Recommendations to Support the Mental Wellbeing of Nurses and Midwives in the United Kingdom: A Delphi Study

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All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*):

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Conflict of Interest

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Abstract

Aim: To use Delphi technique to identify and prioritise recommendations for research and practice to improve the mental wellbeing of nurses and midwives in the United Kingdom (UK).

Background: Although there is evidence that self-reported mental wellbeing among nurses and midwives in the UK is poor, interventions have not adequately considered the wider context in which they work. The wide range of individual, organisational, occupational, and wider sector-level factors that can influence wellbeing requires the involvement of different stakeholders to identify the most pressing actions required.

Design: A three-round Delphi technique conducted in 2019.

Methods: In the first round, 16 subject matter experts generated, reviewed, and discussed recommendations from a review of the research evidence with potential to support the mental wellbeing of nurses. A second group with 23 stakeholder representatives then rated and provided feedback on the developed recommendations through two additional rounds. Recommendations that received an 'essential' or 'important' rating from at least 80% of participants were retained and prioritised.

Results: In total, 45 recommendations met the consensus agreement and were retained. More than half (57%) involved action at the organisational level, 27% to public policy and 13% to research. Only one recommendation related to the individual. Collectively, these recommendations highlight the importance of taking direct action to tackle poor mental wellbeing among the workforce and initiating change at the policy and organisational level.

Conclusion: Our findings emphasise the need to take a systemic approach to improving the mental health of nurses and midwives in the UK with input from different stakeholders. There is clear consensus that action is needed at the organisation and policy levels, rather than at the individual level as is current practice.

Impact:

This study provides a framework, alongside a set of practical recommendations, that provides a starting point for different stakeholders to understand, address and support the mental wellbeing of nurses and midwives. Although UK-focused, it has relevance to healthcare workforces internationally.

Keywords: Delphi, nurses, midwives, interventions, policy, mental wellbeing, mental health, burnout, workforce health

Introduction

The mental wellbeing of nurses and midwives in the United Kingdom (UK) has been identified as an issue of concern by many stakeholders, including the Royal College of Nursing (Marangozov et al., 2017), the Nursing and Midwifery Council (2021), and the King's Fund (2021). It also forms a key commitment under the National Health Service (NHS) People Plan that emphasises the importance of the NHS looking after its workers (NHS England, 2020). Poor mental wellbeing will not only have a major impact on workers and their families, but evidence is growing for its detrimental effects on other key outcomes such as retention and recruitment (Laschinger et al., 2012) and the quality of patient care and satisfaction (Aiken et al., 2012; Hall et al., 2016). These were significant concerns prior to the COVID-19 pandemic and have been compounded by current working conditions (Maben & Bridges, 2020). Supporting the mental wellbeing of nurses and midwives in the UK is therefore a priority and identifying the needs of the workforce is essential to target appropriate and effective interventions. Crucially, international evidence shows similar concerns about poor mental wellbeing (Heinen et al., 2013; International Council of Nurses, 2020; Poghosyan et al., 2010), demonstrating the importance and relevance of this issue at a global level.

While some intervention studies have been conducted with nurses and midwives, reviews of the literature show that initiatives are predominantly at the individual rather than the organisational level (e.g., Kinman et al., 2020b). These studies have typically focused on specific types of intervention, such as mindfulness and resilience-building (Hart et al., 2014; van der Riet et al., 2018), and offer recommendations that limited potential to inform practical and effective interventions at a sector level. As mental wellbeing among the healthcare workforce is complex and multi-determined, a broader approach is needed to identify effective support initiatives considered relevant to the working context. We therefore

conducted a Delphi study with nursing and midwifery stakeholders in the UK to identify and prioritise recommendations for practice and research to better support the mental wellbeing of this workforce.

Background

Concerns for the state of nurses and midwives' mental wellbeing in the UK are supported by high prevalence rates of mental health problems reported using various measures and across different specialties. We use the term 'mental wellbeing' to refer to a dynamic mental state where an individual can, among other things: achieve their potential; work and live work productively and cope with and adapt to times of change and uncertainty (Foresight Mental Capital and Wellbeing Project, 2008). This definition encompasses both positive (e.g., life satisfaction, work engagement) and negative manifestations (e.g. work-related stress, burnout, and common mental health disorders) of wellbeing that can be situated inside and outside of work.

Studies have found between 29% and 51% of nurse participants met the criteria for emotional exhaustion (Berry & Robertson, 2019; Chana et al., 2015; Sherring & Knight, 2009), while 49% of the 154,569 nurses and midwives participated in the 2020 National Health Service (NHS) Staff Survey reported being unwell due to work-related stress (NHS Staff Survey Coordination Centre, 2020). There is also a high prevalence of common mental health disorders (such as depression and anxiety), with between 24% and 41% of the workforce reporting symptoms at levels warranting intervention (Chambers et al., 2016; Johnson et al., 2012; Wray et al., 2009). Studies providing international comparisons have found higher levels of burnout among nurses in the UK than the average of ten other European countries (28%) (Heinen et al., 2013). Moreover, the prevalence of burnout has been found to be higher among midwives in the UK compared to those in Australia, New Zealand, and Sweden (B.

Hunter et al., 2019). Recent research in the UK has also found high levels of dissatisfaction and demoralisation among the workforce (Senek et al., 2020). Despite these concerns, it should be noted that nurses and midwives report the highest levels of work engagement of all occupational groups in the NHS (NHS Staff Survey Coordination Centre, 2019).

