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The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom

Professor Gail Kinman, Dr Kevin Teoh and Professor Anne Harriss

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"COVID-19 will have further detracted from the mental health of nurses and midwives, as detailed in this report. 2020 is the International Year of the Nurse and Midwife, and this must now be a priority."

Professor Anne Harriss
President, The Society of Occupational Medicine

"This report is very timely and clearly shows that the stress of work leads to long term and widespread mental health problems and burnout among nurses and midwives. While the report was written before the COVID-19 pandemic, the situation has further highlighted how essential it is for nurses and midwives to have supportive work environments. It is really important that policy makers and workforce planning take into consideration the recommendations in this report."

Helen Donovan
Professional Lead for Public Health, Royal College of Nurses

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Professor Gail Kinman, Dr Kevin Teoh and **Professor Anne Harriss**

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EXECUTIVE SUMMARY

This report aims to summarise the research evidence on the mental health and wellbeing of nurses and midwives working in the United Kingdom. The review was conducted prior to the COVID-19 pandemic. The high levels of work-related stress, burnout and mental health problems identified are likely to have risen further due to the exceptional pressure that many nurses and midwives are experiencing during the pandemic and will likely increase for some time to come. Many staff are at high risk of post-traumatic stress symptoms and are experiencing moral distress. The prevalence of presenteeism (i.e. working while sick) is also likely to have risen in the sector. The challenges presented by the pandemic and the potential impact on nurses and midwives will be considered at various points in the report.

The report considers four questions:

i. What is the current state and prevalence of mental ill health and wellbeing among nurses and midwives?

ii. What are the factors that influence the mental health and wellbeing of nurses and midwives?

iii. What impact does the mental health and wellbeing of nurses and midwives have on the workforce and patient care?

iv. What mental health and wellbeing interventions have been conducted with nurses and midwives and how effective are they?

A systematic review found 100 studies, published in the last ten years, that shed light on the occupational, organisational and individual factors that influence the mental health and wellbeing of nurses and midwives and the implications for the workforce and the quality of patient care. Interventions that have the potential to improve the wellbeing of nurses and midwives are also considered.

Key findings include:

- Nurses and midwives are at considerable risk of work-related stress, burnout and mental health problems such as depression and anxiety. The risk, including the rate of suicide among female nurses, is greater than that of the general working population. Rates of poor mental health appear to be increasing in response to rising demands, staffing shortages and diminishing resources. These pressures are often systemic in nature and require intervention at public policy and organisational levels.
- Overall, nurses and midwives are deeply engaged in the work they do and strongly motivated to make a positive difference to the lives of patients and their families. Little is known, however, about how these positive aspects of wellbeing can be increased in these professional groups.
- Nurses and midwives strive hard to ensure that their working conditions and any stress they may experience does not adversely affect their patients. Nonetheless, there is strong evidence that poor mental health and wellbeing among staff impairs the quality of patient care. Nurses and midwives are at particularly high risk of moral distress if institutional pressures and constraints stop them from pursuing what they believe to be the most appropriate course of action for their patients.
- Satisfaction with job demands, control, support and role clarity are lower among nurses and midwives than other professional groups in the UK and strongly linked to stress and burnout.
- Nurses and midwives are at particularly high risk of harassment and bullying which is a key source of distress. Such experiences appear to have become more common over time, but a 'culture of silence' surrounding this issue has been identified meaning that it is not openly or adequately addressed. Staff from Black and Minority Ethnic (BAME) backgrounds are at greater risk of bullying and harassment than other groups. More research is needed that examines bullying and harassment in healthcare settings to inform the development of interventions to reduce this harmful behaviour.
- There is also an urgent need for research that examines important gaps in our understanding of how the experiences of diverse groups of nurses and their radically different working environments impact on their mental health and wellbeing. Longitudinal studies are particularly needed to examine how working conditions and demographic factors impact on mental health and wellbeing.
- The demands for nurses and midwives to provide compassionate, patient-centred care means that the high risk of compassion fatigue should be acknowledged, and interventions put in place to reduce its harmful effects.

- Work-life balance is generally poor among nurses and midwives and a major cause of stress. Longer shifts, as well as limiting opportunities for rest and recovery, can also be detrimental for their mental health, wellbeing and job satisfaction. Adequate opportunities to recover from the job mentally as well as physically are vital to ensure health and optimum job performance.
- Rather than take time off to recover, nurses and midwives often continue to work when they are unwell. There are several reasons for this 'presenteeism', such as low staffing levels, feelings of responsibility to their patients, and a reluctance to let their colleagues down. Presenteeism is more costly than absenteeism and has serious implications for the wellbeing of staff and patient safety. It is therefore vital to highlight the risks of presenteeism for staff and patients and implement systemic interventions to identify and manage the factors that encourage nurses and midwives to work while sick.
- Retention rates in nursing and midwifery are generally poor. Low staffing levels, high workloads, and an inability to provide the standard of care required are the most frequent reasons for wishing to leave, as they reduce feelings of commitment to the organisation and increase the risk of stress and burnout. Early career staff appear to be at particular risk of leaving the professions.
- The poor mental health and wellbeing found among UK nurses and midwives and its implications for patient care should be of grave concern to all stakeholders in the healthcare sector.
- The stigma associated with mental health problems and a perceived 'failure to cope' means that many nurses and midwives are reluctant to disclose such difficulties and therefore may not access support. It is crucial to tackle the stigma associated with seeking help, otherwise, even the best-planned and resourced support initiatives will not be effective.

It is vital to build a culture within healthcare organisations that explicitly recognises how the nature of the work and working conditions can impact on the wellbeing of staff. This review highlights the need for healthcare organisations to carefully scrutinise their cultures and take the action required to implement systemic change. Particular focus should be placed on tackling the sources of workplace stress (i.e. improving working conditions) rather than merely aiming to enhance resilience at an individual level.

In total, 45 recommendations are made, with eight highlighted as key priorities. These are:

1. Action is needed to address the organisational factors found to underpin poor mental health and wellbeing in nurses and midwives (e.g. high work demands, poor leadership, lack of resourcing and workplace bullying)
2. Optimum staffing levels for nurses and midwives are essential
3. Staff should be required to take their full entitlement to breaks and have access to appropriate food and drink and bathroom facilities at all times
4. All organisations should have a mental health strategy that is fully implemented, demonstrating their commitment to improving the wellbeing of all nurses and midwives with holistic interventions in place to address prevention, treatment and rehabilitation
5. Managers and shift coordinators need a better understanding of the impact of shift-work on health and how this can be mitigated
6. Managers need to have the opportunity, time and resources to support the wellbeing of their staff effectively without putting their own wellbeing at risk
7. Regular audits are needed to assess the scale of mental health problems and the key contributory factors within the nursing and midwifery workforce
8. The issues of bullying, harassment and power imbalances and their impact on the mental health and wellbeing of the BAME nursing and midwifery workforce is a priority for research and practice.

The implications of this report for different stakeholders are presented below.

Urgent action required: what this report means for different stakeholders

The conclusion and recommendations from this report highlight the need for urgent action to support and enhance the mental health and wellbeing of nurses and midwives. A preventative approach is required where interventions are structural and systemic. Improving the wellbeing of the workforce will have wide-ranging benefits for individuals, organisations and society as well as for healthcare professionals themselves, as retention, staff performance and the quality of patient care are likely to be enhanced. There is also a need to better understand the experiences of BAME staff in the workplace and to address the causes of inequalities between ethnic groups. It should be noted that many individuals, teams, organisations and national bodies in the NHS are working hard to foster climates of fairness, inclusion, compassion and equality[173]. More research is needed that examines the experiences of BAME nurses and midwives in order to inform action, however, as few studies have considered ethnic differences or report data by ethnic group.

Based on the report findings, recommendations and discussions, the key messages for different stakeholder groups, from policy makers to individuals, are provided below.

Policy makers

This review highlights the key issues that underpin the generally poor mental health and wellbeing of nurses and midwives. For this to improve, focus should be placed on ensuring optimum staffing levels, implementing incentives to attract and retain nurses and midwives, and designing induction and preceptorship programmes that are targeted to the needs of early career staff. Attention to reducing bureaucracy and administration across these staff groups is not only likely to reduce work-related stress among staff, but also enhance patient care. Flexible approaches to help retain experienced staff and help them return to work following periods of sickness should be encouraged. It is also crucial to include additional time worked when estimating the overall hours that staff work.

Professional bodies

More proactive involvement is needed to identify and regulate the causes of poor wellbeing among nurses and midwives (e.g. high work demands, poor leadership, lack of resourcing, and workplace bullying). The implications of poor wellbeing for the wellbeing and safety of patients should also be widely communicated. Administering panel surveys using validated measures on a regular basis will highlight the mental health and wellbeing profiles of staff over time, and the causes and consequences, as well as identify the impact of any interventions. Research is clearly needed to examine the implications of the COVID-19 pandemic and its aftermath on the wellbeing and mental health of nurses in the UK. Capturing the experiences of little heard groups, such as BAME staff, male nurses and midwives and those working in non-NHS settings, is particularly important. Professional bodies should continue to campaign for better support for the wellbeing of nurses and midwives at an organisational level and reinforce the need for evidence-informed strategies for self-care and mental wellbeing promotion in pre-registration training. It is also crucial to continue to work towards dispelling the stigma of disclosing poor mental health and wellbeing and accessing support in order to foster healthier working cultures.

Regulators

There is a need for regulators to recognise and highlight the importance of nurse and midwives' mental health and wellbeing in relation to the professional Code and Standards, including the need to ensure safe and appropriate working conditions. The Code could be used to enhance psychological safety among nurses and midwives by enabling them to advocate for their own wellbeing as well as for their patients. Crucially, regulators should work alongside the nursing and midwifery workforce to encourage open discussion around mental health and wellbeing, and to discourage a culture of fear and stigma where nurses and midwives may be concerned about any potential repercussions of disclosing that they are having difficulties coping.

Organisations

Organisations have a major role to play in improving working environments for nurses and midwives and preventing poor mental wellbeing from occurring at source. NHS organisations should implement and adequately resource the recommendations from NHS Improvement and Employers and the Advisory Board on ways to enhance health and wellbeing in their staff. Perhaps most importantly, a workplace culture is needed that recognises the risks to staff wellbeing and encourages rather than stigmatises help-seeking.

A review of leadership practice is urgently required, as well as the development of effective leaders within the organisations to lead on change in general and more specifically ensure a change of culture surrounding mental health in the workplace. All organisations should have clear and accessible policies (e.g. mental health at work, workplace bullying, racial harassment, sickness absence) that inform practice and their effectiveness should be carefully evaluated. It is crucial that basic human needs are met, including entitlement to breaks and access to appropriate food and drink and bathroom facilities. Organisations should also ensure that essential equipment is available and works efficiently.

Organisations should provide standard, mandatory training to managers on how to monitor and manage staff wellbeing and this should also be a regular review item in their annual appraisal. Staff also need more guidance on the support for mental health and wellbeing that is available to them. As well as being more visible, support services should be better resourced in order to meet demand, and barriers to access identified and removed. The role played by occupational health and the processes involved should be clarified for staff and managers. Careful consideration of how occupational health services could be used to implement and evaluate primary, secondary and tertiary interventions is also likely to be beneficial.

A supportive organisation should consider the wellbeing of staff when decisions are made (e.g. targets and deadlines) and sufficient opportunities for staff to have input into change initiatives and decision making are essential. Awareness of 'change fatigue' and how it can manifest itself is also required. Staff should be offered support that better fits their needs (e.g. through formal processes such as reflective supervision, mentoring and team development, Schwartz Rounds®, providing opportunities for colleagues to spend time with each other informally, or using technology to provide positive dynamic feedback). Changes to work practices, including more creative and tailored flexible working options, are needed to improve work-life balance and encourage return to work after sickness absence. Greater flexibility will also enable staff to participate in wellbeing interventions and training and access support systems, as well as provide crucial input into change initiatives. It is also crucial to acknowledge the health and safety risks of sickness presenteeism, identify its causes and implement interventions to tackle such behaviour.

Managers

Managers at all levels need a greater understanding of how the work can impact on the mental health and wellbeing of nurses and midwives and how best to engage and support staff who are experiencing difficulties. Insight into how the design of work can promote the professional values of nursing and midwifery and consequently boost morale, job satisfaction, and the quality of patient care, is also needed. Managers need a keen awareness of nurses' and midwives' roles and duties, together with a well-informed and flexible approach to the allocation of workload, tasks, and shifts. The importance of managers involving staff in decision making is recognised as well as making opportunities to work closely with them to identify and implement small local changes that can improve their working environment. Managers need to develop the competencies associated with effective leadership,

as well as those required to support the wellbeing of staff and how to make reasonable adjustments for those with health concerns. It is important to recognise, however, that many managers are doing their very best in difficult circumstances. Moreover, feedback in the NHS Staff Survey shows that many healthcare workers are satisfied with the support they get from their line manager. Managers should be given the time and resources to fulfil this key aspect of their role effectively as well as the opportunity to protect their own wellbeing and to seek help if required.

Occupational health

All nurses and midwives should have access to occupational health support and be able to self-refer to this, and other support services, rather than going through their managers. Occupational health staff need to be aware of the working conditions of staff and how they can impact on mental health and wellbeing. They also require additional training on supporting mental health, including taking a proactive preventative approach. Occupational health professionals should be given the opportunity to work closely with managers and human resources to provide optimum and individualised support to nurses and midwives within their workplaces. It is particularly important for occupational health staff to have the training, resources and tools to meet the needs of staff and staffing levels should be sufficient to meet the increasing demand inherent in healthcare organisations. It is likely that the demand for occupational health services for mental health difficulties will rise due to the challenges of the COVID-19 pandemic.

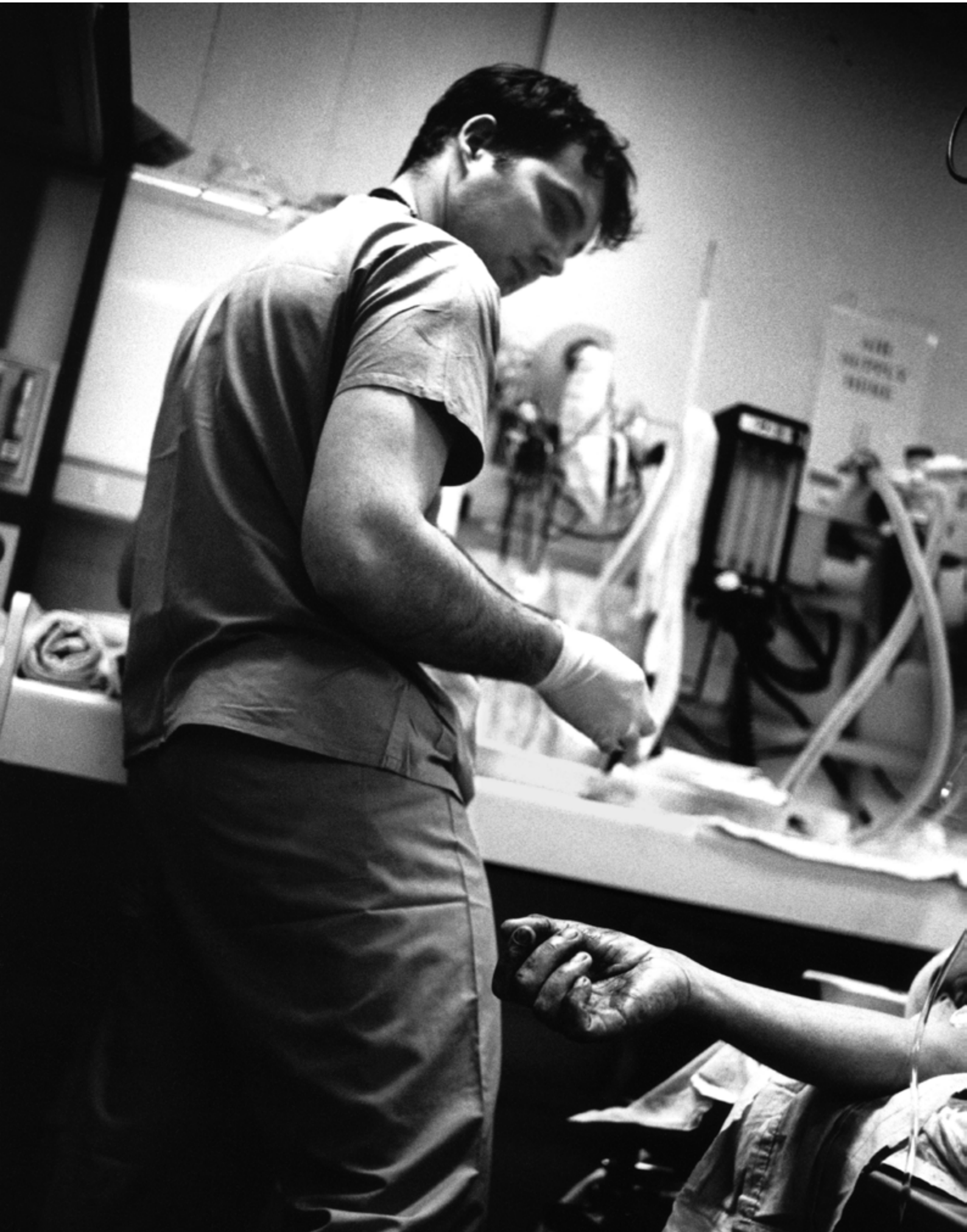
Researchers

Although this is undoubtedly important, research should move beyond identifying the prevalence of mental ill health and poor wellbeing among nurses and midwives and highlight the causes of this and the implications for patient safety and other key outcomes. It is also necessary to consider the impact of poor wellbeing at the group level (e.g. department, ward, hospital) in order to make a clear business case for improvement. More intervention studies are required with groups of nurses and midwives, particularly those that aim to address the structural causes of stress. Longitudinal studies are also crucial to identify causality and the results would strengthen the argument for effective interventions. The findings also have potential to help leaders develop their wellbeing strategy and inform effective line management behaviours, as well as improve the wellbeing of individual staff members.

A focus on positive factors (e.g. those that underpin engagement and flourishing among staff, and positive management behaviours) will also inform interventions to maximise wellbeing among staff rather than merely reduce workplace stress. Further insight into interventions that can promote positive mental and wellbeing is needed in order to introduce evidence-informed strategies. The implications of an ageing, female dominated workforce also require further examination. There is a need to focus on BAME nurses and midwives in particular, as there is some evidence that their wellbeing may be poorer than staff from other backgrounds. Insight is also needed into the experiences of older workers, other groups such as male nurses and midwives and those working outside the NHS. This review highlighted several other topics that are worthy of further exploration, such as the impact of lone working on wellbeing and the effectiveness of whistleblowing guardians.

Individuals

Despite the emphasis on the organisation and wider system, individual nurses and midwives should take steps to engage in appropriate self-care and develop a 'tool-box' of stress management and resilience-building skills. They can also make small, local changes to try to reduce the demands they experience and enhance their sense of control, and/or seek out additional resources (i.e. material and social) that can help them manage their work environments more effectively. The resources in this report, as well as local support from trade unions and wider professional organisations, can provide them with some guidance.



