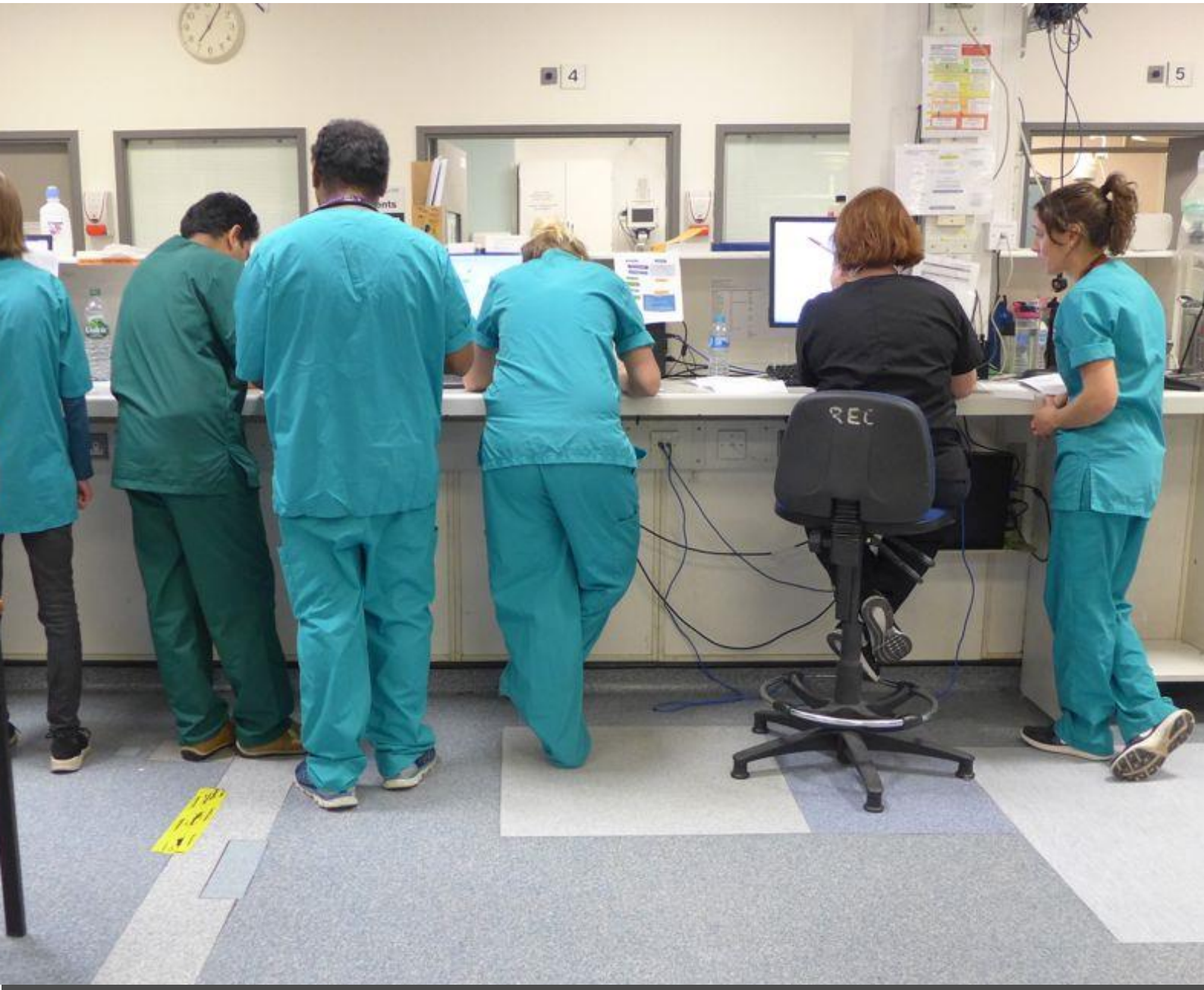
REVEALING REALITY



‘Sink or swim?’ Improving the mental health of staff in hospital emergency departments

A report for Mind

Contents

Executive summary

What prompted this research?

