishing our work. Until then, other efforts to improve efficiency, patient experience and safety outcomes can be seen as building a house without laying the foundations… or as one clinical leader told me; the 'cherry' on a cake without the flour.

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