INTRODUCTION

Nursing and midwifery in the United Kingdom (UK) is experiencing unprecedented challenges. More than 10% of nurses have left the NHS over the previous three years[1], and a national shortage of midwives has also been identified[2]. Moreover, there are currently around 40,000 vacant posts in England[3] at a time when demand for healthcare is rising, with serious implications for the wellbeing of the staff that are remaining in post and for the quality of patient care. The COVID-19 pandemic presents additional challenges to the nursing and midwifery workforce. Some of the key problems that have been identified are a lack of personal protective equipment, intensification of demands, an increase in case complexity and assignments to different wards, as well as working under conditions of constant uncertainty and low control[174-176]. Further concerns expressed by staff are anxiety about their own health and wellbeing and concerns about families and caring responsibilities.

Although both nursing and midwifery are rewarding professions, they can be highly stressful. Statistics published by the Health and Safety Executive (HSE)[4] show that healthcare professionals (along with social care staff) report more work-related stress, depression, and anxiety than other occupational groups. The risk of mental health problems, burnout, and suicide ideation also appears to be growing among NHS nurses in line with increasing demands and diminishing resources. Moreover, other factors associated with stress and mental health problems, such as absenteeism, presenteeism, and poor retention, are also on the rise.

A synthesis of the research evidence is required to examine the mental wellbeing of UK nurses and midwives, the key risk factors, and the wider implications for staff and their patients. An overview of interventions is also needed to identify 'what works': how best to support staff wellbeing at the organisational and individual level. This report reviews the research evidence related to the mental wellbeing of nurses and midwives working in the UK over the past ten years.

Reflecting the specific research questions, the report is structured into four sections:

i. What is the current state and prevalence of mental ill health and wellbeing among nurses and midwives?

ii. What are the factors that influence the mental health and wellbeing of nurses and midwives?

iii. What impact does the mental health and wellbeing of nurses and midwives have on the workforce and patient care?

iv. What mental health and wellbeing interventions have been conducted with nurses and midwives and how effective are they?

Within each section of this report, results from the systematic review are summarised followed by supplementary research that provides additional contextual information. Finally, recommendations are provided that arose from a three-stage process: a) an initial review of the research evidence; b) feedback from a Steering Group comprising people with expertise in occupational health research and practice, the wellbeing of nurses and midwives, and the lived experience of being a healthcare professional; c) a review and prioritisation of the draft recommendations by a panel of stakeholders from different areas of nursing and midwifery using the Delphi technique. The methods used in the review and the Delphi process are described in Appendix 2 and 3.

This report is based on a review of research that has sampled groups of registered nurses and midwives working in the UK. Wherever possible we identify whether nurses and/or midwives were included and, if the information is available, the type/s of nursing specialty covered. Commonly, however, researchers do not provide such detailed information on sampling and some studies will have included mixed groups of nurses and midwives and possibly healthcare assistants. Where relevant, we provide some direct quotes from studies of nurses and midwives to highlight specific issues. Nonetheless, it should be recognised that nurses and midwives are not a homogenous group; they work in a wide range of specialties and contexts and their working conditions and experiences are likely to differ.

SECTION I

The current state of mental wellbeing among nurses and midwives in the UK

The mental health of nurses and midwives has been measured in several ways: work-related stress, burnout, general mental health problems, as well as more specific symptoms such as depression and anxiety. Some studies extend the notion of health as freedom from disease and assess positive mental health and wellbeing.

This section reviews the available research in five broad areas: work-related stress, burnout, psychiatric morbidity, suicide, and positive wellbeing. Where available, estimates of prevalence are provided for nurses and midwives, with any differences between professions and specialties that are reported highlighted. The antecedents and outcomes of poor mental health in these professional groups are then discussed in Sections II and III of this report.

Work-related stress

The most commonly used definition of work-related stress in the UK is from the Health and Safety Executive (HSE): "the adverse reaction people have to excessive pressures or other types of demand placed on them"[5]. Studies have examined the severity of self-reported work-related stress among groups of nurses and midwives, as well as their perceptions of how stress affects their health.

- Data from the 2018[A] NHS Staff Survey[6], showed that 43.5% of the 127,564 registered nurses and midwives in England who responded reported feeling unwell due to work-related stress. Perceived stress was most frequent among the 9,096 midwives that participated (51.6%), followed by mental health nurses (49.5%), health visitors (47.9%), and district and community nurses (46.3%).
- Similar rates of work-related stress (50%) were observed in a 2013 RCN survey of 2,000 nurses employed in the NHS and the private sector[7].
- A study of 1,997 midwives working in the UK found that 32.9% reported experiencing moderate, severe or extreme levels of work-related stress[8]. This is higher than the level of stress reported by samples of midwives working in Sweden, Australia, and New Zealand.

"[I am] so tired on my days off that I don't have the energy to do the things I want to do." – ***Midwife***[9]

A. The 2018 NHS Staff Survey was the most recent version during the review process and is reported here. The 2019 NHS Staff Survey results are reported in "Understanding the context" and are similar to 2018.

Burnout

Burnout has three components: emotional exhaustion, depersonalisation, and reduced personal accomplishment[10].

Emotional exhaustion is the core component of burnout whereby individuals become emotionally drained by the interpersonal demands and chronic stress of their work. Depersonalisation refers to the development of negative and cynical feelings towards others, as well as a psychological withdrawal from personal and working relationships. Finally, reduced personal accomplishment represents a lack of effectiveness at work arising from feelings of emotional exhaustion and depersonalisation.

- High prevalence rates of burnout have been found in several studies of nurses[11–14]. Between 29.2% and 50.8% of nurse participants were found to be emotionally exhausted, while a high level of depersonalisation was observed in between 20.5% and 32%. These studies reported low personal accomplishment in between 21.7% and 29.9% of nurse participants. Little difference was found in levels of burnout reported by nurses who worked in acute and mental health settings. No differences between ethnic groups were found in mental health nurses in the only study that examined this issue.[14]
- Studies have found that the prevalence of burnout among nurses in the UK (40%, n=2,918) was higher than the ten other European countries included (the mean prevalence of burnout for the sample as a whole was 28% of a total sample of 20,241)[15]. A separate study of 9,855 nurses working in the UK found they were at greater risk of burnout than nurses working in Germany, but the level was comparable to the four non-European countries included (United States, Canada, Japan, and New Zealand)[16].
- Two recent studies of midwives found a similar level of emotional exhaustion (39%)[17,18]. Between 10.2% and 28% of participants reported a lack of personal accomplishment, but a lower prevalence of depersonalisation (3.8%-28%) was found among midwives than in the studies of nurses reported above.
- A study of 1,997 midwives that measured burnout arising from different aspects of life and work[8] found that 33.1% reported a high level of personal burnout, 19% a high level of work-related burnout and 3.4% a high level of client burnout. Crucially, the rate of burnout found among UK midwives was substantially higher than that found in previous studies of midwives in Australia, New Zealand, and Sweden.

Psychiatric morbidity

Work-related stress and burnout are responses to the working environment, whereas psychiatric morbidity encompasses a range of 'context-free' psychiatric disorders such as anxiety, depression, psychological distress, and suicide.

- The General Health Questionnaire (GHQ-12)[20] is commonly used to assess self-reported mental health problems, anxiety, sleeping difficulties, depression and minor cognitive errors. If an individual exceeds a threshold score (known as caseness) on the GHQ-12, their general mental health is considered poor enough to require intervention.
- A high prevalence of common mental health disorders has been found in studies of nurses working in different contexts, and among samples of midwives. A GHQ caseness rate of 29% was found among community mental health nurses[14], 24.3% in hospital-based nurses[21] and 41% in a mixed sample of nurses and midwives[22]. These rates are considerably higher than those found among the general working population (19%), but are comparable to those reported by medical professionals in the NHS[23]. A study of nurses working in a healthcare telephone advice service in Scotland found a similar rate of mental disorders to the general population (16%), but the proportion of nurses reporting mild distress was substantially higher[24].
- Research findings indicate that a considerable number of nurses[11,25] and midwives[8] struggle to manage symptoms of anxiety and depression. The different measures used in these studies makes comparison difficult, but approximately 34% were found to report at least moderate levels of anxiety symptoms and 37% symptoms of depression. These proportions are higher than those found in studies of the general population[11] and midwives from other countries[8]. Worryingly, these findings suggest that between 6% and 26% of the UK nursing workforce are experiencing clinical levels of anxiety and 6% clinical levels of depression[11,25].
- The traumatic and distressing events that some nurses face in their work makes them vulnerable to post-traumatic stress. Midwives and emergency nurses appear to be at particular risk, with 20% to 33%[18,26,27] of midwives and 39%[28] of emergency nurses reporting symptoms. Moreover, one study found 5% of midwives to have scores commensurate with a clinical diagnosis of post-traumatic stress[27].

"I was fed up with the NHS...I felt undervalued in terms of wages...and in terms of what the government were doing to us. We did not stick up for ourselves...people just felt so beaten down and exhausted." – ***Midwife***[19]

- In terms of suicide, records show that between 2011 and 2015, 148 female nurses in England took their own lives. This represents a 23% higher relative risk of suicide within this occupational group – the sixth-highest rate for females for all occupations collected by the Office of National Statistics[29]. This study does not, however, attribute possible causes for this increased risk of suicide, and highlights the challenges inherent in identifying the causes of suicide in any occupational group due to the many interacting factors.
- Ethnicity was found to be a factor in one study, whereby black nurses and midwives reported higher levels of wellbeing on the GHQ than those who identified as white, Asian and other[22]. Nonetheless, the sample mainly comprised white nurses (90%) so was not representative of the nursing and midwifery population. The small sub-sample of non-white midwives meant it was not possible to detect group differences in levels of stress, depression, and anxiety[8].

"I just didn't want to go to work. I got to the point where I did not want to go to work ... I'd get into the car in the morning and I would cry because I had to go to work, I didn't want to do it; it was just dreadful, absolutely dreadful. I was worrying myself to death about it." ***– Midwife[19]***

"It's draining, and you've got that sense of … when you're driving to work and you're dreading coming in, and you're thinking 'What's happened? What's happened?'" ***– Nurse[30]***

"I woke up at about 1 o'clock in the morning and ran to the window, opened the window and I threw up out of the window, I couldn't make it to the bathroom it was too much. . . I got back into bed, had a drink of water. . .and I was shaking . . . I was on the brink, I was, I was a wreck, an absolute wreck and felt very small." ***– Staff nurse[31]***

Positive wellbeing

Mental health and wellbeing can be assessed on a continuum ranging from poor health on the one end, to happiness, thriving and flourishing on the other[32,33]. Most of the studies conducted with nurses and midwives, however, have focused on burnout and psychiatric morbidity, so little is known about positive manifestations of wellbeing in the professions.

- Job satisfaction is by far the most common way of measuring wellbeing at work[178], but research with nurses and midwives typically focuses on the extent and causes of dissatisfaction. In a study of 2,990 nurses working in England[34], 39% expressed dissatisfaction with their job in general, with wages, study leave, and opportunities for development cited as the key sources of dissatisfaction.
- The findings of the 2017 RCN Survey suggest that the workforce is struggling with their wellbeing, but many nurses also feel highly satisfied and enthusiastic about their role[1]. The survey asked respondents about their negative and positive feelings relating to any exhaustion that they might experience. From 30,365 responses, 45% reported feeling demoralised, 46% felt exhausted and negative, and slightly fewer (40%) felt exhausted but positive. Only 26% of respondents reported feeling fulfilled after their last shift, whereas over a third (37%) felt positively challenged. Moreover, more than six out of ten (62%) of nurses who responded agreed with the statement that on 'most days I am enthusiastic about my job'[35].
- The findings of the 2018 NHS Staff Survey[6] show that nurses and midwives report higher levels of engagement than most professions within the NHS. Work engagement refers to feelings of vigour, dedication and absorption, involvement (perceptions of the quality of leadership and conditions that allow employee voice and participation) and advocacy (the extent to which employees would recommend their organisation as a good place to work or receive treatment)[36]. The survey found little variation between the different nursing specialties, although those working in paediatrics and learning disability reported the highest levels of engagement overall. It is important to note, however, that work engagement scores for nurses are similar to those of the general working population[37].
- A study of midwives also found a high level of satisfaction as well as stress. Analysis of qualitative data from the UK arm of the Work, Health and Emotional Lives of Midwives project found that high workloads and poor staffing were considerable sources of pressure[9]. Nonetheless, the findings also revealed that midwives take considerable pleasure in their work and see it as a major source of pride and self-esteem.
- Beyond the workplace, a study of registered mental health nurses using questions from the Office for General Statistics and other validated scales found lower levels of life satisfaction and happiness than the general UK population[38].

"I enjoy coming to work - sometimes it is a bit stressful, but we also have our good days." – ***Surgical ward nurse***[39]

"If you can nurse someone at home and make them as comfortable as possible in their last days of life, it's a privilege to do it … it's well worth everything you do." – ***Hospice nurse***[40]

Understanding the context

Research findings suggest that UK nurses and midwives are at high risk of job-related stress, burnout, and mental health problems. For several reasons, however, the studies reviewed above may have underestimated the prevalence of these problems.

- Nurses and midwives who are experiencing particularly high demands, or who are struggling with mental health problems, may not be represented in these studies as they lack the time, energy or motivation to complete the questionnaires[42].
- The 'healthy worker effect' should be acknowledged[43]; stress and burnout are common reasons for leaving nursing and midwifery[44], so those who remain working may be better able to cope with the demands of the job.
- Although the information provided by participants is confidential and anonymous, the stigma of disclosing mental health problems or failing to cope with the pressures of the job may also have led to under-reporting[45]. Barriers to disclosure among nurses include fears about the impact on their career progression or of being judged negatively by colleagues[46].
- Most of the studies obtained data from self-reported surveys. Although validated scales were typically used, diagnostic interviews are better able to detect mental health symptoms than self-administered measures[47].
- As well as burnout, there is also evidence that exposure to the suffering of others in high-stress environments can lead to compassion fatigue[48]. This is a condition characterised by emotional and physical exhaustion leading to a diminished ability to empathise or feel compassion for others and has serious implications for staff and patients[179]. The demands for nurses and midwives to provide compassionate, patient-centred care means that the risks of compassion fatigue should be acknowledged, and interventions provided to reduce its harmful effects.
- Despite growing recognition of the disadvantages and lack of voice experienced by ethnic minority groups in nursing and midwifery[35], only two studies examined ethnic differences in levels of wellbeing[8,14]. In both cases, the study sample did not reflect the diversity of the wider nursing and midwifery population. Data on ethnicity is often not collected[11,28], or if collected it is not presented[26,27], making it impossible to determine whether samples represent the ethnic diversity of nurses and midwives in the UK.
- Data from the 2019 NHS Staff Survey[180] show that across all NHS staff, fewer workers who identify as White British report experiencing work-related stress (40.3%) compared to those who are Mixed (41.5% - 47.9%), Black/Black British – Other (44.1%) and White – Other (48.8%). The rates of stress found were all higher than those reported by NHS workers from Asian, Chinese and Black/Black British (Caribbean or African) backgrounds. However, the lack of psychologically safe spaces means that response rates from BAME staff, although improving, remain low and may not accurately reflect the views of the workforce[56].
- This lack of representation also applies to other sub-groups of nurses and midwives, including older workers and those with a disability[22,35]. In addition to making targeted attempts to recruit more representative samples within research, there is a need for studies that focus exclusively on ethnic minority staff and other groups that lack voice.
- Wellbeing is a complex construct that includes measures and manifestations that have not yet been tested empirically among nurses and midwives. There is a growing awareness of a job-specific form of distress among healthcare professionals. Moral distress is a response to situations where staff are unable to adhere to a value system based on providing optimal patient care. Failure to act in a way that preserves their integrity can be a major source of distress[49,50].
- The more recently published 2019 NHS Staff Survey[180], which was outside of the review's search parameters, reported that work-related stress in registered nurses and midwives in England increased slightly to 44% in 2019 from 43.5% in 2018. Once again, midwives, mental health nurses, health visitors, and district and community nurses reported the highest levels of work-related stress.
- Although an examination of the impact of the COVID-19 pandemic was beyond the scope of this report, the initial research indicates that this will take an additional toll on the mental health and wellbeing of nurses. The findings of a recent survey[177] of 2,600 nurses in the UK indicated that 33% reported severe or extremely severe depression, anxiety or stress. This is congruent with a meta-analysis[181] of 12 studies of international healthcare workers showing high levels of psychological distress, including depression (22%) anxiety (23%) and insomnia (34%). What is concerning is that evidence[182-183] from the SARS outbreak in 2003 showed that healthcare workers continued to experience high levels of psychiatric morbidity a year after the pandemic, indicating that there will be a substantial and long-term effect on the mental health and wellbeing of nurses and midwives.

Key points

- Nurses and midwives are at considerable risk of work-related stress, burnout, and mental health problems. The risk of compassion fatigue and trauma is also comparatively high. There is some evidence that the level of burnout experienced by UK nurses and midwives is higher than that found in some other countries.
- Emotional exhaustion appears to be a problem among nurses and midwives. There is also evidence that the emotional demands of the job can have adverse implications for patient care as well as the wellbeing of staff. Although they strive to provide high-quality care, nurses and midwives risk developing compassion fatigue and cynical and depersonalising attitudes towards patients if appropriate support is not provided.
- Nurses and midwives are at risk of moral distress in situations where institutional constraints stop them from pursuing what they believe to be the appropriate course of action. This can increase the risk of burnout and mental health problems.
- The research reviewed in this section indicates that nurses and midwives, like other 'helping' professionals, can be deeply engaged in their work and proud of the care and support they provide to patients, while simultaneously experiencing high levels of stress and exhaustion[51]. While job satisfaction and enthusiasm can, to some extent, compensate for the challenges faced by staff, current conditions of high demand and low staffing are likely to erode engagement and increase attrition over time[9].
- More focus is needed on the factors that underpin positive wellbeing and optimum functioning among nurses and midwives in order to develop interventions to boost engagement, thriving and flourishing in the professions.
- There are key gaps in the existing research meaning that the findings are not likely to represent the experiences of the entire nursing and midwifery workforce.

SECTION II

Factors that influence the mental health and wellbeing of nurses and midwives

This section examines the factors that increase or reduce the risk of mental health problems occurring in nurses and midwives. Studies that have examined a range of individual, occupational, and organisational predictors are reviewed. Also considered is how the job can influence wellbeing and functioning in other life domains (and vice versa) both positively and negatively.

- Individual factors encompass the personal characteristics of nurses and midwives, such as socio-demographic background and personality traits.
- Occupational factors consider the type of work done (such as nursing specialty), work-related issues (such as grade and length of service) and the features of the job (such as dealing with death and dying and providing compassionate care).
- Organisational factors relate to how jobs are designed and organised, such as working hours and shift patterns, workload and pacing, levels of control and support, staffing, and the availability of occupational health services or other resources.
- Work-life balance factors consider how aspects of the job influence personal life and vice versa. Work demands can lead to time-based conflict (where the time spent working reduces that available to spend with family and friends and to recoup mental and physical resources) and strain-based conflict (carrying over feelings of strain engendered by the job into personal life, or worrying about work-related problems when not physically present at work). This category also covers how work impacts on personal responsibilities, such as caring for children, elderly relatives or disabled people, and vice versa.