Poor mental wellbeing among nurses and midwives can have devastating consequences, with female nurses in the UK at a 23% greater risk of suicide than those in other occupational groups (Windsor-Shellard & Gunnell, 2019). It also has workforce management implications, such as high rates of sickness absence and presenteeism (NHS Staff Survey Coordination Centre, 2019; Royal College of Nursing, 2013) and turnover intentions (Marangozov et al., 2017). For example, one study of 2,918 nurses found that those reporting high levels of burnout were more than twice as likely to consider leaving their job (Heinen et al., 2013). Although a direct relationship between mental wellbeing and patient care is not always found (Teoh et al., 2020), it has been associated with lower quality provision of care at the unit level (Poghosyan et al., 2010), more errors being made (J. L. Allan et al., 2014), and poorer self-rated care (Shantz et al., 2016).

To develop effective interventions, it is crucial to identify the work-related factors that make the strongest contribution to the wellbeing of nurses and midwives. By far the strongest influences on wellbeing are at the occupational and organisational level (Kinman et al., 2020a) clearly indicated that this is where interventions should be targeted. Examples of occupational factors linked to poor mental wellbeing include exposure to traumatic and distressing events. These are unfortunately common in nursing and midwifery and can have serious consequences for wellbeing and increase the risk of developing posttraumatic stress (Johnston et al., 2016; Sheen et al., 2015). Similarly, compassion is an integral part of providing care and strongly linked with positive patient outcomes but, without adequate time and resources, there is a high risk of compassion fatigue and burnout (McCloskey & Taggart,

2010). At the organisational level, high workload among nurses and midwives has been found to increase work intensity, extend their working hours, and limit their ability to take breaks. This increases the risk of burnout (Dall'Ora et al., 2015; Yoshida & Sandall, 2013), anxiety and depression (Chana et al., 2015; Mark & Smith, 2012), and job dissatisfaction (Ball et al., 2017). These risks to wellbeing are compounded by short staffing and material resources (Currid, 2009; Royal College of Nursing, 2013). There is evidence that having high levels of support from peers (Mark & Smith, 2012; Sherring & Knight, 2009) and managers (Berry & Robertson, 2019; McPherson et al., 2016) and feeling in control over the work environment (Johnson et al., 2012; Yoshida & Sandall, 2013) can mitigate the negative effects of poor working conditions and is associated with better mental wellbeing.

Research findings highlight bullying, violence, and discrimination (H. T. Allan et al., 2009; Currid, 2009) and poor pay and career progression (Carter & Tourangeau, 2012; Cousins & Donnell, 2012) as other major occupational and organisational factors that contribute to the poor levels of mental wellbeing reviewed above. The 2017 survey of Royal College of Nursing members (Marangozov et al., 2017) reported that 68% of nurses had been verbally abused by patients or their relatives and 31% had been bullied by colleagues. Of some concern, was the findings that more than half of respondents (56%) indicated that they struggled with food and travel costs. Many nurses and midwives also have difficulties 'switching off' from work and achieving a healthy work-life balance which restricts the opportunity to recover from work physically and psychologically, with additional risks for mental wellbeing (Carter & Tourangeau, 2012; Yoshida & Sandall, 2013).

As highlighted above, interventions to improve the mental wellbeing of nurses and midwives are typically at the individual level. This is problematic given that studies show that individual factors (e.g., age, gender) and psychological variables (e.g. resilience, personality, coping behaviours and self-efficacy) have a considerably weaker influence on mental

wellbeing than organisational and occupational factors (Bonner, 2016; Chana et al., 2015; Kinman et al., 2020a). Nevertheless, there is growing evidence that some individual-level interventions, such as mindfulness-based stress reduction (Delaney, 2018; Warriner et al., 2016), improving coping skills (B. Hunter & Warren, 2014), and psychoeducation (Redhead et al., 2011; Slade et al., 2018) can improve an individual's mental wellbeing. How sustainable any benefits might be is hard to establish, however, and not acknowledging the influence of wider contextual factors means that the known structural causes of poor mental wellbeing are not addressed (L. Hunter et al., 2018; Slade et al., 2018).

Interventions at the primary level that aim to address the occupational and organisational causes of poor wellbeing are likely to have a stronger impact (Eurofound and EU-OSHA, 2014). These typically focus on psychosocial risk assessments to identify and prioritise issues of concern and use a participatory approach that involves workers in developing solutions. To the best of our knowledge, no interventions of this type have been conducted with midwives in the UK, but there have been some involving nurses (Gupta & Woodman, 2010; Knight et al., 2017). For example, in a study of child palliative care nurses, team meetings were used to discuss issues of concerns identified in an initial survey, including increasing administrative tasks, excessive work demands, and dealing with patient deaths (Gupta & Woodman, 2010). This led to changes, such as reorganising the distribution of work, revising the administration system, and increasing peer support meetings; all of which were likely to have contributed to the reduced stress levels found the following year. Although undoubtedly promising, evaluations of such interventions involving nursing (Knight et al., 2017) and healthcare workers more generally (Di Tecco et al., 2020; West, 2021), highlight numerous contextual factors (such as lack of management support, conflicting demands, inadequate resourcing, absence of evaluation, and change fatigue) as undermining attempts to address the occupational and organisational influences on mental wellbeing.

The Study

Aims

Despite the growing recognition of the need to support the mental wellbeing of nurses and midwives in the UK, there is a need for intervention research to consider the wider context in which nurses and midwives work and in which interventions are situated. The various individual, organisational, occupational, and wider sector-level factors that have been found to influence mental wellbeing necessitates the involvement of different stakeholders to identify the most pressing actions required. As such, this study used a three-round Delphi technique with two groups to obtain consensus on the required actions for research and practice to improve the mental health of nurses and midwives in the UK.