In 2015 Mind introduced the 'Blue Light Programme', specifically targeted at people working in emergency services. The programme was set up to improve the mental health of emergency services staff and volunteers across England – and later in Wales. Mind's initial scoping research had highlighted that 'blue light' personnel were twice as likely as the general workforce to experience mental health problems but were less likely to take time off or access formalised support.

Mind wanted to know whether staff working in hospital emergency departments (EDs) would benefit from an intervention specifically tailored to the environment and pressures faced in the ED. This could be similar to the support the Blue Light Programme delivered to other emergency services, or something completely new.

This research was commissioned to better understand, in detail, the specific pressures or problems that cause poor mental health in the ED and what kinds of intervention would (or wouldn't) work. It included two phases of ethnographic research within hospital emergency departments. The first phase explored existing support and identified barriers to access. The second tested a pilot intervention called 'Taking care of you', which included a toolkit of resources for staff and the establishment of a 'champions' programme to help ED staff focus on self-care and develop coping strategies to manage the mental health and wellbeing challenges they experienced at work.

The research revealed staff *would* benefit from targeted mental health support, above and beyond what is already in place. In particular, it highlighted a need for less reactive, more proactive support options and strategies. However, as the subsequent pilot intervention confirmed, to be successful it is paramount that mental health support or interventions, and the ways they are communicated, must be tailored for the unique culture within the ED.

Performance, culture and putting patients first

Emergency departments have a powerful performance culture that affects the way people do their jobs and how they think about and act in relation to their mental health.

The ED is a high-stakes, high pressure environment. Staff need to think and act quickly, and their actions can be, quite literally, a matter of life and death. They consider the stakes to be higher for them than for their colleagues in other hospital departments. The unpredictability of the volume, type and severity of cases adds to the pressure staff feel.

The lack of private space means ED staff often feel they are on show, with little or no time to reflect or regroup.

Staff are constantly in high adrenaline, 'reaction' mode. For many of them, this is part of the appeal of working in the ED and they see themselves as 'winners' who are a 'cut above the rest'.

There is a pervasive narrative that the patient comes first. This is often used as a justification for not taking a break and not thinking about yourself at work. Despite the emphasis on performance and patients, ED staff don't associate taking care of themselves with delivering better results for their patients.

They often talk about their work in binary terms. They think of themselves as either succeeding or failing and their assessment of others' performance is often expressed in terms of whether they will 'sink or swim'.

Attitudes towards mental health

ED staff tend to think of mental health in binary terms too. They appear to think of themselves – and others – as either mentally fit or unfit, seeing nothing in between.

They will talk openly about how they feel about particularly traumatic cases but upon probing it's clear that their experiences of mental health vary in nature and severity. Like everyone else, ED staff can be thought of as each being somewhere on a spectrum representing good to poor mental health. Many reported stress, palpitations, low mood and mood swings and described feelings of anxiety about coming into work.

Despite tragic cases being the most memorable and the ones staff refer to most frequently when asked about the impact of work on their mental wellbeing, it seems most stress in the ED is caused by the effects of day-to-day pressures and inefficiencies.

Provision of support

Although both formal and informal support is available in many EDs, it is rarely accessed or sufficient.

Formal support tends to focus on traumatic events or is associated with the 'return to work' process for someone who's been signed off sick. Most activities provided by trusts for managing staff mental health are reactive rather than preventative.

Staff often don't know where to go for support at work and worries about confidentiality put them off seeking help.

They lack informal coping strategies and don't generally share the techniques they do have. Senior staff do not see looking after the mental wellbeing of their staff as part of their role.

Opportunities to improve ED staff mental health and wellbeing

There is a significant appetite for better support options for staff mental health in the ED, and the pilot evaluation demonstrates that even a small intervention can have an impact.

Any support options or resources need to talk to the ED culture of high performance, encouraging staff to see self-care as a way to improve their work and to deliver better outcomes for patients.