Individual differences

Contrary to popular belief, the studies from this review suggest that individual difference factors do not appear to have a strong influence on the mental health and wellbeing of nurses and midwives. While there is some evidence that psychological factors such as resilience, self-efficacy, hope and, to a degree, personality, affect wellbeing, findings indicate that influence of socio-demographic characteristics is generally weak.[184]

Despite frequent study, the findings indicate that socio-demographic factors, such as age, gender, tenure, education and even job grade, are not robust predictors of mental health and wellbeing among nurses and midwives. Several studies have found that these factors were not significantly associated with burnout in midwives[52] or mental health nurses[13] and were also unrelated to job satisfaction[24,53], common mental health disorders[38], and work engagement[37] in samples of nurses from different specialties. Socio-demographics also failed to predict burnout and psychological distress in nurses working in intensive care and acute settings[11,54].

- Other studies found that personal caring responsibilities did not predict common mental disorders in nurses and midwives[22] and other individual characteristics, such as sexual orientation and marital status, were unrelated to work-related stress, burnout, depression, and anxiety in midwives[8].
- Where socio-demographic characteristics have been significantly related to nurse and midwives' mental health and wellbeing, their effects were generally weaker than the other factors considered in this report. There is some evidence though that younger[8,13] and early career[9, 171] nurses and midwives appeared to be at greater risk.
- The role played by ethnicity in predicting wellbeing among nurses and midwives is unclear and research findings are often contradictory. For example, a study that explored morale in the mental health workforce in England found that staff from BAME backgrounds reported higher levels of engagement[14], but the findings of an RCN study indicated that ethnic minority staff tended to be more dissatisfied with their job. While a study of 1,997 midwives found no significant differences across ethnic groups on

measures of stress, depression, and anxiety[8], as outlined above, most respondents (95%) identified as White British/White Other. Other studies also tend to have a small proportion of respondents from BAME backgrounds, meaning that the findings may not be representative, and the low statistical power may not detect any differences that occur.

- In terms of job experience, research findings are contradictory; one study reported that mental health was poorer among new recruits[55], while another found that those who had been working for longer were at greater risk[14]. This may be partly due to the studies focusing on different nursing specialties (acute mental health, surgical, and intensive care) that may influence how experience is related to wellbeing. Geographical location and context also appear to be contributing factors, with working in the North East of England, being based in district general hospitals, and rotating roles within hospitals all predicting burnout, anxiety, and stress in nurses[13,55] and midwives[8,13,55].
- The studies reviewed found little evidence that the personality of nurses and midwives influences their mental health and wellbeing. For example, one study found very few significant associations between the 'Big Five' factors of personality (i.e. openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism) and six different types of stress reactions to work[54]. Nonetheless, critical care nurses who were more conscientious reported less stress related to time pressure, confidence/competence, and management. One possible explanation for these findings is that more conscientious nurses are more likely to use problem-solving strategies to cope with stress. It should be acknowledged, however, that critical care has a higher nurse-to-patient ratio than other specialties, so the role may be more intense but involve a smaller caseload.
- Psychological characteristics, such as hope, efficacy, resilience, and optimism, have been found to predict higher levels of work engagement[37] and lower levels of burnout in nurses[11]. Similarly, midwives who were more resilient and emotionally intelligent tended to be at lesser risk of post-traumatic stress symptoms[26].
- Consistent with the general literature on coping, the strategies that nurses and midwives use to deal with stress have a strong impact on their mental health and wellbeing. The use of emotional or avoidant coping behaviours has been found to increase the risk of depressive and anxiety symptoms[11,25] and burnout[11], whereas adopting more problem-focused coping behaviours was linked with better mental health outcomes.

> "I have always believed myself to be very resilient with high levels of stamina and energy which have been with me throughout life… as I am naturally optimistic and find change a challenge to be welcomed and embraced."
> – *Midwife*[56]

Occupational factors

Nurses and midwives experience potentially distressing and traumatic situations. Repeated exposure to such events can impair their mental health and wellbeing[28,70], but even a single acute event can have serious consequences[64]. Nonetheless, as discussed earlier in this review, studies[1,9] suggest that nursing and midwifery are considered rewarding and meaningful careers and offer a sense of purpose and pride that can enhance wellbeing.

- Providing care and compassion to others is a key feature of nursing and midwifery and many nurses and midwives draw value and a sense of purpose from this aspect of the job. Building positive relationships with patients is considered particularly satisfying[31], enabling nurses and midwives to feel that they are making a difference[57]. The situations that are most meaningful tend to differ according to the type of work done. Research with midwives indicates that providing continuity of care and being part of a patient's pregnancy journey were particularly rewarding[58], while comforting a patient at the end of their life was a strong source of satisfaction for palliative care nurses[40].
- Potentially distressing and traumatic events are those that elicit strong emotional reactions in nurses and midwives, including fear, anxiety, helplessness or horror[27,59]. Although a core aspect of the job for many nurses, dealing with patient death is a common source of distress[11,60,61].
- Providing compassionate care, while beneficial for patient outcomes and staff wellbeing, can come at a personal cost to the wellbeing of nurses and midwives[62]. These include being unable to 'switch off' from work, lack of opportunities for respite and recovery, and impaired personal relationships.
- Having unrealistic expectations of the level of care that they can provide to their patients can engender distress and self-blame among staff when patient outcomes are not as desired. This is evident in mental health nurses after patient suicides[63] and among midwives that have been involved in a perinatal trauma incident[27]. Such incidents have a detrimental impact on nurses' mental health even in settings where traumatic and distressing events are more common, such as emergency departments[60,64], abortion care[65], critical care[66] and palliative care[67].

- Staff who are newly qualified[68] or who feel unprepared[17,67] appear to be at particular risk.
- Events are more likely to have a traumatic impact when they are unexpected[64], involve children[62,69] or patient suicide[63]. Additional risk factors for post-traumatic stress are where nurses and midwives can personally relate to the situation in some way, either through their own or a family member or friend's experience[17,27,66]. This is a particular risk factor if nurses and midwives feel very strongly invested emotionally in their work or in their patients[27,60].
- The number and the extent of exposure to traumatic events increases the risk of post-traumatic stress symptoms[27,28,70]. Repeated exposure has been found to have a cumulative effect on nurses' and midwives' mental health[62].
- Factors such as professional experience, supportive work environments, training, self-esteem and the use of humour can attenuate the negative impact that traumatic events have on nurses' and midwives' mental health[17,28,63,65,66,69,70]. Conversely, not having the time to process such events due to organisational pressures (e.g. shortage of beds, waiting ambulances) exacerbates the risk to wellbeing[28].
- Dealing with patients' family members present further challenges to nurses and midwives as they can distract from patient care, and offering support means that nurses may need to moderate their own emotional responses to events to meet the needs of the family[62,66].
- Linked to these traumatic events is a fear of being held responsible and being accused of negligence[57,71]. Such concerns are a major source of distress which can engender feelings of being unsupported, and a strong sense of dissatisfaction and disillusionment with their profession among staff. Litigation compounds these difficulties, as additional, unfamiliar and anxiety-provoking tasks are required (e.g. writing statements, attending proceedings)[72].

"...the absolute worst bit was walking back into that room with that dead baby in my arms and telling the parents [...] and that was just the worse thing I've truly ever done. And that woman's scream will live with me forever." – ***Midwife***[17]

"I put added stress on myself by beating myself up about the fact that could I have done something about it. That was the overwhelming feeling - what could I have done differently." – ***Midwife***[17]

"Stress and traumatic stress come from lots of different angles... and quite often it can just pick, pick, pick away at you until something major comes in, like a trauma and that's what pushes you over the edge."
– ***Emergency nurse***[28]

Terms and conditions

- Satisfaction with pay is low among nurses, with 61% of participants to an RCN survey (n=7,720) considering their pay/grade to be inappropriate[35]. The extent of dissatisfaction expressed by respondents was considerably higher than the 39% found in a survey conducted two years earlier. Unclear implementation of pay structures and contracts have also been highlighted as a source of dissatisfaction[172].
- Nurses report financial pressures across all pay scales, with those in bands 6 to 7 more likely to be dissatisfied[35]. More than half (56%) of the 7,720 nurses who responded to a recent RCN survey reported having to cut back on food and travel costs, 23% had taken an additional job, 21% struggled to pay their gas and electricity bills, 11% had been late with mortgage and rent payments (or had missed them entirely), and 2% had received support from food banks or charities. It is therefore unsurprising that dissatisfaction with pay has been found to increase the risk of work-related stress and disengagement[73].
- Transitioning from a student to a newly qualified nurse can be challenging[68,74]; this is reflected in the findings of studies where early-career nurses report higher levels of work-related stress[22]. Interview studies with newly-qualified nurses and midwives[74–76] have offered useful insight into the reasons for their stress: they feel apprehensive and unprepared, they are still seen as a student, there is competition between new starters, they feel pressurised by being continually monitored, they have little autonomy, they have to deal with new responsibilities, they struggle with entrenched views and practices, and can experience shock as the role may not be what they expected.
- There is evidence that preceptorship programmes can enhance the wellbeing of newly qualified nurses and midwives[74,77]. They provide support to staff during this crucial period and help them manage stress by offering opportunities to share anxieties, obtain feedback and advice, and improve feelings of competence and confidence. The importance of carefully-planned induction programmes is also highlighted in the findings of the 2018 NHS Staff Survey, as they are associated with higher satisfaction in nurses[78].
- It is not only newly qualified nurses and midwives that struggle; 33% of respondents to an RCN survey reported that they did not feel well-equipped to do their work[35]. Some differences were found between groups: health visitors (53%), community psychiatric nurses (57%) and mental health nurses (58%) stated they were fairly or very well equipped, whereas practice (94%) and research (87%) nurses were the most likely to report being fairly or very well equipped.

At all career stages, training and development not only improve competencies among staff but also increase their confidence and professional identity, and facilitate progress within their work[39,66,78]. The availability of such programmes also signals that organisations are investing in their staff[62] while enhanced feelings of competence increase feelings of control[79]. The opportunity for training and development was a strong predictor of engagement in a study of 42,357 nurses[80]. Lack of time and access to training (e.g. not being based in a hospital), however, tended to restrict opportunities to access these initiatives[58].

- In terms of advancement, only just over a third (34%) of a large sample of nurses felt there were opportunities to progress in their current job[35]. Nonetheless, when additional responsibilities are given or promotions made, it is crucial that these nurses and midwives should be adequately supported and resourced, and appropriately rewarded to ensure that the additional demands do not adversely affect their mental health and wellbeing[79].

"There is a misconception that you can train people to do tasks and pay them less… [in reality] you need well trained staff, able to understand and interpret as well as valuing 'basic' nursing care." – ***Nurse***[61]

"To support myself, I worked overtime, but it had an impact on my health. As a result, I have recently undergone a heart operation and I was advised to take it easy (so no overtime and no additional income). I feel degraded, as (…) I can't support myself." – ***Staff nurse***[35]

Discrimination, bullying, and violence

- The scale of the discrimination, harassment, and violence experienced by nurses and midwives is highlighted in the findings of the 2018 NHS Staff Survey[6]. In the previous 12 months, 23.6% of the approximately 217,000 nurses and midwives in England who participated had experienced at least one violent incident from patients, service users or their families. In terms of harassment or bullying, 39.5% had experienced at least one such incident from patients, service users or their families, 14.7% from their managers, and 21.9% from colleagues. Almost one participant in ten (9.9%) also reported being discriminated against by patients, service users or their families with 8.5% experiencing discrimination by colleagues or managers. In Scotland, the 2015 NHS Staff Survey (with a total of 60,681 participants) found 9% of the nurses and midwives that responded had been bullied or harassed by managers and 15% by colleagues. In the previous 12 months, more than half (52%) had been subjected to verbal abuse from patients and one nurse and midwife in five had experienced physical violence[81].
- These figures concur with the findings of the RCN Employment Survey[35], where 68% of the 7,720 nurses who responded had been subjected to verbal abuse from patients, service users, or relatives and 31% had experienced bullying or harassment from colleagues during the previous 12 months. Over a quarter of nurses (27%) reported experiencing physical abuse from patients, service users, or relatives which is considerably higher than the 11% previously reported in Wales[82].
- There is evidence that the incidence of bullying from some sources has increased; an RCN survey conducted in 2011[61] found that more than two out of ten (21%) respondents reported having been bullied by colleagues which had increased to 31% six years later.
- Analysis of the NHS Staff Surveys in England from 2006 and 2009 revealed that staff who had experienced violence and harassment from members of the public and colleagues were at greater risk of work-related stress and reported lower job satisfaction[83]. Interestingly, harassment from other members of staff had a more powerful influence on wellbeing than experiencing violence from patients. It is surprising to note that the negative effects of violence and harassment appeared to be intensified where support from supervisors was greater. The authors explained these findings by supervisor involvement being more likely where incidents of aggression are more severe, or where supervisors were the perpetrators or were held accountable for exposure to violence.
- Further analyses of the NHS Staff Survey in England have found self-reported harassment from staff to be strongly linked to lower levels of work engagement[73]. Contrary to the finding described above, however, harassment from patients had a stronger impact on nurses' and midwives' job satisfaction than harassment from colleagues[84]. This suggests that antisocial behaviour from different sources affects staff in different ways. It should also be noted that the incidence of harassment was higher for ethnic minority nurses than white nurses[84].
- The relationships reported above are supported by findings from interview-based studies that identify bullying and harassment from colleagues as a key source of stress for mental health nurses[85], newly-qualified nurses[68], nurses from overseas[86] and a mixed sample of RCN members[61]. Such experiences are not conducive to a harmonious working environment; they also undermine confidence and self-efficacy among staff, lower mood and impede their ability to carry out their work effectively.

- The RCN survey found that nurses from Black African or Caribbean backgrounds were more likely to report experiencing physical and verbal abuse and being subjected to bullying than white staff[35]. The finding that newly qualified, ethnic minority nurses, and those from overseas are particularly at risk[22,68,86] suggests a power imbalance. It is crucial to avoid homogenising these minority groups, however, as nurses and midwives from different parts of the world can have very different work experiences, perceptions of discrimination, and equality of opportunity[87].
- The effects of aggression and violence from patients on nurses is complex. Where patients are seen to have little control over their behaviour, such as with learning disability and mental health nursing[88], dealing with violent incidents tends to be considered part of the job; staff are reluctant to attribute blame to patients and often blame themselves. Nonetheless, even in this context, experiencing violence is still likely to be frustrating and distressing and can cause physical and mental harm. In general, however, exposure to aggression from patients, particularly where behaviours were targeted, derogatory or humiliating, tends to evoke a strong emotional reaction from nurses[89] and is more likely to result in burnout[55].

"Yes, I mean the bullying you see, I was scared and nervous I suppose because you have that feeling of paranoia and you become … I started questioning myself. I started questioning my competencies because people make you feel like that, make you feel incapable, make you feel incompetent, you know you become paranoid, you feel isolated and I felt like that." – ***Overseas nurse***[86]

"…and we have high rates of being sworn at, being spat at, assaulted, violent behaviour… I recently had a few of my colleagues assaulted on the unit, mainly female, occasionally male… you can foresee someone getting a good hiding, or even being killed." – ***Mental health nurse***[85]

"As a black nurse, I get racist comments from patients every day and my employer does not do anything about the issue. Fellow workers are also subtly racist." – ***Mental health nurse***[35]

Organisational factors

- The increase in work demands is evidenced by studies that have highlighted the drastic reduction in the number of nurses and midwives. The RCN surveys show that 55% of respondents had experienced a shortfall of one or more registered nurses on their last shift[1] and that 79% (an increase from 56% ten years earlier) believed that staffing levels were insufficient to meet patients' needs[35]. Other findings indicated that 63% of nurses felt under too much pressure at work[35] and that between 65% and 71% reported having to work extra hours on a regular basis[35]. Moreover, nine out of every ten nurses who responded to this survey reported having to work through their breaks at least some of the time[35].
- The RCN survey found that only just over half (52%) of nurses who responded were satisfied with their working hours[35]. Whether eight or 12-hour shifts are preferable has been debated extensively and findings are mixed[90,91]. For example, a study that interviewed 22 nurses working on two older people's wards (one with 12-hour shifts and the other with eight-hour shifts) indicated that, although a longer working day could be tiring and affect care and communication, many preferred them. Nursing staff generally felt unable to accomplish as much work as in longer shifts, they believed that the continuity of care and relationships with patients were affected, and the number of handovers was increased[91]. This study also highlighted concerns among respondents that eight-hour shifts had a negative impact on the recruitment and retention of nurses. Nonetheless, data from patient discharge surveys found no statistically significant differences in satisfaction or the perceived quality of interactions with staff.
- Although longer shifts may be popular with some healthcare professionals, there is evidence that they may be detrimental to their mental health and wellbeing. A survey of 31,627 nurses from 12 European countries (including England)[92] found that those who worked more than 12 hours had an increased risk of emotional exhaustion (OR: 1.12), depersonalisation (OR: 1.12), reduced personal accomplishment (OR: 1.32), and job dissatisfaction (OR: 1.40). Similar findings were observed in a study of UK-based nurses and midwives, where longer shifts increased the risk of job dissatisfaction[90] as well as emotional exhaustion[52].
- Although shift work is intrinsic to many nursing and midwifery roles, it is a source of dissatisfaction for many[31,90]. Nevertheless, it is likely that shift type (i.e. working during nights and weekends) and poor rostering makes a strong contribution to dissatisfaction and poor mental health among staff[61].
- Workload is represented more broadly by job demands, which refers to how demanding a particular role is perceived to be[5]. Using an established benchmark measure from the Health and Safety Executive (HSE), the level of job demand experienced by nurses was found to be higher than the UK average[61]. This is a concern, as high job demands among UK nurses have been found to increase the risk of burnout[14], symptoms of anxiety and depression[11,25], work-related stress[73,93], and lower work engagement[73]. High job demands can also have physiological effects via elevated heart rates[94], with clear implications for the long-term health of staff. A heavy workload, along with lack of staffing and resources, has also been identified

as a major source of stress in several qualitative studies of nurses working in different contexts[9,31,61,85].