Design

The Delphi technique is a method used in research to generate consensus from a panel of experts. We carried out a three-step modified Delphi technique between October and December 2019. This allowed us to engage with a broad range of nursing and midwifery stakeholders in a structured manner to generate and prioritise recommendations to support the mental wellbeing of nurses and midwives in the UK. Through this process, a panel of relevant stakeholders reviewed, revised and generated recommendations through an iterative process via a series of online surveys (Button et al., 2019; Keeney et al., 2006; Massaroli et al., 2017). We used three rounds, as consensus is typically achieved at this stage (Hasson et al., 2000). Across each round, recommendations were rated by the panel and those that did not reach consensus regarding its importance were excluded. This process of refinement resulted in those recommendations considered particularly important being retained. The widely distributed and anonymous nature of online Delphi studies allows panels to be more inclusive with regard to location, representation and power dynamics (Keeney et al., 2001;

Powell, 2003). The value of Delphi studies is reflected in its growing use in nursing research (Button et al., 2019; Cadée et al., 2018; Massaroli et al., 2017; Meskell et al., 2014). For consistency, in this study, we report the findings using the Delphi reporting guideline checklist (Supplementary Table A) (Jünger et al., 2017)

Participants

The first panel (i.e., the first round of the Delphi study) comprised 16 subject matter experts from the project Steering Group in relevant areas such as healthcare workers' mental health, nursing and midwifery education (n=5), and stakeholder representatives for nursing and midwifery leadership (n=5), professional bodies (n=6), and trade unions (n=5). This reflected the importance of including participants in Delphi research who are likely to have diverse viewpoints on particular issues (Powell, 2003). Participants were recruited through the Royal College of Nursing and the Society of Occupational Medicine in the UK. Participants were recruited based on their role, rather than as individuals, so demographic details were not collected.

Drawing on guidance on best practice for Delphi studies, the second panel (the Advisory Group that formed Rounds 2 and 3 of the Delphi study) focused on recruiting informed advocates and representatives of nurses and midwives (Linstone & Turoff, 1976; Meskell et al., 2014). This ensured that we could obtain the views not only from subject matter experts, but also from front-line nurses and midwives to maximise reliability and relevance (Cornick, 2006). We used purposeful sampling via professional networks to ensure representation across different specialities, demographic backgrounds, and geographical locations in the UK. In total, 23 nurses and midwives were recruited representing mental health (n=6); occupational health (n=5), midwifery (n=4), adult (n=3) and practice (n=2) nursing. Representatives from diabetes, intensive care and paediatric nursing were also included.

Date Collection and Analysis

Round 1

The first panel was asked to review the findings of a systematic review previously conducted by the authors on the antecedents, outcomes and interventions relating to the mental wellbeing of nurses and midwives in the UK (Kinman et al., 2020a). Participants were presented with 47 recommendations extracted from the review that set out the actions needed to better support the mental wellbeing of the workforce (see Figure 1). They were asked to comment on the recommendations and to identify: a) whether recommendations should be added and b) whether any existing recommendations should be amended or removed entirely. The panel then returned their amended recommendations by email to the research team. The panel's recommendations were subsequently reviewed by two members of the research team. The original recommendations were edited where required, with any additional recommendations analysed using content analysis to form new recommendations to be rated in the next round. The research team reviewed the congruence of new and revised recommendations in relation to the original systematic review, although additional recommendations were required to address gaps in the literature previously identified from this review. To ensure that all feedback and recommendations from the Steering Group were treated equally, all new and revised recommendations were subsequently rated by the panel in Round 2 along with the approved recommendations (Button et al., 2019).

[Insert Figure 1 here]

Round 2

Each participant from the second panel was emailed a link to an electronic survey with the recommendations generated from Round 1 (Figure 1). Participants were invited to rate the

importance of each recommendation on a five-point scale (1= should not be included; 2= not important; 3= Don't know/ depends; 4= important; 5 = essential) based on the rating scale from Langlands et al. (2008). An open-ended question also allowed participants to submit additional comments or recommendations to be included in the subsequent and final round of the survey. Round 2 was carried out over a three-week period, with a reminder email sent at weekly intervals.

Results were analysed for consensus regarding the importance of each recommendation. As there is no universal consensus on agreement in Delphi studies (Hasson et al., 2000), in this study we used a higher level of agreement than usual to filter out recommendations that were of a lower priority. A more conservative approach of 80% agreement was utilised (Langlands et al., 2008), where each recommendation was sorted into one of the following three categories: *Recommend* (the recommendation received an 'essential' or 'important' rating from >80% of participants); *Re-rate* (the item received an 'essential' or 'important' rating from 70–79% of participants); or *Reject,* where the item was not considered sufficiently important (rated as 'essential' or 'important' by <70% of participants).

Round 3

In Round 3, all 23 members of the second panel were invited to rate all the recommendations that were classed as 're-rate', along with any new recommendations collected from the second round. With the second survey, participants were sent a personalised report summarising the findings of Round 2, comprising a list of items that they had recommended and rejected. For the items that needed to be re-rated, each member of the advisory group was also 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, with a reminder email sent at the end of the first and the third week. At the end the survey period, each rated recommendation

was classed as either *Recommend* (the recommendation received an 'essential' or 'important' rating from >80% of participants) or *Rejected* (the recommendation was rated as 'essential' or 'important' by <80% of participants).

Ethical considerations

Participants in the first panel were part of the steering group for the project and therefore were aware of each other's participation, whereas participants in the second panel were blinded to each other. As individual participant's data from Rounds 2 and 3 were linked by their email addresses, they were not anonymous to the researchers. However, all responses and participation throughout the process were kept confidential, ensuring quasi-anonymity (McKenna, 1994). All participants consented to take part in the research based on the information provided and had the right to withdraw at any point.

Validity and reliability

We adhered to best practice guidelines for Delphi studies (Hasson et al., 2000; Keeney et al., 2001, 2006; Massaroli et al., 2017) in nursing research to ensure rigour throughout the process. The consensus approach used, the three rounds during the Delphi process, and re-rating of agreed recommendations in Round 3 helped ensure reliability across participants. Facilitating the process remotely without direct interaction between participants mitigated against group dynamics, politics, and the domination of individuals during the process which is a risk factor when conducting research at the group level (Hasson et al., 2000). Content and face validity is supported by drawing the initial recommendations from the findings of a systematic review as well as nursing and midwifery stakeholders from a variety of backgrounds and experience (Cadée et al., 2018).