Helping staff develop a clearer sense of mental health as a spectrum, rather than a binary concept, should enable them to have better conversations about their own mental health.

Without the senior leadership team feeling responsible for the team's wellbeing and being actively involved in the dissemination of and/or messaging about support, resources can have limited appeal and uptake.

How this could be improved

There are significant opportunities to improve wellbeing interventions and mental health support for ED staff. However, for any support to be effective, it needs to be designed specifically for the staff in this environment. It must take account of their attitudes and the practicalities of their work. And it must be led and prioritised by those perceived to have credibility and authority.

To maximise the likelihood of success, the research suggests interventions and the communication about them must:

- Be tailored to take account of the environment and culture within in the ED
- Promote an understanding that mental health isn't binary – there is a spectrum of mental health and wellbeing
- Encourage preventative strategies that promote mental wellbeing and self-care as a key determinant of high performance
- Make senior members of staff directly responsible for looking after the wellbeing of their staff.

Definitions

For the purposes of this research, mental health was defined as "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"[1]. Mental health was thought of as a spectrum ranging from mental wellbeing to severe mental distress. Poor mental health was therefore understood as long-term anxiety and low mood as well as diagnosed conditions (e.g. depression, obsessive compulsive disorder, schizophrenia). Poor mental wellbeing included a range of issues relating to mood, motivation or cognition including stress, high-emotion, low mood or low-level anxiety.

Throughout the document we will also refer to the object of this scoping study as the ED (emergency department) rather than A&E (accident and emergency) as this is the term preferred by the staff who took part in the research.

[1] World Health Organisation, 2014 (http://www.who.int/features/factfiles/mental_health/en/)

1. Introduction: ED staff need better mental health support

EDs are unique places to work. They provide a 24-hour service, treat a wide range of patients and types of emergency, and are 'open' for people to walk into as well as arrive via the emergency services. There are often a lot of people being treated, and even more waiting to be seen. EDs are frequently busy and, at times, can feel chaotic.

Working in this environment are a variety of clinical and non-clinical staff – porters, receptionists, security, healthcare assistants, nurses and doctors – who daily face an unpredictable caseload. Beyond the ED itself, there are organisational, structural and external pressures that can exacerbate the intensity felt by staff – increased demand, financial pressures, targets, 'bed blocking', patient safety and media scrutiny.

Staff see themselves as a tough breed, able to deal with this working life. Clinical professionals have a strong narrative around the ED being a place you 'sink or swim' as a professional. The perception is that only a certain type of doctor or nurse can work there.

But this doesn't mean ED staff find it easy to cope with the intensity of their work or that they don't face mental health challenges working in this environment. ED staff need and deserve support and guidance to better manage their own wellbeing and mental health.

In 2015 Mind introduced the 'Blue Light Programme', specifically targeted at people working in emergency services. The programme was set up to improve the mental health of emergency services staff and volunteers across England – and later in Wales. Mind's research had highlighted that 'blue light' personnel were twice as likely as the general workforce to experience mental health problems, while being less likely to take time off or access formalised support.

Mind wanted to know whether ED staff would also benefit from an intervention, specifically tailored to the environment and pressures faced in the ED. This could be similar to the Blue Light Programme support delivered to other emergency services, or something completely new.

This research was commissioned to better understand, in detail, the specific pressures or problems that cause poor mental health in the ED and what kinds of intervention would (or wouldn't) work.

It found that staff *would* benefit from targeted mental health support, above and beyond what is already in place. In particular, it highlighted a need for less reactive, more proactive support options and strategies.

But for any support to be effective, it needs to be designed specifically for the staff in this environment. It needs to take account of their working culture, their attitudes and the practicalities of their work. And it must be led and prioritised by those perceived to have credibility and authority.

2. Our approach

Research background and objectives

This report is the product of two phases of research for Mind on staff mental health within hospital emergency departments.