- A sense of control over one's working environment is important for sustained mental health[95]. This is typically assessed as job control which, similar to job demands highlighted above, has been found to be lower among nurses in the UK than in other professional groups[61]. Other studies of nurses and midwives have found that job control can protect staff from burnout[14,52], anxiety and depression[25], and enhance work engagement[96]. Job control has also been linked to more positive mood in nurses working in Scottish surgical and medical wards[94]. More specific manifestations of low job control, such as uncertainty[11], lack of autonomy[97], and low participation in decision-making processes[12], have also been found to impair the mental health and wellbeing of nurses.
- As with job demands and control, there is evidence that nurses in the UK are less likely to feel supported than the general working population[61]. This is an important finding, as a body of evidence shows that a lack of social support can impair the mental health and wellbeing of nurses. Studies have associated workplace support with a reduced risk of several markers of mental health and wellbeing such as burnout in mental health nurses[12,14], anxiety and depression in a mixed sample of nurses[25], burnout and symptoms of depression and anxiety in acute nurses[11], disengagement and work-related stress in hospital nurses[73,98] and disengagement in nurses who care for older people[97]. Qualitative explorations of the implications of social support among midwives further highlight how it enhances feelings of empowerment and belongingness and enables them to build comradeship and morale[9].
- Focusing more specifically on leadership and management, the availability of clinical supervision was found to be associated with a lower risk of burnout in three different samples of mental health nurses[12,13]. This is because supervision provides a safe space for reflection where staff are encouraged to express and explore their emotions[99]. Similarly, research findings show that having a supportive and approachable manager makes nurses feel appreciated, that their developmental needs are recognised, and that support is available for personal issues[31,52,61]. Finally, early-career nurses reported lower levels of burnout when they perceived their leaders to behave ethically[100]. Perception of ethical behaviour is likely to be linked to moral distress, discussed earlier in this report.
- As well as higher demands and lower control and support outlined above, there is evidence that the roles and boundaries of nurses in the UK are not as well-defined as the general working population[61]. This is not only a powerful source of stress, but has also been associated with an increased risk of burnout among midwives[52]. Research findings also indicate that nurses and midwives feel that managers and patients lack awareness of their role and duties and they feel obliged to work beyond their competence on a regular basis[61,62]. This is a major source of concern, particularly where staff believe they have too many tasks to do in the time available, for which they may be held accountable.
- Several studies have noted that bureaucracy and administration are major sources of stress and dissatisfaction for nurses and midwives[31,40,58,61,62]. Administrative work removes nurses from direct patient care and increases their workload. These studies highlight the strong belief among staff that the focus on meeting targets undermines the care that they can provide to patients and this can create a division between front-line staff and management. Bureaucracy can also make work processes more cumbersome and hinder decision-making, especially where the necessary resources (e.g. staff, equipment, IT systems) are not available[31,58,61].
- Awareness is growing of the importance of a healthy work-life balance for sustained mental health and wellbeing. Only just over a third (34%) of a sample of 7,720 nurses reported feeling satisfied with their work-life balance[35]. Moreover, a study of nurses working for NHS Direct in Scotland found that conflict between their work and family lives was related to lower levels of job satisfaction[24]. Poor work-life balance was also a major source of burnout in midwives[52] and of work-related stress and low engagement among hospital nurses in England[73]. The pressure of the job means that nurses often have difficulties 'switching off' psychologically from work[85], limiting their ability to rest and recover. Conversely, there is also evidence that difficulties experienced in a nurse or midwife's personal life can impact on the job[61].
- Nurses and midwives who see their organisations as more supportive tend to report being more engaged in their work[73,96] and be at less risk of burnout[101] and work-related stress[73]. Clear and open communication is a key characteristic of supportive organisations and crucial in optimising work engagement in nurses[80]. Nonetheless, there is evidence that changes within the organisation can be a powerful source of stress for nurses[61], particularly when they interfere with work processes and environments, or require adjustments to their job roles. This is a problem, as the scale of change experienced by nurses in the UK is substantially higher than that of the general working population[61].

- Synthesising these research findings, it is evident that job demands, job control, and social support are the strongest predictors of mental health and wellbeing among nurses[11,25]. Many studies of employees more generally have highlighted their powerful effects[152]. The importance of job control, in particular, is noted as it has sometimes been found to attenuate the negative impact of job demands on nurses' mental health[25].

"Pressure to achieve targets, demands to follow procedures which duplicate practices, and increased paper exercises which impact on practice and decision making." – ***Community nurse***[61]

"I feel like I'm spinning plates, except the plates are patients – that to me is the worst feeling. A feeling of having no control. Going from crisis to crisis continuously is so incredibly stressful. Frontline staff feel like they are working on a battlefield; we don't know who to go to first. We are constantly having to prioritise, but some patients need your help just as urgently as the next."
– ***Adult acute nurse***[1]

"I am a single mother of a 12-year-old boy, and he has recently transitioned to secondary school. I cannot remember the last time I finished a shift on time, nor can I remember the last time I finished and had the energy to give my son the positive attention he deserves."
– ***Nurse***[1]

"There is indirect racial abuse and blame culture, stopping people going on courses and work promotions even you have enough experience, qualifications and good skills. Because you do not belong to my colour skin and do not speak Queen's English." – ***Staff nurse***[61]

Understanding the context

In considering the evidence obtained from this systematic review, the following points from the research literature more generally should be considered:

- The studies reviewed have typically been cross-sectional and correlational. Cause and effect cannot therefore be established: for example, working conditions such as high workload demands can increase the risk of burnout but, equally, nurses and midwives who are burned out may be likely to see their work as more demanding. Moreover, relationships between personal traits such as optimism, conscientiousness and self-efficacy and wellbeing outcomes may be explained by staff who are more stressed considering themselves to be more pessimistic, careless and ineffective at work. Well-designed longitudinal studies are clearly required that examine how working conditions and personal characteristics impact on mental health and wellbeing over time to enhance understanding.
- One in every five nurses and midwives are from BAME backgrounds, with higher levels in some areas of the UK[102]. The disadvantages that they face in the NHS are documented in the Workforce Race Equality Standard Report[103]. This commits to ensure that BAME employees in the NHS have equal access to career opportunities and receive fair treatment in the workplace and demonstrates that those from ethnic minority backgrounds are under-represented at management level, less likely to be appointed following shortlisting, more likely to be harassed, abused and bullied, and less likely to have access to non-mandatory training and CPD. BAME staff are more than twice as likely to be discriminated against by a manager or colleague and more likely to be entered into formal disciplinary procedures.
- Urgent action is crucial as research commissioned by the HSE found strong links between work-related stress and ethnicity among UK workers in general[104]. As discussed earlier in this report, the role of ethnicity in predicting mental health and wellbeing among nurses and midwives is difficult to establish due to contradictory findings, likely due to a lack of balance in sampling. Future research should utilise stratified sampling techniques to ensure that the findings are representative of the wider working population. Additional research is also needed that explores in greater depth the experience of the diverse groups of nurses and their radically different working environments on their mental health and wellbeing.

- It should also be acknowledged that antecedent factors may be proxies for, or confounded by, other factors. For example, certain geographical locations are areas of social deprivation[13,55], which will increase the demands and reduce the resources available, placing additional pressures on nurses and midwives. Similarly, an ageing workforce may increase the rate of chronic health conditions, sickness absence and retirement[105] among staff, leading to understaffing and skill loss.
- There is evidence that nurses in the UK find their jobs more demanding and perceive less control and support than the UK workforce in general. Nonetheless, as the study reviewed was conducted several years ago and change has continued to be extensive and wide-ranging, it would be useful to revisit staff perceptions of working conditions using the HSE framework.
- The 'healthy worker effect' discussed in the previous section should also be acknowledged when reviewing the relationships discussed here, as nurses and midwives who perceive higher demands, lower control, and less support may have reduced their working hours (thus improving their wellbeing) or left the professions entirely.
- Studies that have been reviewed in this section suggest that bullying, harassment, and discrimination are commonly experienced by nurses and midwives working in the UK. BAME staff are at particular risk of physical and verbal abuse and bullying[35,103]. It should be noted, however, that the terms 'bullying' and 'harassment' are often used interchangeably. Harassment has a legal definition: the Equality Act 2010 sees it as 'bad treatment that is related to a protected characteristic, such as age, sex, disability, race, gender or sexual orientation'. Bullying is defined as 'offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power that undermines, humiliates, denigrates or injures the recipient, emotionally or physically'. In order to identify the scale of the problem and inform targeted interventions, it is therefore important for future research to examine the different types of antisocial behaviours experienced by nurses and midwives more specifically.
- Experiences of bullying in nursing can be horizontal (perpetrated by co-workers) or vertical (from managers to their staff) and the cultural, organisational and individual factors that underpin such behaviour and the implications for the wellbeing of nurses and midwives should be further examined. Midwives who experience bullying report feeling undermined, humiliated, and unable to ask for help[9] so attention is needed to tackle the stigma associated with disclosure.
- Although conflict between work and personal life has been strongly linked to mental health outcomes and wellbeing among nurses and midwives[106,107], relatively few UK studies have been conducted. Moreover, as measures tend to assess how aspects of work influence 'family life' (and vice versa), little is known about the experiences of staff who are single, or who have no caring responsibilities. It is likely, therefore, that the proportion of nurses and midwives who struggle to maintain a healthy work-life balance is underestimated.
- A recent review of longitudinal studies examining the impact of shift-work on mental health found that women shift-workers are at greater risk of depressive symptoms than those who work standard hours[108]. This is of concern given that nursing and midwifery are female-dominated professions. There is certainly evidence that shift patterns can influence the mental wellbeing of nurses and midwives, but the effects of different shift patterns are not clear-cut. Satisfaction with 12-hour shifts is subject to individual differences in personal health, the quantity and quality of sleep, family responsibilities, work-load tolerance and personality[109]. Nonetheless, a large-scale, cross-sectional European study found that those working 12-hour shifts were at greater risk of burnout than those who worked shorter shifts and were more likely to wish to leave[92]. More longitudinal research is needed to examine the effects of different shift patterns on the health of nurses and midwives and on subjective and objective indicators of patient care.
- The expectation for nurses to be role models for a healthy lifestyle is set out in the UK Nursing and Midwifery Council Competence Standards[110]. Nonetheless, nurses and midwives are at higher than average risk of obesity, and working long hours and night shifts can make it difficult to adopt healthy lifestyles[111]. The heavy workloads and high stress experienced by staff, together with workplace barriers to healthy behaviours, have also been found to discourage behaviour change[112]. Organisations, therefore, play a pivotal role in creating work environments that facilitate or prevent staff engaging in healthy lifestyles.
- Understaffing clearly makes a major contribution to the demands experienced by nurses and midwives and will intensify the risk of stress and burnout.

The discontinuation of the bursary for student nurses in 2017 in England has serious implications for future staffing levels[35], especially in view of the ageing workforce. Latest UCAS figures[113] show that applications for nursing degrees in England have fallen by 13,000 since 2016, so replenishing staffing levels at a time of increasing demand for healthcare will be challenging. The recent decision to reinstate student nurse bursaries, with enhanced payments for specialist disciplines that are hard to recruit for, may be effective in the future. Similarly, the National Retention Programme[186] has been associated with a drop in turnover rates for national nursing staff from 12.5% (2017) to 11.9% (2019).

- A recent scoping review found that education for people entering health and social care work does not adequately prepare students for practice. It is particularly important to support nurses during the transition from university into the workplace through mentors who demonstrate authentic leadership and provide career guidance, offer opportunities to develop self-efficacy and confidence, and support to manage the physical and emotional demands associated with professional practice[187].
- Wellbeing is a broad construct and while focus has rightly been placed on work-related stress and burnout, little is known about other aspects relevant to nurses and midwives, such as financial wellbeing. It is also important to consider the implications of a female-dominated and ageing workforce for the future wellbeing of nurses and midwives. NHS Employers have recently recognised the impact of menopause on wellbeing, sickness absence and retention and provide training to enhance managers' knowledge and offer suggestions for targeted support[114].
- Also regarding gender, little is known about the experiences of male nurses and midwives. Currently, only around one in ten nurses are male and more insight into their experiences will help encourage them into the professions and support them through their training and subsequent career.
- Many studies examining the job characteristics that impact on the wellbeing of nurses and midwives do not differentiate between specialties.

Insight into the factors that influence the mental health and wellbeing of nurses and midwives working in different contexts is required. For example, professional isolation appears to be a particular problem for practice nurses[115], dealing with child protection issues for paediatric nurses[116] and compassion fatigue for hospice nurses[117]. It is also important to note that 20% of nurses and midwives in the UK do not work for the NHS (15.3% are employed in the private sector; 4.3% in another public sector; 2.2% in the charity/voluntary sector)[118] and more research is needed to understand their experiences and how they impact on wellbeing and mental health[119].

- The emphasis on patient-centred and compassionate care is fundamental to nursing and midwifery and laudable. Nonetheless, it is crucial to recognise that staff are at high risk of compassion fatigue and, while this can increase the likelihood of burnout, appropriate support can help offset this risk[120].
- Many of the issues highlighted above will have been intensified by the COVID-19 pandemic. For example, a recent survey[177] of 2,600 nurses found that 62% either reported that their training was either non-existent or inadequate, 52% had worked over their contracted hours on their last shift, 66% were not paid for their additional work, and only 44% agreed that appropriate personal protective equipment was always available. More personally, 4% felt their own health was at risk during the pandemic and 92% were worried about risks to family members due to their clinical role. These findings echo those of a recent systematic review and meta-analysis[176] of 59 studies which found that healthcare workers with high exposure to the virus during a pandemic were 1.7 times more likely to develop symptoms of post-traumatic stress and psychological distress. Being younger and of more junior status and being the parents of dependent children, lacking practical support and stigmatisation of disclosure were risk factors. In contrast, the factors that protected staff against mental health problems included having clear communication, access to adequate personal protective equipment, having adequate rest and receiving practical and psychological support.

Key points

- Individual characteristics, such as personality, demographics, caring responsibilities and job grade, have considerably weaker effects on the mental health and wellbeing of nurses and midwives than job-related factors, such as high workload and lack of job control and support. Meeting administrative demands is particularly challenging and thought to diminish the quality of care that nurses and midwives can provide.
- Satisfaction with job demands, control, support and role clarity is lower among nurses and midwives than other professional groups in the UK. The level of demand appears to be increasing in line with reductions in staffing levels and other resources and further threatens the wellbeing of the workforce. Satisfaction with some terms and conditions of employment, such as opportunities for training and advancement, is also low and many staff are experiencing financial pressures. This can increase the risk of work-related stress and low engagement.
- Nurses and midwives are at high risk of harassment and bullying from patients, colleagues and managers and this is a key source of distress. There is some evidence that such behaviour has become more common over time. Bullying and harassment appear to be particular problems for staff from BAME backgrounds.
- There is some evidence that positive psychological characteristics such as optimism, self-efficacy, conscientiousness and resilience, and the use of problem-focused coping strategies are linked to better wellbeing among nurses and midwives.
- Satisfaction with work-life balance is low among nurses and midwives and a major source of stress. Longer shifts, as well as constraining opportunities for rest and recovery, are also detrimental for the mental health, wellbeing and job satisfaction of staff.
- Providing compassionate care, while beneficial for patient outcomes, can come at a personal cost to nurses and midwives. The emotional labour inherent in healthcare roles increases the risk of burnout and compassion fatigue when work demands are high and support is lacking.

SECTION III

The wider implications of mental health and wellbeing in nurses and midwives

This section reviews the research that has examined the broader implications of the mental health and wellbeing of nurses and midwives. How this can impact on sickness absence behaviours, recruitment and retention as well as patient care and safety and the quality of healthcare in general, is considered.

Sickness absence and presenteeism

Presenteeism, or continuing to work while unwell[128], is a serious issue that warrants further exploration. Not only does this behaviour undermine the accuracy of sickness absence statistics (and the estimated costs of ill-health among staff), there is growing evidence that working while unwell can be detrimental to both patients and staff[128,184]. The 2018 NHS Staff Survey in England[6] found that 58.8% of the nurses and midwives who responded reported having worked while sick in the previous year, perceiving pressure to come into work from their manager (24.7%), their colleagues (22.4%), or themselves (93.3%). The fact that a previous survey of RCN members found a presenteeism rate in the previous year of 81.7%[61] suggests that more research is needed into the experiences of nurses and midwives as independent groups and the factors that influence such behaviour, along with the implications for staff and patients. The most recent RCN survey found that presenteeism was higher among nurses from Black African/ Caribbean backgrounds[35]. This may be partly explained by nursing staff from BAME backgrounds being more likely to report working additional hours than staff who identified as white.

"I think the process of becoming overly anxious at work probably built up over a period of about two years. Before I went off sick for a month, I was probably more aware of it within the last two or three months I suppose." – ***Staff nurse***[31]

"We are threatened with disciplinary action if we go over three episodes of sickness over a 12-month period. The reasons for sickness are not taken into account." – ***Community nurse***[61]

Turnover and retention

- The RCN Employment Survey[35] reported that nearly four out of ten nurses (37%) who responded were seeking a new job. The findings of an RCM survey[121] of 2,000 midwives indicated that 66.6% had considered leaving the profession entirely in the previous six months. The reasons provided for leaving intentions were dissatisfaction with staffing levels (60%), being unable to provide the quality of care required (52%), high workload (46%), poor working conditions (37%), and the model of care (30%). Information on the model of care that was most favoured was not, however, provided. Midwives who intended to leave reported significantly higher levels of work-related stress, mental health problems and burnout than those who wished to remain. A further survey conducted by the NMC[122] offered insight into the reasons why nurses and midwives actually leave the register, apart from retirement. The most common being working conditions (e.g. staffing and workload: 44%), a change in personal circumstances (e.g. health problems or childcare responsibilities: 28%) and disillusionment with the quality of care provided to patients: 27%.
- Several other studies show that nurses and midwives who are experiencing poor mental health and wellbeing are more likely to wish to leave their job. For example, one found that nurses who were experiencing burnout were 2.08 times more likely to consider leaving[15]. Other factors linked with intentions to leave include job dissatisfaction in nurses[123], and burnout[52] and post-traumatic stress symptoms in midwives [26,27]. A national survey of nurses and midwives working in the UK found that high levels of work-related stress and low engagement were strong predictors of leaving intentions[73].

- The commitment that nurses have to their organisations, a key indicator that they intend to remain working there[53], is also influenced by their mental health and wellbeing. Job satisfaction[53], mental health and work engagement[96] were the key contributory factors.
- Interpreting relationships between the mental health and wellbeing of nurses and midwives and their leaving intentions is not always straightforward, as turnover is strongly influenced by working conditions[15,121]. A study of 261 UK nurses[123] found negative associations between job satisfaction and turnover, but 'off-the-job embeddedness' (the extent to which people are bound up with forces outside work, such as relationships with other people and community ties) tended to intensify these effects. This suggests that there are multiple factors, both within and outside work, that influence turnover.
- The NMC data[122]summarised above offers some useful insight into the most common reasons for leaving the register, but most studies of nurses and midwives look at turnover *intentions*, not actual turnover. One exception is an interview study where midwives who had left their job in the UK to migrate to Australia reported that burnout and stress due to increasing workload and bullying strongly influenced their decision to leave.

"Why did I choose this for a career? When my daughter told me that she wanted to be a nurse, I was actually disappointed, and I thought 'Why would you want to do that?'" – ***Nurse manager[35]***

"It came to a time in my career, I was on a burnout path actually in the job I was in, so I was actually very glad to get out because I couldn't have sustained it...It was too hard." – ***Midwife[19]***

Patient care

- There is evidence from the studies reviewed that poor wellbeing impairs the performance of healthcare professionals and, in turn, this reduces the quality of patient care. For example, nurses working for NHS Direct who rated their shifts as more stressful tended to make more information-processing errors and were less likely to meet their key performance indicators[124]. Poor wellbeing also influences nurses' and midwives' behaviours towards patients. For example, mental health nurses who reported feeling angry were more likely to endorse using restraint to manage patients[89]. Depersonalisation, a key aspect of burnout discussed above, and compassion fatigue are also likely to impair relationships with patients as they engender feelings of emotional detachment and cynicism.
- A review of 50 letters of complaint from patients to a Scottish Health Board, found that staff fatigue and a lack of compassionate care were the most common reasons for complaint[125]. More specific causes ranged from a perceived failure to meet expected standards of communication to deliberate attempts to cause distress. Analysis of the complaint letters showed that patients' judgements of good quality care tended to be based on their prior experiences of compassionate care, further emphasising its importance in underpinning patient satisfaction.
- Higher levels of engagement among the 42,357 nurses and midwives who responded to the 2011 NHS Staff Survey in England were strongly linked with perceptions of personally providing better quality care to patients[98].
- Staff mental health and wellbeing are not unique predictors of perceived quality of care but interact with many other workplace factors[130,188]. A particularly influential factor is colleague support, where negative mood among staff was associated with poorer quality of care but the damaging effects were exacerbated if support from their colleagues was low[126].
- Beyond perceptions of care at the individual level, a study found that nurses who were experiencing burnout tended to rate the care provided by their unit as poor[16]. Of the burnout dimensions, depersonalisation had the strongest impact on perceptions of unit-level care. Another study of hospital nurses found that depressive symptoms and burnout dimensions predicted their perceptions of patient safety at the individual (e.g. the safety of personal practice) and the work unit level (e.g. the likelihood of making errors)[127].