Findings

Round 1

In Round 1, all 16 members of the project Steering Group returned responses. All 47 recommendations arising from the review that were provided were subsequently modified. A substantial number of written comments informed the editing and refinement of the recommendations. Revisions to the existing recommendations and the inclusion of others resulted in a total of 58 recommendations for the second round. Based on content analysis of panel comments, the recommendations were divided into four categories, relating to "public policy" (*n*= 16, 28%), "organisational" (*n*=24, 41%), "individual" (*n*=4, 7%) and "research" (*n*=14, 24%).

Round 2

Eighteen out of the 23 (78%) professionals invited to participate in the second panel took part in Round 2. Participants were presented with the 58 recommendations from Round 1 (Supplementary Material B), of which 41 (75%) surpassed the consensus threshold. This included 73% of recommendations related to public policy, 83% of organisational, 25% of individual, and 57% of research (Table 1). Nine (16%) recommendations fell within the re-rate threshold, with a consensus level between 70% and 79%. The remaining eight (14%) items did not meet the required consensus threshold for progression into Round 3 of the study and were therefore excluded. Although there were only four recommendations originally in the 'individual' category, two (50%) were excluded. A smaller proportion of recommendations were excluded for the categories covering public policy (20%), research (13%) and organisations (4%).

Altogether, 30 comments were made about the existing recommendations and suggestions for additions. This led to 18 new recommendations for inclusion in Round 3. As these comments also required edits to existing recommendations that had already met the consensus threshold, they were again included in Round 3 (McIlrath et al., 2010).

[Insert Table 1 here]

Round 3

In total, 68 recommendations were rated in Round 3 consisting of those that had met the re-rate threshold in Round 2 (n=50) or were developed from the feedback from Round 2 (n=18) (Supplementary Material C). Once again, most recommendations focused on the organisation (*n*=33), followed by research (*n*=16), public policy (*n*=14), and individuals (*n*=5).

Twenty one of the 23 panellists invited to participate (91%) submitted ratings. Out of the 68 recommendations, 45 (66%) were retained after a consensus agreement of at least 80% (Table 1). From these, more than half (*n*=26, 57%) related to the organisation, 27% (*n*=12) pertained to public policy and six (13%) focused on research. Only one (2%) recommendation – "An evidence-based 'emotional' curriculum is needed to highlight the need for self-care and build effective coping and resilience during initial training" - related to the individual. The full list of these 45 recommendations can be found in Supplementary Material C.

Seven recommendations achieved 100% consensus as either "essential" or "important". These are shown in Table 2 and indicate that supporting the mental wellbeing of nurses and midwives requires improvements primarily at the policy and organisational levels.

[Insert Table 2 here]

Discussion

This Delphi study provides a wide range of recommendations to support the mental wellbeing of nurses and midwives working in the UK. The recommendations can be divided into four categories – those relating to public policy, organisations, individuals, and research. This highlights the need to take a systemic approach to improving the mental health of the workforce with input from a range of stakeholders. Crucially, there is clear consensus that

action is needed at the policy and organisation levels rather than at the individual level as is current practice.

The need for interventions at the organisational level is particularly evident, with 58% of the most highly prioritised recommendations relating to such initiatives. This is not surprising given that organisational policies and practices primarily determine the physical and psychosocial working conditions of nurses and midwives and therefore strongly influence their wellbeing (Dollard & Bakker, 2010). Moreover, organisations are well positioned to determine how these policies and practices are shaped and enacted. This is seen in the four recommendations with full consensus that emphasise the need to enforce what should already be in place, namely: (i) staff being able to take full break entitlements; (ii) managers being appropriately trained and having sufficient time and resources to support their staff; (iii) a better understanding of the impact of shift-work on key outcomes such as wellbeing and performance; (iv) trusts having a mental health strategy that demonstrates commitment to improving mental health among employees. This implies a potential failure in executing existing policies and practices. For example, the NHS Health and Wellbeing framework (NHS England, 2021) encourages organisations to implement these actions, while existing legislation limits hours worked and specifies break and rest allowances (Royal College of Nursing, 2022). This concern is further evident in the remaining 22 recommendations for organisations, which can be broadly grouped according to the need to apply and evaluate policies that should already be in place (e.g., for flexible work, whistleblowing, sickness absence, abusive behaviours); balancing staff wellbeing in relation to work duties (e.g., task setting and deadlines, supporting new starters, efficient resources); and the challenge of stigma and increasing access to help-seeking for mental health issues.

These recommendations also reinforce the point that mental wellbeing is not only an individual issue but inextricably linked with the general management and efficiency of the

organisation (Inceoglu et al., 2018; Royal College of Physicians, 2016). Interventions based on risk assessments and employee participation are therefore imperative, as workers are best placed to feedback on issues around implementation and suggest potential improvements that are congruent with the local context (Cox et al., 2010). Similarly, evaluation of interventions is necessary not only to determine whether they were effective, but also to consider the process of implementation to understand what worked, for whom, why, and in what circumstances (Nielsen & Miraglia, 2017). Our findings suggest that supporting mental wellbeing does not necessarily require introducing *more* interventions, but enacting policies that are already in existence or are planned, or improving the delivery of initiatives already in place (Cox et al., 2010).