Phase 1 was commissioned to investigate the pressures faced by, and the mental wellbeing of, a range of staff in the ED and assess whether a tailored intervention akin to the Blue Light Programme could be applied to its setting and culture. The research explored existing support, identified barriers to access and opportunity areas for potential future interventions.

Specific objectives included:

- Understanding the main pressures and drivers of poor mental health among ED staff
- Mapping the mental health needs of staff across different roles within the department
- Exploring the existing interventions that support the mental wellbeing of staff in the ED
- Understanding the drivers and barriers to accessing mental health support among staff
- Providing opportunities for Mind to deliver a similar support programme to that offered within the wider Blue Light Programme.

Following this work, Mind developed the 'Taking care of you' toolkit and champions programme as a pilot intervention to help ED staff with self-care and coping strategies to manage the challenges of their workplace. The intervention had two parts. The first element was a toolkit of self-management techniques for ED staff to employ before, during, and after their shift. The second part established a network of volunteer ED staff 'wellbeing champions' to raise awareness, signpost to support, and promote positive mental health and wellbeing in the workplace.

Phase 2 of this research aimed to evaluate the effectiveness of the pilot intervention and explore how the materials were implemented and used within the ED. More specifically, the objectives were to:

- Test the feasibility and acceptability of the intervention (i.e. champions model + toolkit)
- Explore awareness and uptake of tools and support options during the intervention period
- Understand how EDs implement the toolkit and champions model
- Understand the barriers and opportunities to a successful intervention within an ED

The 'Taking care of you' pilot intervention aimed to support mild to moderate challenges with mental health and provide proactive approaches to managing wellbeing. The resources were not intended to support people dealing with more severe mental health challenges or traumatic experiences.

Methodology

Both phases of research were primarily qualitative, although phase 2 included a quantitative survey. They focused on exploring needs, motivations and influences on staff experiences of mental health and support as well as engagement with the pilot intervention.

Key elements of the approach included ethnographic observation in several EDs and intercept interviews conducted on the shop floor and in-depth interviews with staff working in a wide range of roles, including medical, nursing, clerical and facilities.

In phase 2, an online staff survey across all five EDs indicated the scale of awareness of the toolkit after two months in each ED and the appeal of the different elements of the toolkit.

Six sites were included in the initial scoping research, selected to include a range of EDs (regional, urban, trauma, etc.), workload (in terms of number of patients seen each day) and current performance rating (NHS performance statistics).

Five of these hospitals went on to participate in the pilot intervention. This meant the research team was able to explore behaviours and attitudes to the pilot intervention in the context of detailed knowledge about the culture, support available around mental health and staff pressures in each setting.

To maintain the anonymity of staff who shared their experiences, the EDs have not been named in this report. We thank all those who talked to us and let us observe them at work.

Further information on the research methodology is available in the appendix at the end of this report.

3. Performance culture in the ED: High stakes, high pressure and high expectations

The breadth of patients and types of emergency that a hospital ED treats can be vast. This is made more challenging because the ED is always 'open' and people can walk in as well as arrive via the emergency services.

As a result, EDs are frequently busy and, at times, can feel chaotic. The staff – clinical and non-clinical – are all facing a daily, unpredictable caseload. What's more, beyond the ED itself, there are organisational, structural and external pressures that can exacerbate the intensity of the environment.

As a result, emergency departments tend to develop a defined culture based on perceptions of performance. This influences the professional identity of staff and runs through their shared narratives, ultimately affecting their motivations and behaviour.

This chapter describes this performance-related culture, staff identity and the tensions between accepted narratives and day-to-day reality.

The ED is a high-stakes, high-pressure environment

The actions taken by staff working in the ED can be, quite literally, a matter of life and death. Staff often need to make quick decisions in situations where the stakes are high, in contrast to what they perceive employees are doing in other departments.