"I do feel quite burnt out you know. How much compassion have I left? I do feel very tired." – ***Community children's nurse[62]***

"I am tired and worn out and am concerned that if this continues, I might make a tragic mistake." – ***Midwife[121]***

Understanding the context

The evidence from this review shows that the mental health and wellbeing of nurses and midwives can have a major impact on sickness absence and presenteeism, turnover intentions, and patient care. When assessing the evidence, however, the following issues should be considered:

- Studies that have examined retention among nurses and midwives typically measure leaving intentions, not actual turnover. Nonetheless, working conditions and short- staffing, as well as stress and burnout, appear to be a common reason for nurses and midwives leaving the register[122]. The major problems with retention highlighted by recent employment statistics and the implications for staff workload and patient care highlight the urgent need for more insight into the factors that underpin turnover among nurses and midwives on a regular basis, possibly using multiple methods such as exit interviews and staff turnover records. It is also crucial for surveys to differentiate between staff who are considering leaving their current role and those who wish to leave the profession entirely.
- Research reviewed suggests that presenteeism is commonplace among nurses and midwives; indeed there is evidence that it is endemic among healthcare workers in general[128]. The demands of the job, pressure from management and fears that patients will be put at risk, especially when staffing levels are low, are key factors, but there are also concerns about robust attendance management policies that can penalise those with chronic health problems. Research with healthcare professionals[128], in general, indicates that presenteeism is considerably more common and costly than absenteeism and the risk that a reduction in sickness absence may lead to increased rates of presenteeism must be acknowledged. The personal and financial costs of staff working while unwell are, however, difficult to establish; unlike absenteeism, presenteeism is unlikely to be monitored by organisations and staff may be reluctant to disclose such behaviours due to feelings of duty, stigmatisation of sickness and fears for their future career. Moreover, although there is evidence that working while sick can impair job performance and increase the risk of error-making[184], establishing the associated costs is likely to be challenging. Nonetheless, the implications of an organisational culture that expects and rewards presenteeism, both directly and indirectly, should be acknowledged and efforts made to discourage it. The importance of identifying and managing the causes of presenteeism has been emphasised and the need for multi-level interventions that can help foster a more 'healthy' sickness absence culture in organisations highlighted[128].
- The financial implications of working conditions and poor wellbeing among nurses and midwives are difficult to determine, but a recent paper[129] has estimated the total costs of bullying and harassment to the NHS in England to be £2.281 billion. This figure includes the costs of sickness absence (£302.2 million), sickness presenteeism (£604.4 million), employee turnover (£231.9 million), productivity (£575.7 million) as well as industrial relations, compensation and litigation costs (£83.5 million).
- The link between work engagement and the financial performance of NHS Trusts has been highlighted in a report by the King's Fund[36], where a change of one standard deviation on the 2015 NHS Staff Survey engagement measure (i.e. 0.12 on a five-point scale) was associated with a saving of £1.7 million on annual agency staff costs for the average Trust. This results in the saving of £365,000 through 2,000 fewer sickness absence days.
- Research that examines patient outcomes tends to use different measures and methods, which may explain any conflicting findings[130]. Many studies rely on staff perceptions of the quality of care they provide, and this is subject to bias. In order to demonstrate cause and effect, longitudinal research is required that obtains data from patients as well as staff. While it is crucial to obtain subjective perceptions of service quality from patients, organisation-level outcomes, such as length of stay in hospital and safety records, would also help determine the implications of staff wellbeing for patient care[130].
- Although burnout can impact on the quality of patient care, the magnitude of these effects is likely to be underestimated[189]. Healthcare professionals tend to be expert emotional labourers and able to provide authentic, compassionate care to patients even when experiencing personal health challenges. Nonetheless, regulating feelings in order to respond appropriately to patients requires emotional effort and will intensify the risk of burnout and other mental health problems over time[107,120].

Key points

- Concerns are often raised about the scale of sickness absence among healthcare professionals, but presenteeism is considerably more common among nurses and midwives and likely to have serious implications for the wellbeing of patients as well as staff. A combination of factors, including high demand, staff shortages and feelings of duty to patients and colleagues, is likely to encourage staff to work while sick. More research is needed to determine the causes of sickness presenteeism among nurses and midwives and how best to reduce such behaviour.
- A high proportion of nurses and midwives are considering leaving the professions. Working conditions, such as low staffing levels, high workloads, and inability to provide the standard of care required, are the most frequently cited reasons for wishing to leave, as they lead to stress and disengagement, reduce commitment and increase the risk of burnout. It is crucial to increase retention among nurses and midwives so that staffing levels that are already low do not deteriorate further. Failure to ensure optimum staffing levels will compound the pressure on the staff remaining and impair the quality of patient care.
- Nurses and midwives typically strive hard to ensure that their working conditions and any stress they may be experiencing does not have an adverse impact on their job performance. Nonetheless, there is strong evidence that poor mental health and wellbeing among staff reduces the quality of patient care. Several mechanisms have been identified to account for links between staff wellbeing and patient safety and satisfaction, such as an increased risk of error-making, low engagement (lack of vigour, dedication and absorption in work), as well as factors that directly influence interpersonal relationships such as depersonalisation, cynicism and compassion fatigue.

SECTION IV

Interventions to improve the mental health and wellbeing of nurses and midwives

This section reviews the interventions that have been implemented to support the mental health and wellbeing of nurses and midwives. In view of the many factors that influence wellbeing that were outlined earlier in this report, a broad-based approach to reviewing interventions is needed.

Workplace health interventions are generally conceptualised at three levels: primary, secondary and tertiary (see Table 1)[131]. This taxonomy is used to review studies that have examined mental health and wellbeing interventions in groups of nurses and midwives. As shown below, interventions can be situated at the primary level (avoiding or reducing the risk entirely), the secondary level (helping staff to cope more effectively with their working environment), and the tertiary level (rehabilitating staff who are experiencing mental health problems). Within the wider literature on workplace health, primary-level interventions have typically been found more effective than secondary or tertiary-level interventions, as they aim to address the causes of work-related stress and are therefore likely to be more sustainable[131,132]. Given the complexity of the healthcare sector and the wide range of factors that influence the mental health and wellbeing of staff, however, workplace wellbeing strategies should be systemic and incorporate interventions at all three levels. Focusing exclusively on secondary and tertiary initiatives not only means that the underlying causes of poor wellbeing are not addressed, but also implies that protecting mental health and wellbeing is the responsibility of the individual not the organisation. On the other hand, the complexity of developing and rolling out primary interventions in healthcare organisations requires considerable time and financial investment, meaning that complementary initiatives (i.e. at secondary and tertiary levels) are needed to support mental health.

Some useful frameworks have been developed to help organisations plan systemic interventions to improve the mental health and wellbeing of employees: for example, the mental health core standards from the Thriving at Work report[133], which include introducing a mental health at work plan, developing mental health awareness, encouraging conversations about mental health, improving working conditions, and monitoring employee mental health and wellbeing. Resources to support the implementation of these standards are available from NHS Employers[134] and Mind[135] and include risk assessments, planning documents, case studies and toolkits. The RCN's Healthy Workplace Toolkit[136] for health and social care, has five domains (work-life balance, dignity at work, health and safety at work, job design and learning and development in the workplace) and is designed to facilitate organisational health checks to improve working environments. Another resource specifically targeted to healthcare contexts is the NHS Health and Wellbeing Framework[137], which sets out the standards for NHS organisations to achieve in order to support staff in feeling well, healthy and happy in their work. The framework highlights organisational enablers (e.g. essential leadership, data and communication) and health interventions. Although these frameworks draw on best practice guidance and research evidence, the extent to which they have been implemented by healthcare organisations and their effectiveness has not yet been evaluated. Nevertheless, they are appropriate resources that highlight good practice in informing interventions and strategies to support positive mental health and wellbeing amongst nurses and midwives.

Table 1: The different levels of mental health and wellbeing interventions

Level	Description	Target	Examples
Primary	Focus on identifying potential risks in the psychosocial work environment, with the aim to eliminate or reduce the identified risks at source	The work environment; the organisation	Job design and workload management; staffing and resourcing; organisational policies and procedures; enhancing control and support for nurses and midwives; management training, supervision and mentorship
Secondary	Aim to modify how a worker manages or responds to potentially harmful work environment factors, and to reverse or delay the progression of health problems caused by these factors	The individual worker	Training on how the individual reacts (e.g. mindfulness, resilience), manages their environment (e.g. time management, assertiveness training) or develops task competence (e.g. IT training, specific medical procedures)
Tertiary	Seek to reduce or minimise the negative health effects associated with chronic exposure to psychosocial risks, and to enable a return to normal functioning	The individual worker	Employee assistance programmes; counselling and therapy services; return-to-work programmes

Primary interventions

Interventions that take a preventative approach to remove or reduce the effects of harmful aspects of the work environment are considered primary interventions[131]. This approach reflects the employer's legal and moral duty of care to protect the health, safety, and welfare of their staff. Health and safety legislation requires organisations to assess the risks arising from workplace hazards, including work-related stress, and take steps to prevent their employees from experiencing health problems as a result of their work. Failure to take 'reasonable' care of an employee's mental and physical safety is a breach of contract and staff may receive compensation.

Carefully planned risk assessments are crucial in order to diagnose the factors that contribute to poor mental health and wellbeing in an organisation or work group and decide how best to intervene. Information can be obtained from staff via questionnaires and checklists, scrutiny of organisational data, and/or informal discussions with employees. To help guide this process, the Health and Safety Executive (HSE) has developed a set of standards to help organisations assess and benchmark their performance against six work-related hazards: demands, control, support from managers and colleagues, role, relationships and change[5]. This approach was utilised in the 2013 RCN Survey[61] and, as highlighted earlier in this report, the risk of all six hazards was found to be higher among nurses than the general working population in the UK.

This review found three primary-level interventions that relate to nurses in the UK, but none involving midwives.

- The first example of primary intervention involved ward-based nurses[138], where a brief engagement measure was administered and the results were shared with nurse managers and the hospital's head of nursing. A project team was then formed to recommend minor but potentially effective initiatives, such as changes to handover processes, safety briefings, and manager responsibilities. Regular focus groups were also conducted to obtain feedback from these initiatives and inform subsequent decisions. The intervention not only led to improved work engagement among nurses, but also resulted in better patient outcomes through increased satisfaction and a reduction in acquired avoidable pressure ulcers. Although mental health was not measured in this study, as discussed earlier in this report, engagement is a key element of wellbeing and any improvement is likely to have wider beneficial effects.
- The second study used a participatory team-based approach to reduce stress levels in children's palliative care nurses[139]. A survey was initially administered to identify the sources of work-related stress; these were then discussed in regular team meetings and opportunities to remove them or mitigate their negative effect were determined. The most common stressors highlighted were short-staffing, increased expectations and demands, patient deaths, too many meetings, and not having enough time for administrative tasks. Some of the potential changes that emerged from discussions included reducing the frequency of service meetings but increasing peer support meetings and reorganising caseloads, as well as introducing a team-based job-share model and a revised administrative processing system. One year after implementation, self-rated stress levels were found to be reduced.
- Finally, a participative intervention using a non-randomised matched control group was implemented with a sample of nursing staff working on acute older people's wards in order to improve work engagement[97]. The intervention was developed from an initial survey of staff and subsequent workshops where nurses and managers reflected on the findings and identified interventions. However, work engagement did not improve following the intervention; this was attributed to other projects that may have impacted on the study findings, a lack of support from management, conflicting time and task demands, and project fatigue experienced by nurses. This study illustrates the wide-ranging difficulties of implementing primary interventions in dynamic healthcare environments.
- Other types of primary interventions that emerged from the review process include the development of policies that set out the characteristics of an acceptable work environment. The importance of formulating and implementing policies that are fit-for-purpose is highlighted by the findings of a study revealing that burnout and turnover intentions reduced in nurses when their organisations had effective anti-harassment policies[84]. This effect was particularly pronounced for nurses from ethnic minority groups, suggesting that formal policies and procedures are more salient for workers with less social power.

"When you listen to other people's issues that they bring, you understand you're not the only one, or that other people are experiencing the same sort of problems that you are and that you're not alone on the matter." – ***Emergency nurse***[140]

Understanding the context

Very few primary intervention studies have been conducted with nurses in the UK and, to date, there appear to be no initiatives that have been implemented with groups of midwives. This review therefore draws on best practice and evidence from studies of other occupational groups to identify other initiatives that might be effective. Crucially, in practice, the development and implementation of primary-level interventions should have a beneficial impact on all healthcare staff, not just nurses and midwives.

- All NHS organisations are required to have a policy on managing work-related stress[141] and should also have a policy on staff mental health. It is crucial for NHS Employers to recognise that work-related stress is a health and safety issue and stressors must be measured and managed like any other workplace hazard. The stress policy should be clear and accessible and apply to everybody in the organisation. Nonetheless, a policy will not be effective unless it includes a clear action plan that sets out the strategies that are (or will be) implemented.
- Managers are responsible for the implementation of the stress policy and the organisation must make the necessary resources available. There is some evidence, however, that managers in the NHS lack knowledge of initiatives to manage work-related stress[142,143]. Nurse managers may also feel they do not have the skills for this role, and this can undermine their effectiveness[144]. The HSE provides an evidence-informed framework to help managers develop the competencies to support the wellbeing of their staff[145]. Nonetheless, managers need enough time and support to accomplish this key role and their own wellbeing must also be protected.
- Policies and procedures, whether in relation to stress, mental health, or staffing, should incorporate proactive measures to support workers. For example, in light of the ageing workforce, it is crucial to provide support for older nurses and midwives; this may include offering more attractive phased retirement options (e.g. change in roles, reduced hours) that will help extend the working lives of healthcare staff who might otherwise opt for full early retirement[146]. Similar flexible options, such as phased retention, can also help nurses and midwives who are struggling with their mental health to manage this more effectively, enabling them to remain in work rather than take sick leave. Equally, organisations should be actively working to address the disparity between the experiences of white and BAME members of staff, as identified in NHS Workforce Race Equality Standards[103], such as with BAME staff networks, diverse shortlisting, and mentoring[147,148].
- Primary interventions are also about ensuring that basic rights and necessities are available to workers. Employers have some responsibility for identifying and removing the barriers to healthy lifestyles at work for nurses and midwives. It is also crucial for staff to be able to take regular breaks away from their workstation and have access to appropriate food and drink options at all times.
- Primary interventions are more effective than secondary or tertiary initiatives but are less commonly implemented and evaluated[149]. As discussed above, changing an organisation is often viewed as more complex and costly than implementing individual-level initiatives that help people improve their stress management skills. It should be recognised, however, that some interventions, particularly those that aim to enhance collaboration and communication, do not require a major financial outlay or a great deal of time and effort to organise and can reap major benefits for wellbeing. Nonetheless, implementing primary interventions will be challenging in large, complex institutions that are subject to constant change, such as the NHS.
- Long-term commitment to primary interventions and regular evaluation is essential, as any improvements may not be seen for some time. This means that it will be challenging to disentangle the effects of external factors such as changes in healthcare policies and funding, restructuring, staffing levels, patient demographics and health profiles and many other factors[149].
- It is vital to base primary interventions on a systematic diagnosis of the major work-related hazards in the target organisation. Risk assessments can highlight problems in particular work units (e.g. wards) and among specific groups of staff (e.g. specialist roles, grades, demographic factors) as well as providing a general overview of the organisation itself[131]. The literature reviewed earlier in this report suggests that some of the causes of poor mental health and wellbeing stem from the type of work that is done; the HSE management standards approach discussed above can be supplemented by measuring more job-specific hazards to inform change initiatives that are relevant and acceptable to staff.
- Participatory interventions to improve work-related wellbeing are likely to be particularly effective, as they involve staff in directing and implementing change. Nurses and midwives are best placed to identify the work-related hazards they face and suggest interventions that are fit-for-purpose.

Nonetheless, participatory approaches are time-consuming and rely on staff being available to attend sessions at the same time. This is likely to be a problem for those working in busy wards or clinics, or in the community.

- By restricting the review to studies of nursing and midwifery staff, those that sampled mixed groups of healthcare workers were excluded. There is evidence for the effectiveness of initiatives such as Schwartz Rounds®, which are regular one-hour sessions that enable staff to share and reflect upon the emotional, ethical and social challenges they experience at work. Large-scale evaluations of Schwartz Rounds® have found they can reduce psychological distress in attendees[150]. Participants also see rounds as a source of support, normalising emotional responses to practice, facilitating reflection, enhancing empathy and understanding, and helping staff consider different perspectives in multidisciplinary work.
- Primary-type interventions can draw on theoretical frameworks (e.g. the PERMA model[151] or the Job-Demands Resources Model[152]) to inform their development. For example, the PERMA model advocates that workplaces should develop the following five elements to allow workers to flourish: Positive Emotions (i.e. enabling self-reflection and the sharing of experiences and knowledge); Engagement (i.e. a deep psychological connection); Relationships (i.e. connecting and developing relationships); Meaning (i.e. developing a sense of purpose for the individual); and Achievement (i.e. appreciating that the success of the individual enables the success of the team).

Secondary interventions

"If anything, you get a telling off for not taking a break, but you are pushed to discharge women by certain times meaning there is no time to do it."
– Midwife[9]

Interventions at the secondary level aim to improve the ability of workers to cope with demanding aspects of their work[131]. This can involve changing the way that challenging situations are perceived or reacted to (e.g. resilience training, mindfulness) or helping workers manage such situations more effectively (e.g. conflict resolution training, time management training).