Twelve (27%) of the recommendations related to public policy and three reached full consensus. First, that more work is required to identify the scale of mental health problems within the nursing and midwifery workforce. Next, is the need to guarantee optimum staffing levels, which is essential to ensure sufficient cover for work duties, manage work pressures, and enable access to supervision and support. In turn, this will help reduce work intensity, enable sufficient rest and breaks, and reduce working hours (Marangozov et al., 2017; Royal College of Nursing, 2019a; van Oostveen et al., 2015) – all of which are likely to improve the mental health and wellbeing of staff and reduce turnover. This finding concurs with existing research highlighting the need for optimum staffing to ensure patient safety (Rogowski et al., 2015; Thomas-Hawkins et al., 2020). Other recommendations also reflect current patient care initiatives, such as including overtime hours within overall working hours, using National Institute for Health and Care Excellence guidelines to support staff wellbeing, and a recognition that administration and bureaucracy impacts both staff wellbeing and patient care. The underlying theme is that factors that influence patient care and safety are similar to those that affect the mental wellbeing of staff, and that efforts across these areas should be more

collaborative and involve different stakeholders (Teoh et al., 2021). The second priority from the public policy recommendations is the need for action to address the issues previously identified to improve mental wellbeing among the workforce. Numerous reports (Francis, 2013; Marangozov et al., 2017; NHS England, 2019) have highlighted this issue and made recommendations, but little is known about whether they have been enacted and, if so, how successful they have been. What is evident is that, to date, there has either been insufficient, or inefficient, action to address existing recommendations to support staff wellbeing.

The public policy recommendations highlight the need for actions by a broad group of stakeholders beyond the organisation level, including policies and actions from government, NHS England, the Royal Colleges, universities and training providers, and the professional regulator. Most of these recommendations involve actions by various stakeholders. For example, the need to support new staff when transitioning to the workplace, managing return to work following sickness absence effectively, and better collaboration between occupational health and organisations. These issues should be subject to policy developed at the national level with best practice identified and disseminated across the sector.

Despite the emphasis on direct and urgent action, the panellists agreed there is a need to address specific research gaps within the literature. This includes research to that highlights the impact of staff wellbeing on patient care at group levels (e.g., wards, hospitals) as well as investigating the causes and outcomes of mental wellbeing over time. Moreover, although mental wellbeing is on a continuum ranging from negative to positive, much of the research with healthcare workers has focused on ill-health, particularly burnout (Schaufeli, 2007; Teoh et al., 2018). This may explain why the panellists in this study highlighted the need for more research on positive factors of wellbeing which can inform best practice guidelines. Other recommendations at this level highlighted the need for insight into the role

and effectiveness of whistleblowing guardians, the effect of lone working, and the occupational health needs of nurses and midwives and how they can best be met.

Notably, only seven recommendations pertaining to the individual were generated and just one was retained in the final list. No individual-level recommendation achieved 100% consensus. The emotional curriculum within the retained recommendation may involve organisational and policy changes based on best practice for supporting staff wellbeing but is classed as individual given the target of change is that individual employee. This may reflect nurses' and midwives' views the responsibility for improving mental wellbeing should lie less with the individual employee but via improved support at the policy and organisational level (Kelly et al., 2019). It would be useful to explore this issue in future research, but previous studies have found that concerns such as blaming individuals for any distress they experience, failure to address the primary contributing factors, absolving responsibility for wellbeing from the organisation or system can encourage such views, along with, the challenge of implementing and sustaining change at a structural level (Traynor, 2018). This also creates a paradox given the prevalence of individual-level interventions such as resilience, mindfulness, and psychoeducation among nurses and midwifes (Kinman et al., 2020a) and highlights the need for stakeholders to take responsibility for action and focus on the wider contextual factors. It may also be that our panellists did not prioritise individual-level interventions because of they are ubiquitous and a crucial part of a multi-level approach to supporting the wellbeing of the workforce, whereas organisational and policy actions are needed to supplement rather than replace those at the individual level.

Although this Delphi study was carried out just before the start of the COVID-19 pandemic, its onset has increased the salience and relevance of the recommendations provided. Meta-analytic research of international studies (Galanis et al., 2021; Saragih et al., 2021) have consistently shown a further decline in the mental wellbeing of nurses and

midwives since the pandemic. This has been highlighted as a major contributing factor in the subsequent increased exit of nurses and midwives, accentuating staff shortages and compounding workplaces pressures and demands (Andel et al., 2022; Lopez et al., 2021). While there have been more unique pandemic-related risk factors – such as fear of exposure, lack of personal protective equipment, and work reassignments as well as concerns related to mental health such as moral distress – studies have also repeatedly identified the same occupational and organisational factors covered in this study which led to the recommendations proposed (Eagen-Torkko et al., 2021; Franklin & Gkiouleka, 2021; Kinman et al., 2020b; Kisely et al., 2020).

The upheaval and adjustment to working conditions and patient care during the pandemic has in some instances seen the implementation of some of our recommendations for healthcare workers more generally. For example, an enhanced provision of food and rest facilities provided by some hospitals have been well-received (Spiers et al., 2021). Similarly, there has also been a greater recognition of the need for healthcare staff to access support for mental health, in line with evidence of deteriorating wellbeing and the need to reduce recognised risk factors such as such as reducing bureaucracy and improving peer support and supervision (Baker et al., 2021; Mhawish & Rasheed, 2021). Of some concern, however, is that the rapid development of guidelines and interventions to support staff wellbeing during a time of unprecedented demand has predominately focused on the individual, (Vera San Juan et al., 2021). Crucially, it is argued that the emergence of the "heroic health care worker" narrative has been detrimental, as it places further onus on the individual nurse and midwife to take responsibility for managing their own wellbeing, to be self-sacrificing, take on additional risks, and demonstrate invincibility (Halberg et al., 2021). This is problematic and further underlines the relevance of our recommendations that additional interventions are

required at organisational and public policy level, with politicians and healthcare managers being more accountable for the mental health and wellbeing of the workforce.