> *"They say they're busy and they're just sitting there drinking coffee and having a look at screens"*
> Nurse

> *"There's a lot of pressure from relatives and management, we're expected to solve everything"*
> Nurse

> *"In other departments, they have days to make a decision. In the ED, you have to send people home and deal with the uncertainty"*
> Registrar

Some decisions play on people's minds. One psychiatric liaison nurse described worrying about whether a patient would take their own life after she had discharged them. Often, more senior team members described being under considerable decision-making strain – one senior consultant spoke about having to make decisions about whether *other people's* decisions were reliable.

At particularly busy times, relentless caseloads leave little or no time for staff to mentally 'warm up' before dealing with a situation. Staff across all the trusts described how they and others were "thrown in at the deep end". One GP trainee reflected on not having time in between cases, and how when these cases were complex, this added to the feeling of pressure. A staff nurse said being a new starter in the ED was tough – he'd had to earn his colleagues' respect by proving he was unflappable and could perform under pressure.

The unpredictability of the volume, type and severity of cases adds to the pressure staff feel in the ED.

> *"The red phone would ring in the resuscitation area and I would just watch the door, waiting to see what would come through"*
> Staff nurse

> *"There could be nothing going on, then you have three or four people calling you at once"*
> Security officer

In some hospitals, metaphors of intense conflict, such as 'battlefield', 'warzone' or being 'in the trenches', were used to describe particularly challenging days or shifts. Less busy periods or less pressurised situations were often downplayed.

Various people at one ED mentioned that they don't use the 'Q word', meaning quiet – reinforcing the idea that they are always busy. One lead nurse in the resuscitation area appeared visibly strained when she received a call during a busy period to say four trauma patients had arrived within 45 minutes. Shortly afterwards she had to leave the floor to address a personnel issue: one of the nurses had been hit by a car on their way home. Although she was back within minutes, other nurses and doctors regrouped to cover her while she was away. This kind of disruption can magnify the intensity of the ED.

There was much talk of the pressure building; that every year the ED got busier and busier, that there was a constant process of adapting to "the new normal" or "recalibrating the thermostat". In some cases, staff thought of the department as the only functioning part of the hospital system. When describing their conditions, staff referred to "just managing" or "coping".

At the same time, staff in all the hospitals were striving for efficiency. Maintaining the 'flow' of patients was of utmost importance, not only to try to hit the four-hour target to admit, transfer or discharge patients, but also so that patients were being physically moved out of the ED to make space for other emergencies to come in for treatment.

When patients had been in the ED so long that they needed to be supplied with hospital food, staff felt they had failed.

> *"The worst smell in A&E isn't the smell of blood or bodily fluid, it's the smell of food. That's the smell of failure"*
> Senior sister

Staff at all levels were, in some way or another, developing ways to try to make things run more smoothly. During a handover at 7.30am, the nurses were discussing patients and sharing notes – the staff nurse on the next shift being sure to add her notes in a different colour to make sure they didn't get mixed up or lost.

The high-stakes, fast-paced, unpredictable environment in the ED led staff to feel under constant pressure to perform – to make the 'right' decision, not to make any mistakes, not to miss any targets.

> *"The potential to panic is high in this line of work – patients expect nurses to act, not freeze"*
> Staff nurse

Physically, the lack of private space meant many felt they were always 'in the spotlight', their work was always on show. It also left little scope for reflection or decompression, away from other staff and patients. Sometimes there was a lack of computer stations. Often there were screens, but no seating, and staff said it was hard to concentrate.

> *"You have to make complicated decisions in a space where there's no room for concentration – you're in a constant state of distraction"*
> Junior doctor

> *"The floor is a bit of a fishbowl – there's nowhere to go and be quiet"*
> Staff nurse

Some staff improvised and took advantage of the out-of-the-way or little used areas. One staff nurse described using the sluice, a cupboard where all the bodily fluids are taken for disposal. Others identified the toilets as being the one place where they could sit for a couple seconds unbothered.

"There's a horrible smell and no one wants to go in there, but if you can stand that, you can get a bit of time to yourself."
Staff nurse, about the sluice

Staff are constantly in high adrenaline, 'reaction' mode

Staff across a range of roles described the ED environment as unpredictable and intense. It was hard for them to predict what their working day would be like or to plan their schedules. They needed to be alert and on guard throughout their shift, to react and adapt to the circumstances and perform at the best of their abilities.