- In the last decade, the number of secondary interventions that aim to improve the mental health and wellbeing of nurses and midwives in the UK has increased substantially.
- Options for secondary interventions include psychoeducation based initiatives[18,153], self-compassion training[30,154], supervision[13,99,] reflective group practices[140], mindfulness-based stress reduction strategies[155–157] and online discussion forums to improve coping skills[170].
- There is evidence that participating in such interventions can be beneficial for the wellbeing of nurses and midwives. Studies have found evidence for reduced levels of depersonalisation in psychiatric nurses[153]; work-related stress in midwives[155]; depersonalisation, post-traumatic stress symptoms and job dissatisfaction in midwives[18]; and burnout in nurses in Scotland[156]. Improvements on related markers of wellbeing, such as resilience, coping, recognising trauma symptoms in themselves, and compassion for others and the self, have also been found[18,154–156].
- Studies that have explored participants' experiences of these secondary interventions have found that group-based initiatives can offer a safe space to share emotions, experiences, and learning[30,140]. Participation also helped build support networks that were not only useful during the intervention period, but also an additional source of support in the workplace more generally[157]. A number of these interventions sought to enable participants to reconnect with their values and passion for the job, and to enhance their self-care[30,157]. Moreover, these initiatives often increased awareness of thoughts and feelings among participants that, in turn, enabled them to act in a more 'emotionally intelligent' way[157,170]. Finally, some of these interventions also aimed to improve practical skills and knowledge concerning work tasks, self-care and working with others[30,170].
- Challenges that have undermined the effectiveness of secondary initiatives included lack of time, feeling uncomfortable exploring and understanding themselves, as well as not persevering with the intervention or continuing to use the techniques learned[157]. The primary focus on the wellbeing of others means that many healthcare professionals feel guilty about taking time out for themselves and feel they need 'permission' to be self-caring and self-compassionate.[158]
- It is important to note that nearly all the intervention studies reviewed in this section relied on self-reported outcome measures and failed to investigate the impact at the unit or organisational level. Although some studies assessed the effects of initiatives after six months[18,155], most only examined the impact immediately after the intervention. Finally, while some studies of nurses and midwives found benefits for mental health and wellbeing, not all of the

interventions showed positive effects for all the health outcomes examined[153].

Understanding the context

- Secondary interventions focus on changing the person, not the organisation – as a result, they overlook the structural causes of stress[131,159]. While initiatives that aim to enhance stress management and resilience-building skills can be effective, even the most resilient nurse and midwife will be unable to cope with working conditions that are pathogenic. It is also argued that individual-level interventions divert attention from the collective responsibility of society to protect employees, reinforce the status quo, and absolve organisations of their duty of care[159].

"It's been difficult in terms of people doing long shifts … not everybody is in on the day when there is the reflective practice group, so some people haven't been to many or any." – ***Emergency nurse***[140]

  This means that failure to cope with workplace 'challenges' can be seen as a failure of the individual, who is considered insufficiently resilient, rather than acknowledging the impact of contextual factors, such as excessively high work demands and insufficient resources.

- Reviews of research with groups of doctors have found good-quality evidence that primary-level interventions result in greater and more consistent improvement to wellbeing[160,161]. Any potential benefits of individually focused interventions are limited by failing to address the source of the problem. Although doctors are clearly a different professional group to nurses and midwives, these findings demonstrate the potential effectiveness of primary interventions within the healthcare setting, highlighting their importance alongside secondary interventions.
- Organisations that only offer individually focused interventions to support employee wellbeing are likely to find that uptake is poor due to cynicism and resistance among staff[149].
- Secondary interventions are subject to selection effects: they may only be beneficial for people who have an interest in them. For example, there is evidence that mindfulness-based training attracts people who are more 'naturally' reflective[162]. Moreover, interventions that aim to improve self-care may be resisted by those who feel they lack the time or energy required to make changes in their lives. It is crucial to ensure that people can access interventions that they believe may be beneficial for them[149].
- There is some evidence that supervision can reduce the effects of burnout in mental health nurses[13,99]. It is crucial, however, that supervision provides a safe environment for staff to reflect on their experiences and debrief after challenging and stressful situations[99,190].
- In order to accommodate individual differences in needs and preferences, organisations should aim to provide staff with a 'tool-box' of stress-management strategies that will help different types of people manage the diverse demands that they face[134,149]. It is vital to involve nurses and midwives in decisions about the type of initiatives that would be most effective, when they should be scheduled, and how they could be evaluated[131].
- It is also important to recognise publication bias, as only interventions that are effective may have been written up and published – this applies to all intervention studies[132].
- It is crucial for nurses and midwives to appreciate that 'putting on their own oxygen mask' before helping others is a fundamental requirement of the job. The need to implement an evidence-based 'emotional curriculum' for students has been emphasised[163], with regular top-ups to ensure that they maintain effective self-care strategies. To maximise effectiveness, input on key issues such as mental health awareness, self-care and stress management should be carefully and creatively integrated into the curriculum rather than provided in brief 'add-on' sessions or handouts[131].
- Carefully designed induction and preceptorship programmes are also likely to improve the wellbeing of nurses and midwives during these important transitions[78]. The importance of maintaining support for staff with mental health needs during career transitions is also recognised, possibly via 'Passports of Risk', to ensure continuing care from occupational health.
- The Mental Health First Aid (MHFA) initiative has become increasingly popular in healthcare organisations. Nonetheless, the effectiveness of this initiative should be demonstrated before it is rolled out further. A review published by the Health and Safety Executive (HSE)[164] found that MHFA training can increase awareness of mental ill-health conditions, but there is no evidence that it changes staff behaviour or improves how mental health is managed in the workplace. MHFA should, therefore, be part of a holistic approach to tackling workplace wellbeing rather than a substitute for support from qualified professionals. Care must also be taken to support staff who are providing MHFA and provide them with enough time to fulfil their role.

Tertiary interventions

This type of intervention offers people who are experiencing poor mental health and wellbeing rehabilitation and support to return to work[131].

- Occupational health services are available in all NHS organisations, and nurses and midwives who are struggling with poor mental health and wellbeing should contact them for support. Nonetheless, a survey of RCN members found that 14% of respondents did not know they had access to occupational health services in their workplace[61].
- A representative survey of nurses found only 12% were aware that counselling services were available to them and just over half (51%) did not feel well informed about the availability of support for their health and wellbeing more generally[165]. Awareness among nurses at management level was greater, suggesting that the information is not being disseminated effectively to staff working on the frontline.
- Common themes emerging from studies of occupational health services among nurses and midwives highlight the barriers to help-seeking. This is important information, given that only just over half (54%) felt confident that contacting occupational health would be beneficial[61]. Practical barriers to accessing support identified in the survey include lack of time, long waiting lists, lack of information provided, or services being in an inconvenient location[61,165].
- As well as the practical barriers to seeking support, disclosing mental health problems and a 'failure to cope' appears to be stigmatised among healthcare staff[165]. People may be particularly unlikely to access support services if they are situated in their own place of work[166]. Concerns around stigma and confidentiality are especially salient where nurses and midwives are unable to self-refer: an estimated 39% of the workforce[61]. This is likely to be a particular concern for the 25% of nurses who would be uncomfortable approaching their line manager about problems they are experiencing[165].
- There is evidence that occupational health services are seen to lack the expertise required to deal effectively with mental health problems experienced by healthcare professionals[166]. The effectiveness of occupational health is also likely to be constrained if practitioners have little understanding of the working conditions experienced by staff who are seeking help[61,166]. Rehabilitation back to work often involves returning to environments under 'adjustments' that may be unrealistic or ineffective, or where managers may even ignore guidance provided by occupational health. This issue is compounded by line managers who lack an understanding of the role of occupational health services.[167]
- Failure to seek appropriate help can encourage staff to manage their own health problems, with one study finding that 48% of nurses believe they can self-diagnose and 12% consider it acceptable to self-medicate[165].
- Online support can be effective in helping healthcare staff who are experiencing work-related stress or mental health problems. A Delphi study[168] identified ways to encourage uptake of such a service among midwives working in the UK. Participants agreed that it was important for online platforms to be easy to navigate, to maintain confidentiality, to have appropriate moderation, and to provide effective information to help staff identify symptoms of psychological distress. The importance of including self-care techniques in online support services was highlighted, but the need to prompt users to seek professional help if appropriate was also indicated.

Understanding the context

- Tertiary interventions can be effective but tend to focus on the individual rather than their working environment[131]. Unless the work-related factors that cause stress and burnout are identified and managed effectively, the mental health and wellbeing of nurses and midwives is unlikely to improve.
- It is not enough to offer staff opportunities to improve their stress management skills, they must be given the time and opportunity to take up such initiatives in order to improve their wellbeing[140].
- Data highlighting the availability of (and access to) occupational health services is useful, but more up-to-date information is needed about the awareness of such services among nurses and midwives, as well as the factors that encourage and discourage their uptake[166]. There has been a recent call to increase the resourcing of occupational health services for NHS staff, as providers are currently stretched due to increased demand by staff combined with the frequent need to provide services to external organisations[167].
- The low uptake of occupational health support services is a major concern considering the growing number of staff who are experiencing work-related stress, burnout, and mental health problems, as prompt intervention is recommended to stop symptoms from worsening[119]. Services should also bear in mind that their response to an initial request for help is crucial in determining whether somebody will continue to access professional support[166].

- The research reviewed above[119, 166] suggests that occupational health staff need more training in addressing mental health problems experienced by healthcare workers and greater awareness of their working conditions. Realistic rehabilitation programmes, jointly negotiated with line managers and human resource practitioners, are required to ensure that staff receive the accommodations they require.
- Successful return-to-work is a key goal for rehabilitative approaches[169]. Phased returns and flexible options offer staff a choice in how their return is managed and should draw on best practice guidelines. These include clear written policies, an agreed rehabilitation plan, and regular health assessments[169]. As discussed above, the importance of introducing 'phased retain' as well as 'phased return' initiatives has been highlighted.
- Studies are urgently needed to evaluate the effectiveness of the tertiary and rehabilitation services available to nurses and midwives in order to make improvements that are informed by firm evidence. Crucially, a joined-up, better resourced, collaborative and more visible occupational health service has the potential to provide systemic interventions at primary, secondary and tertiary levels[119]. For example, it can offer guidance on preventative health and advise on healthy shift patterns (i.e. primary), provide advice to individuals on 'what works' in terms of individual strategies and self-care (i.e. secondary), and offer rehabilitative services to guide successful return to work (i.e. tertiary).
- A list of sources of support available to nurses and midwives is provided in Appendix 1. Nurses and midwives may also be able to receive support from their RCN health and safety representatives and their employer's Employee Assistance Programme. It should be emphasised, however, that nurses and midwives who are experiencing serious mental health problems should be referred to the mental health multidisciplinary team and other support services (e.g. Employee Assistance Programmes and Mental Health First Aid) should not be considered a substitute for this.

Key points

- In order to support the mental health and wellbeing of nurses and midwives, systemic evidence-informed interventions are required at primary, secondary, and tertiary levels[131,133]. Although individually focused initiatives can be less costly for organisations to implement, it is crucial to identify and alleviate the structural sources of stress. Long-term commitment to such interventions at all levels of the organisation is required.
- The key psychosocial hazards at work should be carefully diagnosed to inform policies and practices that are precisely targeted to the problem areas.
- Staff should be given opportunities to improve their stress management skills and given enough time and opportunity to take up such initiatives[149].
- Very few intervention studies at a primary level have been conducted with nurses and none with midwives. These are urgently required to guide systemic interventions that support wellbeing and mental health among staff working in different environments. Evidence gained from intervention studies conducted with mixed samples of healthcare staff and other occupational groups can also be useful. Nurses and midwives work in a wide range of settings, so generic, 'one-size-fits-all' interventions are unlikely to succeed, and initiatives must be tailored to the unique needs of the site, department or team[149].
- Participatory interventions to improve work-related wellbeing are likely to be particularly effective as they involve staff in directing and implementing change and reduce resistance[131].
- Occupational health services should be better resourced and fit-for-purpose and more training is required for staff, especially in tackling mental health issues[119]. Services are currently stretched as they are unable to keep up with demand. More creative and flexible return-to-work options are required, and decisions should be jointly negotiated between employees, occupational health professionals, and line managers.
- Healthcare organisations often offer a free and confidential counselling service to staff to discuss personal issues as well as work-related problems. Such services appear to be in high demand, however, and staff may need to be referred by their line manager rather than themselves. For several reasons, nurses and midwives may be reluctant to do this.

RECOMMENDATIONS AND CONCLUSION

This systematic review shows that many nurses and midwives in the UK are struggling with their mental health and wellbeing. Although there are variations, based on the data presented in the papers reviewed in Section I, we estimate that between 30-40% of nurses and midwives experience symptoms of burnout[11-16] and a similar proportion experience work-related stress[6, 7]. Equally concerning is the high level of mental health problems found by the review, characterised by anxiety and depression[11, 25], post-traumatic stress[27], and the increased prevalence of suicide among female nurses[29]. Crucially, where comparisons have been made, the extent of mental health problems experienced by nurses and midwives in the UK is consistently higher than the general working populations and the prevalence of burnout is greater than studies of nurses and midwives in many other countries[15,16]. It is nonetheless important to acknowledge that nurses and midwives experience high levels of work engagement compared to other healthcare professionals and typically find their work satisfying and rewarding.

- The main causes of work-related stress and burnout for nurses and midwives are organisational factors such as high workload[11,14,25] and lack of support[12,14]. Satisfaction with job demands, control, support and role clarity is poorer than the UK average[61], opportunities for training[80] and advancement[35] are generally unsatisfactory and many staff are experiencing financial pressures[35,73]. Nurses and midwives are at increased risk of harassment and bullying from patients, colleagues and managers which is a further source of distress[6,35,61,81]. Providing compassionate care, a fundamental aspect of nursing and midwifery, is beneficial for patients but can threaten the wellbeing of staff when work demands are high and support and other resources are lacking[62]. Meeting administrative demands is considered particularly challenging and can reduce the quality of care that nurses and midwives can provide[31,58,62]. Conflict between work and personal life is common among healthcare professionals and lack of opportunity for rest and recovery can also threaten mental health, wellbeing and job satisfaction[184].
- There are clear limitations in the existing research, particularly around how well the findings represent the experiences of the existing nursing and midwifery workforce. Although there is limited evidence showing a difference in mental health and wellbeing outcomes across different ethnicities, those from BAME backgrounds are more likely to experience physical and verbal abuse, be discriminated against in the workplace, be entered into disciplinary procedures and have less access to training and development[35,103]. All of these factors have strong potential to threaten their mental health and there is, therefore, an urgent need to explore in greater depth the experiences of the diverse groups of nurses and how their radically different working environments affect their mental health and wellbeing.
- The growing risk of mental health problems and work-related stress faced by nurses and midwives has serious implications for retention[15], sickness absenteeism and presenteeism[35], and the quality of patient care[124]. A high proportion of nurses and midwives are considering leaving the professions due to the stress engendered by ever-increasing workloads, low staffing levels and poor working conditions[19,122]. Clearly, growing turnover rates will increase the pressure on the staff that remain in post and threaten the effectiveness of healthcare organisations. Although staff strive to maintain optimum patient care, working in a healthcare system that is under growing pressure has intensified workloads to such an extent that this can be compromised[128]. This is a considerable source of distress for staff. Presenteeism appears to be endemic among nurses and midwives due to pressure of work and a strong sense of duty and there is evidence that this can not only impair their own wellbeing but compromise their job performance[35,184]. It should therefore be recognised as a serious health and safety risk.
- Few primary intervention studies have been conducted with nurses in the UK and none with midwives. Those[18, 153-157] that are available have focused predominantly on improving their stress management and coping skills and knowledge surrounding work-related trauma rather than seeking to identify and alleviate the sources of work-related stress[138,139]. In order to support the mental health and wellbeing of nurses and midwives, interventions that are systemic and evidence-informed are needed at primary, secondary, and tertiary levels[131]. Research evidence from other sectors suggests that participatory initiatives are likely to be particularly effective in improving work-related wellbeing as they involve staff in directing and implementing change[132,160].

Recommendations

Based on the evidence reviewed above, the authors of this report, working closely with the Steering Group, have identified a series of recommendations that should be addressed in order to improve the mental health and wellbeing of nurses and midwives. In line with the systemic approach advocated in this report, the recommendations were categorised under five headings: (1) public policy; (2) organisations; (3) managers; (4) individuals; as well as (5) research priorities.

After generating draft recommendations from the evidence reviewed, a Delphi approach was used to rate and prioritise them. This process involved the input of an Advisory Group comprising 23 nurses and midwives from different specialties, demographic backgrounds, and geographical locations. The method used is described more fully in Appendix 3. In total, 68 recommendations were reviewed by the Advisory Group in two stages and rated on a five-point scale (i.e. essential, important, don't know/depends, unimportant, or should not be included). The rate of consensus relating to the perceived importance of each recommendation was identified.

A list of all 68 recommendations is presented in Appendix 4 along with the rate of consensus for each. Of these recommendations, 45 (shown below) were considered 'essential' or 'important' by at least 80% of the Advisory Group and form the final recommendations of the report. It should be emphasised, however, that the recommendations not included below are still crucial for improving wellbeing among the workforce but were not considered by the Advisory Group to be urgent.

Prioritising the recommendations

Of the 45 recommendations from the report (Tables 2-6), seven were unanimously rated as 'essential' or 'important' by the Advisory Group and should, therefore, be given priority. In addition, we include an eighth priority action point to recognise the urgent need for research that examines the mental health and wellbeing and the work experiences of ethnic minority nurses and midwives, and this underpins the remaining recommendations.

1. Action is needed to address the organisational factors found to underpin poor mental health and wellbeing in nurses and midwives (e.g. high work demands, poor leadership, lack of resourcing and workplace bullying).
2. Optimum staffing levels for nurses and midwives are essential.
3. Staff should be required to take their full entitlement to breaks and have access to appropriate food and drink and bathroom facilities at all times.
4. All organisations should have a mental health strategy that is enacted, demonstrating their commitment to improving the wellbeing of all nurses and midwives with multilevel interventions in place to address prevention, treatment and rehabilitation.
5. Managers and shift coordinators need a better understanding of the impact of shift-work on health and how this can be mitigated.
6. Managers need to have the opportunity, time and resources to support the wellbeing of their staff effectively without putting their own wellbeing at risk.
7. Regular audits are needed to assess the scale of mental health problems and the key contributory factors within the nursing and midwifery workforce.
8. The issues of bullying, harassment and power imbalances and the effect on the mental health and wellbeing of the BAME nursing and midwifery community is a priority for research and practice.

Although the recommendations are presented under seven different headings relating to policy, organisation, management and research, it should be acknowledged that responsibility for addressing them is shared among different stakeholders. Few recommendations targeted at individual nurses and midwives were retained following the review and Delphi process, and none made the list of seven priority recommendations above. This emphasises the importance of addressing wider systemic and contextual factors, rather than focus on individuals, to improve the mental health and wellbeing of nurses and midwives effectively and sustainably.

When considering how to address the list of recommendations arising from this review shown below, it may be useful to see them as transformational and transactional, and sometimes both. In this context, transformational refers to changes to the embedded processes, characteristics, strategy and culture of the system. Clearly, systemic change is more challenging to implement but will be more likely to lead to lasting improvement in the wellbeing of nurses and midwives.