Limitations

This research has provided insight into how the mental wellbeing of nurses and midwives might be better supported. Nonetheless, some limitations should be acknowledged. Despite the more conservative consensus threshold used, it could be argued that 45 recommendations are a substantial number and may hinder prioritisation. Nevertheless, the seven recommendations (Table 2) that obtained 100% consensus represent the most pressing areas for change. In future, an approach that explicitly ranks or prioritises actions against each other may be effective in identifying areas for change (Davis et al., 2014). It should also be emphasised that, while some recommendations did not achieve sufficient consensus to be considered a priority, they are nevertheless valid and require attention to support the mental wellbeing of nurses and midwives. This also highlights a limitation in using a consensus-based approach such as was the case here, where recommendations that are deemed important for specific subgroups, or those that might challenge the status quo, are not retained as they did not exceed the wider group consensus threshold. The final recommendations may therefore be somewhat utilitarian, in trying to support the mental wellbeing of a heterogenous workforce who experience very different working conditions and are from diverse demographic and professional backgrounds. A larger group of panellists could broaden representation and we acknowledge the absence of members from Northern Ireland and Wales in developing actions for the UK in general. Equally, although there is evidence of poorer wellbeing among nurses and midwives that were trained abroad (Alexis, 2015) and who are from an LGBTQ+ background (Lim & Borski, 2015), we cannot establish representation from these groups as unfortunately they were not criteria for recruiting participants.

Finally, this study was carried out prior to the COVID-19 pandemic, which has led to significant change in the work practices and demands faced by nurses and midwives. Along with a corresponding upheaval in their personal circumstances, there are serious concerns about the impact this will have on the future mental health of the workforce. Nonetheless, while specific and possibly different actions (e.g., the need for appropriate personal protective equipment: Arnetz et al., 2020) may have become more salient, the recommendations highlighted in this Delphi study and the multilevel and systemic approach advocated remain relevant and necessary.

Conclusion

The consensus reached in this Delphi study is that actions to support the mental wellbeing of nurses and midwives in the UK should focus on the organisation and public policy and, to a lesser extent, address identified gaps in research. The implication here is that the mental wellbeing of this workforce is not only an individual issue. Instead, it requires ownership of the problem by those who have influence over the organisations and systems in which nurses and midwives work and who can implement change. At its roots, supporting the mental wellbeing of nurses and midwives is crucial for the provision of safe and high quality care (de Lange et al., 2020), so a more unified approach is required for both efforts. The recommendations provided here at different levels offer a starting point, or a list of actions, for different stakeholders to follow through. While meeting these recommendations may appear challenging, it should be noted that many effective interventions can be implemented that require low cost and effort. A major change at the sector level has been implemented since this Delphi study was carried out, in that the UK government has reinstated the student bursary – a financial grant - for nursing students in England (Glasper, 2020). Although the immediate impact of this action is on nursing students and not the current qualified workforce, it has been identified as pivotal in attracting nursing students and has major

implications for future staffing levels and working conditions (Royal College of Nursing, 2019b), with inadequate staffing levels associated with poorer working conditions and staff wellbeing outcomes (Aiken et al., 2002; Jomaa et al., 2021). It is clear that urgent action is needed to address the concerns raised in this study and a recognition is needed that, in most cases, more interventions are not required, but a more efficient execution of existing policies that take into account local contexts and needs.

Conflict of Interest

No conflict of interest has been declared by the authors.

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Table 1: Overview of recommendations decisions Round 2 and Round 3

	Round 2				Round 3		
	Recommend	Re-rate	Reject	Total	Recommend	Reject	Total
Public Policy	12	1	3	16	12	2	14
Organisations	20	3	1	24	26	7	33
Individual	1	1	2	4	1	4	5
Research	8	4	2	14	6	10	16
Total	41	9	8	58	45	23	68

Table 2: Recommendations that achieved 100% consensus.

Recommendation	Type
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	Public Policy
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	Public Policy
3. More awareness is needed of the scale of mental health problems within the nursing and midwifery workforce	Public Policy
4. Staff should be required to take their full entitlement to breaks and have access to appropriate food and drink and bathroom facilities	Organisation
5. Training is crucial to improve managers' skills, but they need the opportunity, time and resources to support the wellbeing of staff effectively	Organisation
6. Managers and shift coordinators need a better understanding of the impact of shift-work on health and how this might be mitigated	Organisation
7. All NHS trusts should have a mental health strategy that demonstrates their commitment to improving the mental health welfare of all nurses/midwives.	Organisation

Supplementary Material A. Delphi Reporting Checklist

Reporting Criteria	Comment
Purpose and rationale: The purpose of the study should be clearly defined and demonstrate the appropriateness of the use of the Delphi technique as a method to achieve the research aim. A rationale for the choice of the Delphi technique as the most suitable method needs to be provided.	This is provided under the "Aims" section on page 8, with further justification provided in the subsequent "Design" section.
Expert panel: Criteria for the selection of experts and transparent information on recruitment of the expert panel, socio-demographic details including information on expertise regarding the topic in question, (non)response, and response rates over the ongoing iterations should be reported.	Criteria for selection and background for participants are provided in the "Participants" section on page 9. This includes their specialities and backgrounds, but we did not collect sociodemographic information and therefore are unable to report this. The response rates for each iteration is reported in the Findings section (under the respective reporting of each Round).
Description of the methods: The methods employed need to be comprehensible; this includes information on preparatory steps (How was available evidence on the topic in question synthesised?); piloting of material and survey instruments; design of the survey instrument(s); the number and design of survey rounds; methods of data analysis; processing and synthesis of experts' responses to inform the subsequent survey round; and methodological decisions taken by the research team throughout the process.	This is covered in the "Data Collection and Analysis" section on page 10, with more specific breakdown according to each Round provided.
Procedure: Flow chart to illustrate the stages of the Delphi process, including a preparatory phase, the actual "Delphi rounds", interim steps of data processing and analysis, and concluding steps.	This is presented in Figure 1.
Definition and attainment of consensus: It needs to be comprehensible to the reader how consensus was achieved throughout the process, including strategies to deal with non-consensus.	This is covered in the "Data Collection and Analysis" section on page 10, with more specific breakdown according to each Round provided.
Results: Reporting of results for each round separately is highly advisable in order to make the evolving of consensus over the rounds transparent. This includes figures showing the average group response, changes between rounds, as well as any modifications of the survey instrument such as deletion, addition, or modification of survey items based on previous rounds.	Results are reported for each Round separately (under the Findings section on pg. 12-14). The corresponding figures are also made explicit through Table 1 and Table 2. The recommendations and their responses for the Rounds are presented in Supplementary Material B and C.
Discussion of limitations: Reporting should include a critical reflection of potential limitations and their impact of the resulting guidance.	This is covered in the section "Limitations" on page 18.
Adequacy of conclusions: The conclusions should adequately reflect the outcomes of the Delphi study with a view to the scope and applicability of the resulting practice guidance.	The "Conclusion" section on page 20 summarises the paper and reflects on next steps.
Publication and dissemination: The resulting guidance on good practice in palliative care should be clearly identifiable from the publication, including	The full set of recommendations are presented in Table 3 and are discussed in more detail in the paper.