"It's a very fine line between it fuelling you and you being able to ride on that."
Senior sister

For many people, the adrenaline produced in these situations was part of the appeal of working in an ED. Both clinical and non-clinical staff loved the intensity and thrived on the pressure.

"No two days are alike. It's a busy job, and a rewarding job in a lot of ways."
Receptionist

But it wasn't always described in positive terms. Staff said they were constantly busy, and under pressure, in an intense reactive mode. They saw themselves invariably playing catch-up, running from one patient to the next.

"You're dealing with everything: sudden death, paediatric death, telling someone their six-month-old child has died, telling a drunk not to speak rudely, a teenager in an RTC [road traffic collision]."
Consultant

Being in a constant high adrenaline mode - combined with the pressure and expectation driven by the ED's performance culture – was a further reason staff found it hard to take time off the 'shop floor'.

"I don't always take a break on a night shift, sometimes I just want a coffee and a Mars bar. I need the adrenaline to keep going. If I stop I might not start again."
Registrar

"As soon as you arrive, you get to it and that's it. You can't take a break. You'll be doing something, a patient will interrupt you, and your brain is still on what you were doing before"
Registrar

Performance is at the core of professional identity in the ED

While many staff complained about the pressures of working in the emergency department, most were conscious that the adrenalin-fuelled atmosphere, the unpredictability, the variety of challenges and the opportunities to contribute to saving lives were a huge part of the appeal and kept them working there. Both clinical and non-clinical staff loved the intensity and thrived on the pressure, even if it at times it could feel overwhelming.

"I love working on a night shift, it's like I've got my team on the battlefield"
Registrar

One doctor working across wards described how she felt physically and emotionally better after working in the ED as she was able to "learn more and achieve more". In many cases, staff said the pressure helped them perform better, and although it was intense, it was something many people loved about the job.

Staff showed pride in their ability to work in these pressurised conditions. Many people who thrive in the ED saw themselves as 'winners' who were a 'cut above the rest'.

> *"Nurses in A&E tend to be harder – not that they're not compassionate – but they have to be tough to stand up to people and deal with them appropriately"*
> Senior nurse

> *"ED nurses are a different breed of person – you have no time and just get on with it"*
> Staff nurse

One of the lead consultants described the "glory boys" working in the department, who "like the buzz", ran on adrenaline and looked to take on the most difficult cases. Another talked of "rampant high achievers".

Staff often saw themselves as professionally superior from those working elsewhere in the trust, saying they "weren't trained as ward doctors" or that "nurses in the ED are there because they don't want to do the daily washing".

> *"Nurses in the ED should be on a higher band than ward nurses for doing what we're doing"*
> Staff nurse

New staff often felt they had to prove themselves to their colleagues, and worried about how it reflected on them or their performance if they made a mistake.

> *"Staff feel that not coping will follow them around in their career and it might be perceived badly. And that's not completely wrong"*
> Consultant

> *"You think you're doing well, then something will expose you as a fraud. You will make mistakes, you never know enough"*
> Junior doctor

Many staff members saw themselves as people who were attracted to the 'toughness' of the environment. This wasn't limited to clinical staff. One receptionist described being asked in his interview for the job if he could handle the pressure. Seven months in and he was proud to say he hadn't been fazed so far.

Some longer-standing or older members of staff tended to see younger, newer colleagues as less strong or resilient, building up their own identity in contrast to others'.

> *"As an older person in the department, I don't really need tips or tricks to cope. I think those would be useful for the juniors"*
> Registrar

Some older staff members also showed frustration at how seemingly quickly and easily younger people progressed in the ED.

> *"The band sevens get younger and younger nowadays. Young people are ambitious, and the positions are there because we are short staffed, but they aren't ready"*
> Senior nurse

Hard work and dedication over a number of years earnt staff a badge of honour – anyone who appeared to be cutting corners or not taking things as seriously wasn't looked at with as much respect.