- The need for systemic change, therefore, underpins nearly all the recommendations identified, as there is overwhelming evidence that the current system is not sustainable. These then are typically long term investments and approaches. For example, the recommendations set out above that highlight the need for action in supporting managers and guaranteeing safe staffing levels will initially require insight into what should be done and how and subsequently necessitate transformational change. Other recommendations in Tables 2 to 6 that could be considered transformational include the need to focus on the prevention rather than alleviation of mental health problems; the creation of more favourable working environments; a greater awareness of the need to reduce bureaucracy and administration; the implementation of more incentives to attract and retain nurses and midwives; and the need to better resource occupational health services.
- Some of the recommendations are more transactional, in that they involve changes to structure, policies, systems and tasks that may be easier to implement and may, therefore, yield more immediate benefits. The priority recommendations that could be considered transactional include the need to ensure that staff take regular breaks and have appropriate rest facilities and the development of a mental health strategy. Further examples of transactional changes also include reviewing the extent to which recommendations from previous reports have been implemented; evaluating how overall working hours are calculated; implementing and evaluating policies around whistleblowing; introducing evidence-informed training for managers in managing mental health and wellbeing in staff; instigating more effective debrief and support systems; and making improvements in guidance and signposting staff to support services.
- In reality, most of the recommendations can be both transformational and transactional. The key recommendation necessitates a large overhaul of working conditions (i.e. transformational) but this can be done through transactional changes. Within the recommendations below there are transactional actions that provide a starting point for change to occur. Crucially, both should work alongside the other, transactional changes should not be tackled in isolation and a deeper, more systemic approach is needed.

Table 2. Recommendations for *Public policy*

Number	Recommendation	Consensus
1	The factors that cause poor wellbeing are well-established (e.g. high work demands, poor leadership, lack of resourcing and workplace bullying). Rather than more research, action is now needed to address these issues	100%
2	Optimum staffing levels for nurses and midwives should be guaranteed and the risks of short staffing to the health and safety of staff and patients recognised	100%
3	More insight is needed into the factors that underpin attrition by nurses and midwives via exit interviews and research	95%
4	Additional time worked, such as shift handovers, extra hours due to sickness etc., should be included when estimating overall working hours	95%
5	Many reports have made recommendations on how to improve the mental health and wellbeing of nurses and midwives. We need to identify whether these recommendations have been implemented, or can be implemented	90%
6	Induction and preceptorship programmes are needed for newly qualified nurses and midwives and those who move to new working environments	90%
7	As well as support for newly qualified nurses and midwives, carefully designed initiatives are required to support staff during their first few years of practice	86%
8	NICE guidelines (England) should be used when supporting staff wellbeing as well as patients	86%
9	Greater awareness is needed of how the increased bureaucracy and administration in nursing and midwifery can increase work demands and impact on staff wellbeing and patient safety	86%
10	Occupational health professionals need to have the training, resources and tools to meet the needs of staff and staffing levels should be sufficient to meet the increasing demand inherent in healthcare	86%
11	Phased approaches to return to work and to retain staff are needed to support nurses and midwives who are struggling with their wellbeing	86%
12	The effects of temporarily losing the student bursary in England on future staffing levels should be recognised	86%
13	More incentives are needed to make nursing and midwifery more attractive professions and to improve retention	86%

Table 3. Recommendations for *Organisations*

Number	Recommendation	Consensus
1	Staff should be required to take their full entitlement to breaks and have access to appropriate food and drink and bathroom facilities at all times	100%
2	All NHS Trusts should have a mental health strategy that demonstrates their commitment to improving the mental health and welfare of all nurses/midwives	100%
3	All organisations should have a clear and accessible policy on mental health at work that informs policy and practice	95%
4	Organisations should work towards creating better work environments for nurses and midwives and preventing stress from occurring at source	95%
5	Action is needed to reduce the stigma of seeking help for stress and mental health problems	95%
6	All staff should have access to counselling or occupational health support, and be able to self-refer if required, rather than going through their managers	95%
7	Staff need to be given enough time to participate in wellbeing interventions and training and access support systems	95%
8	Staff who make official complaints or who 'blow the whistle' on risk or wrongdoing in the public interest should be protected	95%
9	When setting targets and deadlines, the wellbeing of staff who will be expected to meet them should be a key consideration	95%
10	Greater understanding is needed of how various policies (e.g. stress, sickness absence) are being implemented and evaluated by organisations to identify what works	90%
11	More creative and tailored flexible working options are needed to improve work-life balance and encourage return to work after sickness absence	90%
12	The high risk of presenteeism (working while unwell) among healthcare professionals and the impact on their health and performance should be acknowledged by management. Steps should be taken to reduce presenteeism as well as tackle absenteeism	90%
13	Staff need initiatives/debriefing sessions to support them after challenging situations at work (e.g. incidents of trauma, involving children, unexpected deaths, patient suicides)	90%
14	Organisations should have effective policies on dealing with abusive and bullying behaviours at work and must be willing to act on any complaints and support staff	86%
15	More guidance and signposting are needed on the type and availability of support for mental health and wellbeing	86%
16	Staff should be offered support that better fits their needs (e.g. through formal processes such as clinical supervision, mentoring and team development, or providing space and time for colleagues to spend time with each other)	86%
17	Essential equipment and other resources, such as access to systems, should be available and fit for purpose	86%
18	More opportunities are needed for staff to have input into change initiatives and decision making	86%
19	People's understanding of the role of occupational health and counselling services should be enhanced to raise awareness of how they can help. Barriers to access should be identified and minimised	81%
20	More opportunities are needed to provide a safe space for reflexivity and encourage staff to express and explore their emotions	81%

Table 4. Recommendations for *Managers*

Number	Recommendation	Consensus
1	Managers and shift coordinators need a better understanding of the impact of shift-work on health and how this might be mitigated	100%
2	Training is crucial to improve managers' skills, but they need the opportunity, time and resources to support the wellbeing of staff effectively	100%
3	Managers need a greater understanding of how the work can impact on the mental health and wellbeing of nurses and midwives and how to engage and support staff who are experiencing difficulties	95%
4	Managers need a better understanding of nurses' and midwives' roles and duties to avoid expecting them to do tasks for which they are over-qualified or under-qualified	86%

Table 5. Recommendations for *Individuals*

Number	Recommendation	Consensus
1	An evidence-based 'emotional' curriculum is needed to highlight the need for self-care and build effective coping and resilience during initial training	86%

Table 6. Recommendations for *Research priorities*

Number	Recommendation	Consensus
1	Regular audits are needed of the scale of mental health problems within the nursing and midwifery workforce	100%
2	More research is needed into the occupational health needs of staff and whether they are being met	95%
3	More research is needed to identify links between the mental wellbeing of nurses and midwives and patient safety and outcomes at the group level (e.g. department, ward, hospital). This would advance understanding of the wider impact of mental wellbeing and strengthen the argument for effective interventions	86%
4	More research is needed to assess the mental wellbeing of nurses and midwives over time and establish the causes and impact of poor wellbeing on staff and patients	81%
5	It is important to identify positive management behaviours as well as negative, as this will encourage best practice	81%
6	Research is needed into the role and effectiveness of whistleblowing guardians	81%
7	More research is required into the effects of lone working on the health and wellbeing of nurses and midwives	81%

Conclusion

Most of the recommendations emerging from this review reflect the need for widespread organisational change rather than the introduction of more individually focused initiatives. Synthesis of the literature supported by consultation with a panel of nurses and midwives from diverse backgrounds emphasise the need for precisely targeted structural interventions to tackle the work-related stress and burnout that is currently endemic in the sector.

Altogether, 20 recommendations were made at the organisational level and they demonstrate that a culture change within healthcare is crucial if staff wellbeing is to be supported effectively and sustainably. More specifically, the organisational-level recommendations highlight the need to not only formulate clear and accessible policies around mental health, but also to put these policies into action as a matter of urgency. Change is possible and this is evident in the reinstatement of the bursaries for student nurses that should remove some of the staffing pressures in future. Nonetheless, in order to support the wellbeing of staff currently, providing more effective support via counselling, debriefing and occupational health was considered essential. Steps must be taken to tackle the stigma associated with seeking help, however, otherwise even the best planned and resourced support initiatives will not be effective. Taking action to address the bullying, harassment and violence experienced by staff is a priority; this is more prevalent in health and social care than many other types of work[191], but a 'culture of silence' surrounding this issue has been identified[192]. While it is important to implement policies and practices to address bullying at an individual level, organisations should be aware of the cultural forces that can facilitate and even reward such behaviour on the part of managers. Urgent attention is also needed to the increasing level of violence and intimidation experienced by staff from patients, service users and their families. It is important to recognise that many nurses and midwives report feeling satisfied and engaged with their work, and more research is needed to understand and promote the factors that facilitate positive aspects of wellbeing.

A recognition that the nature of nursing and midwifery has, and is, changing is clearly important when considering options for intervention. This means that many nurses and midwives are obliged to carry out duties and assume responsibilities that they had not expected (e.g. role creep), often under challenging working conditions. This may lead to a breach in their psychological contract which, in contrast with the formal employment contract, represents an unwritten set of expectations of the employment relationship[193]. There is evidence that psychological contract breaches can have powerful negative effects on the health of employees, particularly their mental health[194,195].

For nurses and midwives, a key element of psychological contract fulfilment will be how current working conditions enable or threaten their ability to provide optimum care for patients[196]. It also links in closely with the growing awareness of moral distress, as nurses and midwives increasingly find themselves in positions where they are unable to respond to patients in a manner they feel is appropriate.

Leaders and managers have a major part to play in tackling stress at work. They influence organisational culture through leadership, delegation and communication and their key role in promoting staff wellbeing and engagement is widely recognised. Initiatives are currently underway to identify the competencies required by effective healthcare leaders and the skills and behaviours that underpin them. Moreover, recommendations to improve support for staff mental health and wellbeing have also been made at a national level. NHS Improvement and Employers have been working with an Advisory Board to provide recommendations to enhance NHS staff health and wellbeing. These measures include a tested framework and assessment tool and, in 2020, piloting of a senior role (proposed to be an Executive Board Member or Non-Executive Board Member) who will have accountability for ensuring policy, practice and interventions to improve support for staff health. This role will have a major input in supporting measures to improve support for staff mental health and wellbeing and is proposed to be integrated into all NHS Trusts by 2021.

Managers have a legal obligation to support the wellbeing and mental health of their staff; research with nurses indicates that three competencies are particularly important: the ability to manage workload and resources, individual consideration, and a participative approach[197]. Nonetheless, managers need enough time and support to develop and operationalise these competencies and the potential impact on their workload and their personal wellbeing must be considered.

Also emphasised in this review is the need to enhance managers' knowledge and understanding of how current working conditions, and the job itself, can impact on nurses' and midwives' mental health and wellbeing[188,197]. A recommendation that requires particularly urgent attention is to ensure that nurses and midwives can take breaks from work and access food, drink and bathroom facilities as per their statutory right. As well as personally supporting the wellbeing of their staff at work, it is crucial for managers to work effectively with occupational health and human resources. Moreover, involving staff in change initiatives, decision-making and setting targets and deadlines was also considered of major importance.

Extensive and wide-ranging change has led to a high level of change fatigue among healthcare workers. Change will need to be handled sensitively and initiatives that are co-designed by staff are likely to increase their acceptability and effectiveness.

Changes at the public policy level were also considered essential to protect the wellbeing of staff effectively and sustainably. Ensuring optimum staffing levels, carefully monitoring 'actual' rather than 'theoretical' working hours and recognising how the growing administrative burden shouldered by nurses and midwives can threaten staff wellbeing and patient safety were considered crucial. The key role played by adequate staffing in underpinning the mental health of the workforce and for patient safety was considered particularly important; the need for further insight into the factors that underpin attrition, the implications of the ageing workforce and the provision of additional support for newly qualified staff were also noted. Ensuring that all nurses and midwives have access to occupational health services and other sources of support was considered a priority, as well as ensuring that the occupational health provision is more flexible and fit for purpose.

Although people working in emotionally demanding jobs undoubtedly require individual stress management skills to remain well, the intense pressure experienced by many nurses and midwives means that even the most resilient will be unlikely to thrive. Although structural interventions should be prioritised, the need for an evidence-informed 'emotional curriculum' was emphasised. This reflects a growing awareness of the need for health and social care staff to develop effective self-care and coping skills early in their career to help them withstand the pressures of the work.

Many of the factors that underpin poor wellbeing in nursing and midwifery are well-established and urgent action is clearly needed, but several priorities for future research were also identified in this review. These include the need for objective evidence to highlight the wide-ranging health and safety implications of short staffing for staff and patients and insight into the management behaviours that support the wellbeing of nurses and midwives as well as threaten it.

It is particularly important to recognise the heterogeneity of the nursing and midwifery workforce, both in terms of roles and demographics. Ensuring that the experiences of diverse groups are represented will inform more precisely targeted interventions to support the wellbeing of nurses and midwives. There is a particular need to focus on nurses and midwives from BAME backgrounds, as they are almost twice as likely to experience physical and verbal abuse than white staff and the prevalence of bullying is also considerably greater. Being subjected to harassment and bullying is a powerful source of stress, burnout and mental health problems and is also likely to impact on retention. More research is needed to provide insight into this issue among nurses and midwives from diverse ethnic backgrounds. As this report highlights, there is a distinct lack of understanding concerning the work experiences of BAME nurses and midwives and the impact this has on their mental health and wellbeing. This warrants exploration in much greater depth. There is a distinct power imbalance, not only in the workplace but also in the corresponding research and interventions that have been implemented, and this needs to be urgently recognised and reviewed. This work should also recognise the excellent work done by individuals, teams, organisations and national bodies in the NHS that are seeking to foster climates of fairness, inclusion, compassion and equality. Insight is also needed into the experiences of older workers, other groups such as male nurses and midwives, and those who work outside the NHS.

Organisations that carefully diagnose and manage the key psychosocial hazards at source, that introduce evidence-informed initiatives to enhance resilience among staff, and that provide appropriate, well-resourced and equitable support services are likely to have staff who are healthier and more engaged, as well as better retention and improved patient satisfaction rates. A healthy workplace culture underpins the wellbeing and mental health of individual nurses and midwives as well as optimum patient care, so improving their wellbeing will have benefits for all stakeholders. This review has highlighted the need for healthcare organisations to carefully scrutinise their cultures and consider how they might be impacting on the wellbeing of staff, both directly and indirectly, and take the action required to implement culture change.

The current COVID-19 pandemic provides additional challenges and will further compromise the mental health and wellbeing of nurses and midwives. The increased focus on the mental wellbeing of healthcare staff during the pandemic, however, along with the reorganisation of healthcare services at both organisational and policy levels, offers an opportunity to address many of the actions recommended in this report. There is an urgent need for change to be managed appropriately, as failure to do so would only lead to further deterioration in the mental health and wellbeing of the workforce. There are serious concerns about the long-term impact of the pandemic on staff, so action is urgently needed to avoid further mental health challenges that can only have serious consequences for the wellbeing of staff and patients.

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APPENDIX 1:

SUPPORT SERVICES AND RESOURCES FOR NURSES AND MIDWIVES

1: List of occupational and welfare support services and resources for nurses and midwives

Service	Description
RCN Counselling Service T: 0345 772 6100 W: https://bit.ly/2NIipl5	RCN members can obtain free, confidential support and assistance from this telephone-based counselling service to help them deal with any challenging issues that they may face, whether work-related or personal
The NMC Careline pilot T: 0800 587 7396 W: https://bit.ly/2KluAlH	This is a new resource operated by an independent provider that provides emotional and practical support to nurses and midwives across the UK, and nursing associates in England, who are involved in fitness to practise processes
Combat Stress T: 0800 138 1619 W: https://bit.ly/2QReDWY	This charity supports former servicemen and women, including medical professionals, with mental health problems such as anxiety, depression and post-traumatic stress disorder. Support is provided face to face, on the phone and online
Royal British Legion T: Call 0808 802 8080 W: https://bit.ly/2ZXrVFf	The Royal British Legion supports serving or ex-military nurses by providing a wide range of services to help with homelessness, domestic violence, drug and alcohol addiction, as well as mental health problems
Help for Heroes W: https://bit.ly/35pk4l3	This service supports veterans, including nurses, who are struggling with mental health. They provide psycho-education, a psychological wellbeing service for veterans and family members and mental health support in general

2: List of financial, welfare and legal support services for nurses and midwives

Service	Description
RCN Foundation W: https://bit.ly/35yWKSc	The RCN Foundation supports nurses, midwives, health care assistants and nursing students in times of need through grants, bursaries and scholarships
RCN Welfare Support T: 0345 772 6100 W: https://bit.ly/2qO8128	This service provides RCN members with free expert advice and information on benefits, debt, housing and other issues
RCN Lamplight Support Service T: 0345 772 6100 (RCN Members) T: 0345 772 6200 (Non-Members of RCN) W: https://bit.ly/3509gdg	This is a telephone advice and information line for nurses, midwives and healthcare assistants who are facing hardship. It offers tailored advice and information on welfare benefits and tax credits; cutting costs, budgeting and increasing income; how to put together an action plan to improve finances; and other services. There is no need to be a member of the RCN to access this support
RCM Legal Service T: 0808 100 7776 W: https://bit.ly/32Hk3rd	This service provides members with free legal advice and representation on a broad range of issues, including: personal injury (at or away from work); road traffic and holiday accident injuries; employment law; NMC case advice to all those registered; and 30 minutes of free legal advice is available for any non-work-related issues
The RCM Benevolent Fund W: https://bit.ly/36YRWHr	This fund provides support to midwives and maternity support workers in times of financial need, helping to get people's lives and careers back on track. It is operated in partnership with Cavell Nurses' Trust
The Cavell Nurses' Trust T: 01527 595 999 W: https://bit.ly/2For7zV	The Trust helps nurses, midwives and healthcare assistants (both working and retired) when they are suffering personal or financial hardship. This could be due to illness, disability, older age and domestic abuse
The Queen's Nursing Institute T: 020 7549 1400 W: https://bit.ly/2ZVGR6V	The Institute provides hardship grants for community nurses who are experiencing financial difficulties

3: List of general mental health and wellbeing support	
Service	**Description**
Access to Work Mental Health Support Service T: 0300 456 8114 W: https://bit.ly/2rXZdHR	Funded by the Department for Work and Pensions and delivered by Remploy, this is a vocational and confidential service for employees who are struggling at work due to depression, anxiety, stress or other mental health issues. The service offers tailored work-focused mental health support, practical advice and a support plan to keep people in work or help them return
Improving Access to Psychological Therapies W: https://bit.ly/2tvtC0O	This NHS service offers a range of free and confidential talking therapies and specialist support services for people with mild to moderate depression and anxiety and other mental health problems
Mind W: https://bit.ly/2sFJFJn	Mind provides people with advice and support if they are experiencing mental health problems, as well as bereavement, abuse or addiction
Samaritans T: 116 123 W: https://bit.ly/2QtAGUA	This charity provides emotional support to anyone who is in distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland
SANEline T: 0300 304 7000 W: https://bit.ly/2QtUKGm	SANEline is a national out-of-hours mental health helpline offering specialist emotional support, guidance and information to anyone affected by mental illness, including family, friends and carers
Anxiety UK T: 03444775774 W: https://bit.ly/2QRonQT	Anxiety UK's infoline service offers practical advice and information on support services that are available to anybody who is affected by anxiety, stress and/or anxiety-based depression, including their family, friends, loved ones and professionals
SHOUT text line Text 85258 W: https://bit.ly/2FpOx8g	The UK's first 24/7 text service for anyone in crisis anytime, anywhere. This is a place to go for those struggling to cope and in need of immediate help
Stay Alive W: https://bit.ly/2sRiZp0	Stay Alive is a suicide prevention app that offers help and support to people with thoughts of suicide and to those who are concerned about someone else

APPENDIX 2: METHODS

The systematic review was structured according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines[198]. Prior to beginning, a review protocol incorporated feedback from the Steering Group.