recommendations for transfer into practice and implementation. If the publication does not allow for a detailed presentation of either the resulting practice guidance, or the methodological features of the applied Delphi technique, or both, reference to a more detailed presentation elsewhere should be made (e.g., availability of the full guideline from the authors or online; publication of a separate paper reporting on methodological details and particularities of the process (e.g., persistent disagreement and controversy on certain issues)). A dissemination plan should include endorsement of the guidance by professional associations and healthcare authorities to facilitate implementation.	In addition, further recommendation items are made available in the Supplementary Material for readers who may want to take an even broader set of actions.

Supplementary Material B: Recommendations Reviewed in Round 2

Public policy

	Recommendation	Consensus	Action
1	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	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	94%	Recommend
3	More awareness is needed of the scale of mental health problems within the nursing and midwifery workforce	94%	Recommend
4	More insight is needed into the factors that underpin attrition by nurses and midwives via exit interviews and research	89%	Recommend
5	NICE guidelines should be used when supporting staff wellbeing as well as patients	89%	Recommend
6	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	89%	Recommend
7	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	83%	Recommend
8	Phased approaches to return to work and to retain staff are needed to support nurses and midwives who are struggling with their wellbeing	83%	Recommend
9	Induction and preceptorship programmes are needed for newly-qualified nurses and midwives and those who move to new working environments	83%	Recommend
10	The effects of losing the student bursary on future staffing levels should be recognised	83%	Recommend
11	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	83%	Recommend

12	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	83%	Recommend
13	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	78%	Re-rate
14	A ‘summit’ is needed that brings together the key stakeholders to identify how to take collaborative action to improve wellbeing and monitor progress	67%	Reject
15	Regular risk assessments of psychosocial hazards are needed at a national level using best practice frameworks (e.g. the Health and Safety Executive’s Management Standards)	67%	Reject
16	Staff need 'Passports of Risk' (or similar) to ensure that their occupational health needs are recognised through career transitions	39%	Reject

Organisations

	Recommendation	Consensus	Action
1	All organisations should have a clear and accessible policy on mental health at work that informs policy and practice	100%	Recommend
2	Training is crucial to improve managers' skills, but they need the opportunity, time and resources to support the wellbeing of staff effectively	100%	Recommend
3	Organisations should work towards creating better work environments for nurses and midwives and preventing stress from occurring at source	100%	Recommend
4	Action is needed to reduce the stigma of seeking help for stress and mental health problems	100%	Recommend
5	More creative and tailored flexible working options are needed to improve work-life balance and encourage return to work after sickness absence	100%	Recommend
6	Staff need to be given enough time to participate in wellbeing interventions and training and access support systems	94%	Recommend
7	Staff should be required to take their full entitlement to breaks and have access to appropriate food and drink and bathroom facilities	94%	Recommend
8	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	94%	Recommend

9	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	94%	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	94%	Recommend
11	More guidance and signposting are needed on the type and availability of support for mental health and wellbeing	94%	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.	94%	Recommend
13	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)	89%	Recommend
14	Staff need initiatives/debriefing sessions to support them after challenging situations at work (e.g., incidents of trauma, involving children, unexpected deaths, patient suicides)	89%	Recommend
15	More opportunities are needed to provide a safe space for reflexivity and encourage staff to express and explore their emotions	89%	Recommend
16	Staff should be able to self-refer to counselling or occupational health support rather than be required to go through their managers	89%	Recommend
17	Essential equipment and other resources, such as access to systems, should be available and fit for purpose	89%	Recommend
18	Managers and shift coordinators need a better understanding of the impact of shift-work on health and how this might be mitigated	89%	Recommend
19	More opportunities are needed for managers to have discussions or 'catch up' sessions with staff about their wellbeing	89%	Recommend
20	More opportunities are needed for staff to have input into change initiatives and decision making	83%	Recommend
21	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	78%	Re-rate
22	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	78%	Re-rate

23	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.	78%	Re-rate
24	The role of trade unions in improving working conditions should be better highlighted	67%	Reject

Individual

	Recommendation	Consensus	Action
1	Staff need more training on how to manage 'emotional labour' and how to avoid compassion fatigue and burnout	83%	Recommend
2	More wellbeing initiatives based on positive psychology are needed to give staff the skills to manage stress more effectively (e.g., resilience, mindfulness)	72%	Re-rate
3	Staff need to be more aware of the importance of self-care, including diet, sleep and rest, and take the necessary steps to reduce risks to their wellbeing	67%	Reject
4	Financial awareness and literacy should be improved among nurses and midwives (e.g. understanding of pay structure and systems, managing money)	67%	Reject