There were many people who had worked in the ED for a long time, and those who left often wanted to come back. The newest member of one of the security teams had been there four years; the longest-serving had been in the job for more than 30 years.

‘Sink or swim’ - ED staff talk about their work in binary terms

There were numerous instances of ED staff conceptualising or describing aspects of their working lives in distinctly binary terms. This fed into a sense that either they succeeded at work or they failed. Patients were either urgent or non-urgent, to be prioritised or not, treated as majors or minors. Decision-making needs to be quick and correct when the outcome could be life or death. From a management perspective targets were either met or they were missed.

It is therefore perhaps unsurprising that staff members’ assessment of others’ performance was often expressed in terms of whether they would “sink or swim”, particularly when they first joined the department.

This binary approach to success and failure could be keenly felt, especially by new recruits and trainees. There was an accepted narrative that ‘either you have it or you don’t’, which raised the prospect that staff were left on their own to succeed or fail – and that those who did succeed on these terms were then deemed to be able to continue to work in the same way indefinitely.

> *“When I first joined I was told that people generally sink or swim here, I’ve been doing OK so far so I think I’m OK”*
> Receptionist

> *“For new staff coming in, it’s a baptism by fire. It’s sink or swim. They don’t come with that emotional resilience. That’s not something you learn in your training”*
> Senior nurse

There is a pervasive narrative that the patient comes first

Whatever else was going on in the ED, or in an individual’s professional or personal life, there was a pervasive narrative that patients came first.

> *“Everything we are trained in... every single one of our targets, all of it is to ensure the patient comes first, no matter what”*
> Matron

> *“There’s always a new patient to see so you put them first and look after yourself second”*
> Senior sister

Staff talked of feeling that there was always something more that could be done for patients, or that they were letting them down. Some staff worried they had sent patients away without giving them the very best treatment.

> *“The biggest stress is not being able to take care of the patients”*
> Staff nurse

Shabby and untidy staff areas, and culture or policies that downplayed staff members’ own needs reinforced this narrative. It was common to see piles of coats and bags in staff rooms, over the floor and across the tables. Facilities were often out of order.

One consultant commented on a ban on staff drinking water in the ED. Rather than this being for hygiene reasons, he was told this was to “make the patients feel less uncomfortable” if they were going into surgery and couldn’t have anything to drink themselves.

Staff don't associate 'self-care' with better performance

Despite the emphasis on performance, ED staff didn't associate taking care of themselves with performing better.

Indeed, staff seemed to find any form of self-care difficult to prioritise during their professional work, an attitude that was justified by the need to 'put patients first'.

While some staff saw this lack of self-care as a problem, others saw it as a matter of pride how little they needed to look after themselves. Examples often focused on more extreme situations, with staff claiming that the shift was unusually busy, or the case mix was particularly challenging that day.

Within this culture, self-care was sometimes seen as a personal failure, looking after yourself as a weakness. This perception was regularly reinforced by the assertion that ED is a 'sink or swim' work environment and admitting any kind of struggle was evidence of 'sinking'. Self-care was therefore associated with failure rather than success. Further reinforcing these beliefs, staff felt that being exposed as weak could hinder their professional reputation, block career progression or even be a sign that the ED is not the place for them to work in the long term.

> *"It's hard, in the ED. It's a tough environment. You have to prove yourself and that you can do the job. If you're not unflappable, they won't give you the best jobs."*
> Staff nurse

> *"It's the nature of the people who work here. We learn to separate emotions – maybe become a bit dead inside"*
> Advanced clinical practitioner

An example of the difficulty staff had in prioritising self-care was how hard they found it to take breaks. This was in part driven by the performance culture. Without prompting, some staff mentioned how few breaks they had taken or how long they had managed to delay going to the toilet or having a drink of water. Many staff took pride in this and saw it as part of proving themselves.