Data sources and search terms

Eight electronic databases were searched: Academic Search Premier, Business Source Premier, CINAHL, PsychArticles, PsychINFO, PuBAMEd, Web of Science and EMBASE. Search terms focused on variants of the three basic elements of the research question: mental wellbeing (e.g. job satisfaction, burnout, psychiatric health, anxiety, psychiatric morbidity, engagement, wellbeing), nurses or midwives (e.g. nurse*, midwi*) and United Kingdom (e.g. England, Scotland, Britain, Wales, Northern Ireland). The inclusion period was specified from January 1st, 2009 until 2019. To examine the grey literature Google and Google Scholar were also searched. The reference lists of reviewed articles and the articles that cited the included articles were also searched for additional relevant studies.

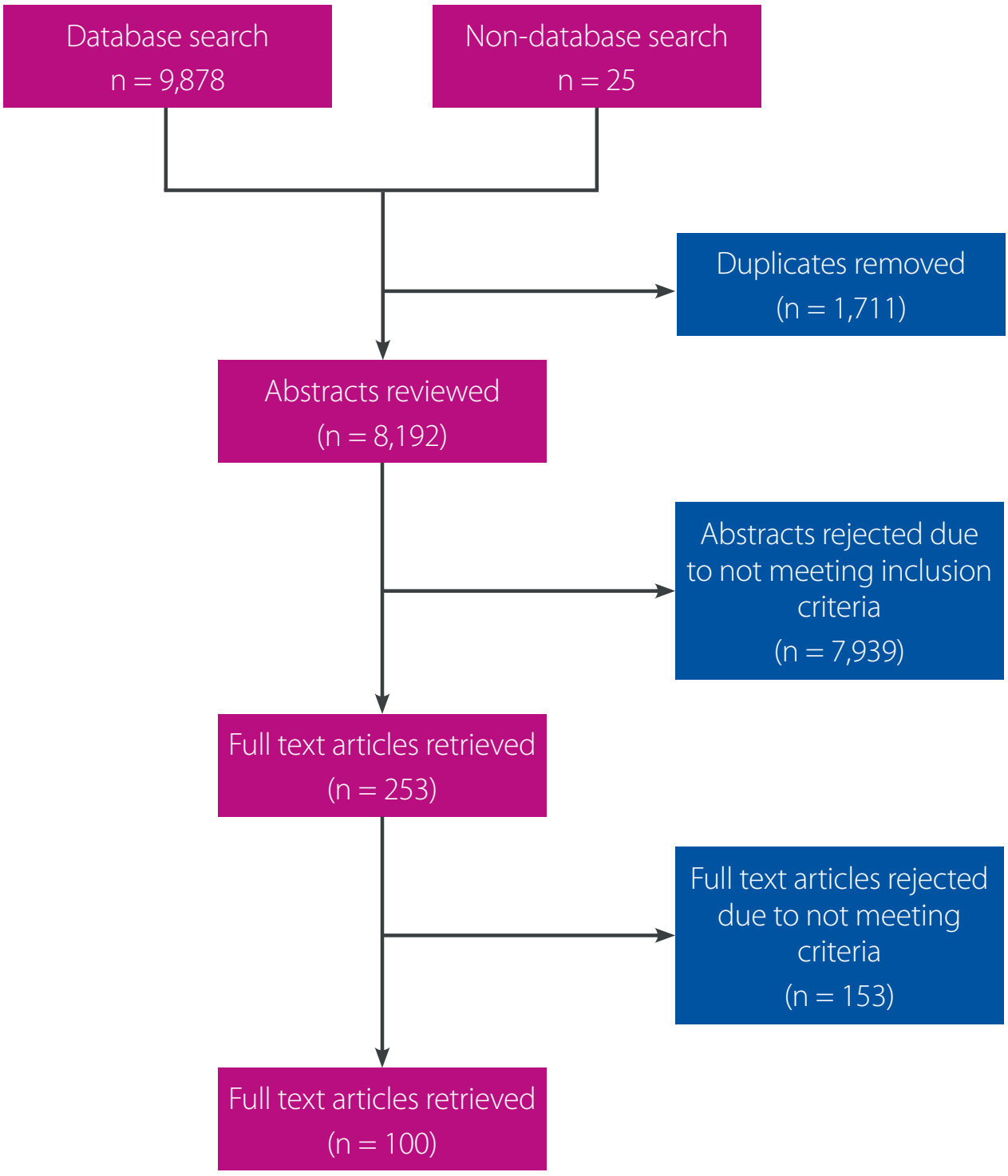
Inclusion criteria

Six inclusion criteria and exclusion criteria were applied to the identified studies. First, included studies had to examine some aspect of mental health and wellbeing. These could be work focused (e.g. work-related stress) or exist beyond the workplace (e.g. depression, lived experience). Studies that only examined physical health (e.g. musculoskeletal disorders) were excluded. Second, included studies had to have an empirical design (e.g. quantitative, qualitative or mixed methods). Editorials, commentaries, and systematic reviews were excluded. Third, the professional group being examined had to be registered nurses or midwives. Studies with mixed samples were relevant where data for nurses or midwives were reported separately. This meant that other healthcare professionals, including healthcare assistants and students were not included. Fourth, samples had to be from the United Kingdom (i.e. England, Scotland, Wales, and/or Northern Ireland). Multi-country studies were included where data from UK nurses/midwives was reported independently or could be extracted from the wider results. Fifth, studies had to be published in the previous ten years (2009 – 2019). Finally, only studies reported in English were included for review.

Search strategy

The search strategy contained two stages (See Figure 1). The database search yielded 9,878 hits with an additional 25 studies included from the non-database searches. From these, 1,711 duplicates were excluded. In the first stage each abstract was assessed by one reviewer against the specified criteria with 7,939 excluded as being irrelevant. Where the reviewer was uncertain the abstract was moved onto the subsequent stage to allow a full-text review. In Stage 2, a full text review was conducted (n=253). The same reviewer conducted the review process as in Stage 2. As a quality check 50% of full-text articles were independently and blindly reviewed by a second reviewer. Strong inter-observer agreement was found (K=.84). In total, 153 studies were excluded. The final number of included studies was 100.

Figure 1. Flow chart of study selection process



APPENDIX 3: PROCEDURE FOR THE DELPHI STUDY

A two-round Delphi study was carried out through an online survey with an Advisory Group to obtain consensus on the relevance of the initial recommendations. The Advisory Group comprised 23 nurses and midwives from different specialties, demographic background and geographical locations.

Stage 1

Each member of the Advisory Group was emailed a survey consisting of the recommendations arising from the systematic review and feedback from the Steering Group. They were instructed to rate each recommendation to its importance on the following five-point scale: ranging from five = 'essential', 'important', 'don't know/depends', 'unimportant' to one = 'should not be included'. The Advisory Group was also invited to submit additional comments or suggestions to be included as actions to be rated in the Stage 2 survey.

After a two-week survey period all ratings were collated, and each recommendation was categorised by the research team into one of the three categories:

i. Recommend (the recommendation received an 'essential' or 'important' rating from 80–100% of the Advisory Group).

ii. Re-rate (the item received an 'essential' or 'important' rating from 70–79% of Advisory Group).

iii. Rejected (the item was not considered sufficiently important (rating as 'essential' or 'important' by less than 70% of the Advisory Group).

All additional feedback and recommendations were collated. These were reviewed and edited to be included for Stage 2 of the Delphi study. An individual report was prepared for each of the panellists. This included a list of all the recommendations classed as 're-rate', with the panellist's score and the overall score by the Group. The report also included the list of recommendations that were recommended and rejected.

Stage 2

In the second stage each member of the Advisory Group was invited to rate all the recommendations that were classed as 're-rate' along with any new recommendations collected from the first round. Along with the second survey, Advisory Group members were sent a personalised report summarising the first survey. The report contained a list of items that were recommended and rejected. For the items that needed to be re-rated, each member of the Advisory Group was reminded how they scored each item in the first survey, and how each item was rated overall by the Group. This stage ran for a three-week period.

Upon completion of the survey period, each rated recommendation was classed as either Recommend (the recommendation received an 'essential' or 'important', rating from 80–100% of the Advisory Group) or Rejected (the item was not considered sufficiently important, rating as 'essential' or 'important' by less than 80% of the Advisory Group).

APPENDIX 4: COMPLETE LIST OF RECOMMENDATIONS

In total, 68 recommendations were reviewed. Of these recommendations, 45 were rated as 'essential' or 'important' by at least 80% of the Advisory Group and form the final recommendations of the report. It is important to emphasise that although the remaining recommendations are crucial for improving nurse and midwifery wellbeing, they were not seen as urgent by the Advisory Group and therefore not prioritised.

PUBLIC POLICY			
Number	Recommendation	Consensus	Decision
1	The factors that cause poor wellbeing are well-established (e.g. high work demands, poor leadership, lack of resourcing and workplace bullying). Rather than more research, action is now needed to address these issues	100%	Recommend
2	Optimum staffing levels for nurses and midwives should be guaranteed and the risks of short staffing to the health and safety of staff and patients recognised	100%	Recommend
3	More insight is needed into the factors that underpin attrition by nurses and midwives via exit interviews and research	95%	Recommend
4	Additional time worked, such as shift handovers, extra hours due to sickness etc., should be included when estimating overall working hours	95%	Recommend
5	Many reports have made recommendations on how to improve the mental health and wellbeing of nurses and midwives. We need to identify whether these recommendations have been implemented, or can be implemented	90%	Recommend
6	Induction and preceptorship programmes are needed for newly qualified nurses and midwives and those who move to new working environments	90%	Recommend
7	NICE guidelines should be used when supporting staff wellbeing as well as patients	86%	Recommend
8	Greater awareness is needed of how the increased bureaucracy and administration in nursing and midwifery can increase work demands and impact on staff wellbeing and patient safety	86%	Recommend
9	Occupational health (OH) professionals need to have the training, resources and tools to meet the needs of staff and staffing levels should be sufficient to meet the increasing demand inherent in healthcare	86%	Recommend
10	Phased approaches to return to work and to retain staff are needed to support nurses and midwives who are struggling with their wellbeing	86%	Recommend
11	The effects of temporarily losing the student bursary in England on future staffing levels should be recognised	86%	Recommend
12	As well as support for newly qualified nurses and midwives, carefully designed initiatives are required to support staff during their first few years of practice	86%	Recommend
13	More incentives are needed to make nursing and midwifery more attractive professions and to improve retention	86%	Recommend
14	Occupational health services need to better understand the role of working conditions on mental health and the importance of primary prevention. They should also advise on shaping organisational interventions rather than just focus on individual health needs	76%	Reject
15	There is a need to enhance mutual understanding between OH professionals and management about the purpose of OH services and a more collaborative approach is needed when deciding how best to implement recommendations	76%	Reject

ORGANISATIONS			
Number	Recommendation	Consensus	Decision
1	Staff should be required to take their full entitlement to breaks and have access to appropriate food and drink and bathroom facilities at all times	100%	Recommend
2	All NHS Trusts should have a mental health strategy that demonstrates their commitment to improving the mental health and welfare of all nurses/ midwives	100%	Recommend
3	All organisations should have a clear and accessible policy on mental health at work that informs policy and practice	95%	Recommend
4	Organisations should work towards creating better work environments for nurses and midwives and preventing stress from occurring at source	95%	Recommend
5	Action is needed to reduce the stigma of seeking help for stress and mental health problems	95%	Recommend
6	Staff should be able to self-refer to counselling or occupational health support rather than be required to go through their managers	95%	Recommend
7	Staff need to be given enough time to participate in wellbeing interventions and training and access support systems	95%	Recommend
8	Staff who make official complaints or who 'blow the whistle' on risk or wrongdoing in the public interest should be protected	95%	Recommend
9	When setting targets and deadlines, the wellbeing of staff who will be expected to meet them should be a key consideration	95%	Recommend
10	Greater understanding is needed of how various policies (e.g. stress, sickness absence) are being implemented and evaluated by organisations to identify what works	90%	Recommend
11	More creative and tailored flexible working options are needed to improve work-life balance and encourage return to work after sickness absence	90%	Recommend
12	The high risk of presenteeism (working while unwell) among healthcare professionals and the impact on their health and performance should be acknowledged by management. Steps should be taken to reduce presenteeism as well as tackle absenteeism	90%	Recommend
13	Staff need initiatives/debriefing sessions to support them after challenging situations at work (e.g. incidents of trauma, involving children, unexpected deaths, patient suicides)	90%	Recommend

ORGANISATIONS			
Number	Recommendation	Consensus	Decision
14	Organisations should have effective policies on dealing with abusive and bullying behaviours at work and must be willing to act on any complaints and support staff	86%	Recommend
15	More guidance and signposting are needed on the type and availability of support for mental health and wellbeing	86%	Recommend
16	Staff should be offered support that better fits their needs (e.g. through formal processes such as clinical supervision, mentoring and team development, or providing space and time for colleagues to spend time with each other)	86%	Recommend
17	Essential equipment and other resources, such as access to systems, should be available and fit for purpose	86%	Recommend
18	More opportunities are needed for staff to have input into change initiatives and decision making	86%	Recommend
19	People's understanding of the role of occupational health and counselling services should be enhanced to raise awareness of how they can help. Barriers to access should be identified and minimised	81%	Recommend
20	More opportunities are needed to provide a safe space for reflexivity and encourage staff to express and explore their emotions	81%	Recommend
21	Working hours should be carefully monitored, including those of staff who are doing bank shifts outside of their usual clinical area	76%	Reject
22	More options for flexible working should be available and staff encouraged to take them up	76%	Reject
23	Attention is needed to the implications of using bank and agency staff to fill vacancies for staff wellbeing	76%	Reject
24	Care is needed to avoid over-reliance on secondary stress management interventions, such as relaxation and time management, as this places responsibility on the individual to adapt to stressful conditions rather than tackle the problems at source	71%	Reject
25	Initiatives to improve the quality of interpersonal relationships between staff are required	67%	Reject
26	A self-referral/walk in service is needed to allow nurses and midwives to obtain urgent support	62%	Reject

MANAGERS			
Number	Recommendation	Consensus	Decision
1	Training is crucial to improve managers' skills, but they need the opportunity, time and resources to support the wellbeing of staff effectively	100%	Recommend
2	Managers and shift coordinators need a better understanding of the impact of shift-work on health and how this might be mitigated	100%	Recommend
3	Managers need a greater understanding of how the work can impact on the mental health and wellbeing of nurses and midwives and how to engage and support staff who are experiencing difficulties	95%	Recommend
4	Managers need a better understanding of nurses' and midwives' roles and duties to avoid expecting them to do tasks for which they are over-qualified or under-qualified	86%	Recommend
5	More opportunities are needed for managers to have discussions or 'catch up' sessions with staff about their wellbeing	76%	Reject

INDIVIDUALS			
Number	Recommendation	Consensus	Decision
1	An evidence-based 'emotional' curriculum is needed to highlight the need for self-care and build effective coping and resilience during initial training	86%	Recommend
2	Staff need more training on how to manage 'emotional labour' and how to avoid compassion fatigue and burnout	76%	Reject
3	Wellbeing sessions should be scheduled at a time when staff are able to attend and not during meal breaks	76%	Reject
4	More wellbeing initiatives based on positive psychology are needed to give staff the skills to manage stress more effectively (e.g. resilience, mindfulness)	67%	Reject
5	Staff should be encouraged to adopt a healthier lifestyle	67%	Reject

RESEARCH PRIORITIES			
Number	Recommendation	Consensus	Decision
1	More awareness is needed of the scale of mental health problems within the nursing and midwifery workforce	100%	Recommend
2	More research is needed into the occupational health needs of staff and whether they are being met	95%	Recommend
3	More research is needed to identify links between the mental wellbeing of nurses and midwives and patient safety and outcomes at the group level (e.g. department, ward, hospital). This would advance understanding of the wider impact of mental wellbeing and strengthen the argument for effective interventions	86%	Recommend
4	More research is needed to assess the mental wellbeing of nurses and midwives over time and establish the causes and impact of poor wellbeing on staff and patients	81%	Recommend
5	It is important to identify positive management behaviours as well as negative, as this will encourage best practice	81%	Recommend
6	Research is needed into the role and effectiveness of whistleblowing guardians	81%	Recommend
7	More research is required into the effects of lone working on the health and wellbeing of nurses and midwives	81%	Recommend
8	More research is needed into the stigmatisation of workplace stress and mental health problems in healthcare and the implications of such attitudes for staff wellbeing	76%	Reject
9	More research is needed into the effects of different shift patterns (e.g. 12-hour shifts) on the wellbeing of staff and the quality of patient care	76%	Reject
10	Insight is needed into the experiences of international nurses and how they impact on their health and wellbeing	76%	Reject
11	More understanding is needed of the work experiences and mental wellbeing of different demographic groups (e.g. ethnicity, sexual orientation, age) and how they can be best supported	71%	Reject
12	More insight is needed into how work and training can be adapted to ensure that nursing and midwifery is sustainable in later working life	71%	Reject
13	More research is needed into the effects of work on the personal life of nurses and midwives. This would highlight the importance of rest and recovery and the implications of taking work home	67%	Reject
14	More insight is needed into the work experiences and the mental wellbeing of specialties within nursing and midwifery, the particular risk factors and how they can be best supported	67%	Reject
15	Research is needed into how technology can be used to support clinical staff with their health and wellbeing	62%	Reject
16	More research is needed to evaluate whether the current application process for nurses is sufficiently open and inclusive	52%	Reject
17	Greater understanding is needed of the implications of a female-dominated workforce for wellbeing	48%	Reject

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Professor Gail Kinman is a Chartered Psychologist and a Fellow of the British Psychological Society and the Academy of Social Sciences. She is an occupational health psychologist with extensive experience in research and practice. Gail's main interests are in the work-related wellbeing of health and social care professionals and developing and evaluating multilevel approaches to improving wellbeing in this context. Professor Kinman is based at Birkbeck University of London.

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Thanks to other members of the Advisory Group not named above.

Supporting occupational health and wellbeing professionals

"This report highlights that workplace happiness is critical to enable nurses and midwives to flourish in their professions. This needs to be sanctioned and role modelled by every nurse and midwife leader, everywhere. It is clearly the responsibility of employers to develop workforce wellbeing strategies to tackle issues of bullying and harassment in the workplace. We already experience nursing and midwifery workforce shortages, so let's look after each other and enable nurses and midwives to stay in the professions they love."

Professor Greta Westwood PhD RN
Chief Executive Officer, Florence Nightingale Foundation

"In 2009 I led work highlighting the key role that staff health has in delivering effective, efficient health care in our NHS. At that time, I called nursing and other NHS staff "cobblers' children", as I found that often their own care needs were regularly neglected, leading to high rates of presenteeism, absence and attrition. Despite much work since then, this frankly, shocking report paints a picture that is worse, not better than ten years ago.

"I recognise the issues laid out in this work, from my own visits to highly motivated, deeply caring, but often tired and overstretched staff. The NHS people plan will require brave leadership and good management to drive the fundamental change needed to reverse this deeply worrying decline."

Steve Boorman
Chair, Council for Work and Health