Research

	Recommendation	Consensus	Action
1	It is important to identify positive management behaviours as well as negative, as this will encourage best practice	100%	Recommend
2	More insight is needed into how work and training can be adapted to ensure that nursing and midwifery is sustainable in later working life	94%	Recommend
3	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	89%	Recommend
4	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	89%	Recommend

5	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	89%	Recommend
6	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.	83%	Recommend
7	More research is needed into the occupational health needs of staff and whether they are being met	83%	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	83%	Recommend
9	More insight is needed into the work experiences and the mental wellbeing of specialities within nursing and midwifery, the particular risk factors and how they can be best supported	78%	Re-rate
10	Research is needed into the role and effectiveness of whistleblowing guardians	78%	Re-rate
11	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	78%	Re-rate
12	Greater understanding is needed of the implications of a female-dominated workforce on for wellbeing	72%	Re-rate
13	Occupational health professionals are themselves at high risk of stress and mental health problems and need to protect their own wellbeing. More research is needed to understand their experiences to provide more effective support	67%	Reject
14	More research is needed to understand the factors that underpin positive wellbeing (e.g. work engagement, job satisfaction, thriving and flourishing) and how this can be enhanced	67%	Reject

Supplementary Material C: Recommendations Reviewed in Round 3

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 recommendations not included the tables below are still vital for improving nurse and midwifery wellbeing, but were not seen to be as urgent and those prioritised by the Advisory Group.

Public policy

	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 awareness is needed of the scale of mental health problems within the nursing and midwifery workforce	100%	Recommend
4	More insight is needed into the factors that underpin attrition by nurses and midwives via exit interviews and research	95%	Recommend
5	Additional time worked, such as shift handovers, extra hours due to sickness etc, should be included when estimating overall working hours.	95%	Recommend
6	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
7	Induction and preceptorship programmes are needed for newly-qualified nurses and midwives and those who move to new working environments	90%	Recommend
8	NICE guidelines should be used when supporting staff wellbeing as well as patients	86%	Recommend
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%	Recommend
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%	Recommend
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%	Recommend
12	The effects of losing the student bursary in England on future staffing levels should be recognised	86%	Recommend
13	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
14	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

	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	100%	Recommend
2	Training is crucial to improve managers' skills, but they need the opportunity, time and resources to support the wellbeing of staff effectively	100%	Recommend
3	Managers and shift coordinators need a better understanding of the impact of shift-work on health and how this might be mitigated	100%	Recommend
4	All NHS trusts should have a mental health strategy that demonstrates their commitment to improving the mental health welfare of all nurses/midwives.	100%	Recommend
5	All organisations should have a clear and accessible policy on mental health at work that informs policy and practice	95%	Recommend
6	Organisations should work towards creating better work environments for nurses and midwives and preventing stress from occurring at source	95%	Recommend
7	Action is needed to reduce the stigma of seeking help for stress and mental health problems	95%	Recommend
8	Staff should be able to self-refer to counselling or occupational health support rather than be required to go through their managers	95%	Recommend
9	Staff need to be given enough time to participate in wellbeing interventions and training and access support systems	95%	Recommend
10	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
11	Staff who make official complaints or who 'blow the whistle' on risk or wrongdoing in the public interest should be protected	95%	Recommend
12	When setting targets and deadlines, the wellbeing of staff who will be expected to meet them should be a key consideration.	95%	Recommend
13	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
14	More creative and tailored flexible working options are needed to improve work-life balance and encourage return to work after sickness absence	90%	Recommend
15	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
16	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
17	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	90%	Recommend
18	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
19	More guidance and signposting are needed on the type and availability of support for mental health and wellbeing	86%	Recommend
20	Staff should be offered support that better fits their needs (e.g. through formal processes such as clinical supervision, mentoring	86%	Recommend

	and team development, or providing space and time for colleagues to spend time with each other)		
21	Essential equipment and other resources, such as access to systems, should be available and fit for purpose	86%	Recommend
22	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
23	More opportunities are needed for staff to have input into change initiatives and decision making	86%	Recommend
24	More incentives are needed to make nursing and midwifery more attractive professions and to improve retention.	86%	Recommend
25	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
26	More opportunities are needed to provide a safe space for reflexivity and encourage staff to express and explore their emotions	81%	Recommend
27	More opportunities are needed for managers to have discussions or 'catch up' sessions with staff about their wellbeing	76%	Reject
28	Working hours should be carefully monitored, including those of staff who are doing bank shifts outside of their usual clinical area.	76%	Reject
29	More options for flexible working should be available and staff encouraged to take them up.	76%	Reject
30	Attention is needed to the implications of using bank and agency staff to fill vacancies for staff wellbeing.	76%	Reject
31	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
32	Initiatives to improve the quality of interpersonal relationships between staff are required.	67%	Reject
33	A self-referral/walk in service is needed to allow nurses and midwives to obtain urgent support.	62%	Reject

Individuals

	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

	Recommendation	Consensus	Decision
1.	More research is needed into the occupational health needs of staff and whether they are being met	95%	Recommend
2.	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
3.	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
4.	It is important to identify positive management behaviours as well as negative, as this will encourage best practice	81%	Recommend
5.	Research is needed into the role and effectiveness of whistleblowing guardians	81%	Recommend
6.	More research is required into the effects of lone working on the health and wellbeing of nurses and midwives.	81%	Recommend
7.	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
8.	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
9.	Insight is needed into the experiences of international nurses and how they impact on their health and wellbeing	76%	Reject
10.	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
11.	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
12.	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
13.	More insight is needed into the work experiences and the mental wellbeing of specialities within nursing and midwifery, the particular risk factors and how they can be best supported	67%	Reject
14.	Research is needed into how technology can be used to support clinical staff with their health and wellbeing	62%	Reject
15.	More research is needed to evaluate whether the current application process for nurses is sufficiently open and inclusive.	52%	Reject
16.	Greater understanding is needed of the implications of a female-dominated workforce on for wellbeing	48%	Reject