> *"I like to just keep on going. I'm like a machine, the Duracell bunny. I don't need a break."*
> Receptionist

> *"I think everyone just wants to keep going. We have a duty to honour"*
> Medical student

In general, the suggestion of thinking about yourself while in a high-performance mindset seemed absurd.

> *"You can't turn your brain off for 90 seconds when you have 10 things to do"*
> Staff nurse

Similarly, the need to put the patient first inhibited people's ability to take time off the shop floor. With the sense that there was always more that could or should be done, staff found it difficult to prioritise their own needs at work. "I treated myself to a wee," and similar sentiments were expressed by several members of staff.

Often, staff found it hard to leave patients – whether for lunch or at the end of shift.

> *"I find it really hard to walk away. There's always something more to be done, I start the next job and before you know it 20 minutes have gone by"*
> Healthcare assistant

Doctors and senior nurses often saw it as their duty to ensure others on their teams took breaks. They would actively check in with staff and encourage them to take a break. However, they felt there wasn't much they could do beyond verbally insisting that they did so.

> *"I try to tell others to 'go for a cup of tea' as a break but it often falls on deaf ears"*
> Senior nurse in charge

They often also didn't feel able to lead by example. Senior consultants and nurses themselves often went through a whole shift without taking a break, feeling that they were needed to make decisions and had to be accessible. Many felt taking a break, particularly during understaffed evening shifts, could jeopardise patient safety.

> *"At night we don't have consultants, so I'm responsible. I just can't take a break, what if someone needs me?"*
> Registrar

For a few of the more experienced staff, self-care was perceived to be an important part of being able to work with the intensity required in the ED and they did feel that staff needed to see looking after themselves as part of their professional identity. These staff felt that the culture of working solidly throughout a long shift put unreasonable pressure on the individual and had consequences for the rest of the team. They also had broader perspective and were concerned about the long-term impacts of working at high intensity over long periods of time. Some had seen colleagues suffer and others "come and go" from the ED environment as it was too much to deal with.

> *"I have to look after myself, otherwise I just can't keep going. It's an important part of being able to do my job properly"*
> Consultant

> *"A lot of people end up taking a break and going to work elsewhere. Often, they come back after a few years. It's like a calling. But sometimes that break can help you get a bit of perspective"*
> Senior nurse.

A minority did take breaks and sought out a 'change of scene' from the ED during their shift.

> *"During breaks I sit and read celebrity gossip in the staff room – it gives me a different angle on life, it takes me to another world"*
> Student nurse

Teamwork is essential in the ED but not everyone is included

For those who are deemed to have proved themselves or earned their stripes, there was a strong emphasis on the importance of teamwork in maintaining the ED's high performance. This was referred to in all the hospitals, by staff in all roles within the emergency department, when talking about what they liked most about their jobs, and was often contrasted to other hospital departments.

> *"The greatest things about A&E are the interesting work and the cohesive team"*
> Consultant

In the more rural hospitals, many referred to their team as their "family". In these hospitals there were often lots of long-standing members of staff who had worked with each other for many years. Many knew each other outside of work or were friends of friends. Some staff members would socialise after work and felt close to their colleagues.

> *"It's a friendly team, no interpersonal issues, good department, patients are fairly pleasant. There's a 'family feel' – we work together in difficult circumstances"*
> Specialist doctor

> *"It's like my second family"*
> Senior nurse in charge

Staff in more urban hospitals also placed considerable emphasis on the importance of the team. However, this related more to working together to provide the best care possible for patients. Staff were proud to say they worked hard together to achieve this.

> *"I love working on nights, we all come together and take on whatever comes our way"*
> Registrar

However, the ED 'family' was seen to splinter into several smaller sub-groups, with strong networks of staff of a similar band, e.g. groups of nurses or receptionists would support each other but seem exclusive to people outside. In one case, a doctor wanted to join a staff choir, but didn't because she felt it was more for the nurses. Staff members felt that there was often little need to communicate with those outside their level.

> *"The nurses always seem very close. I recommend that people just speak to their peers"*
> Security

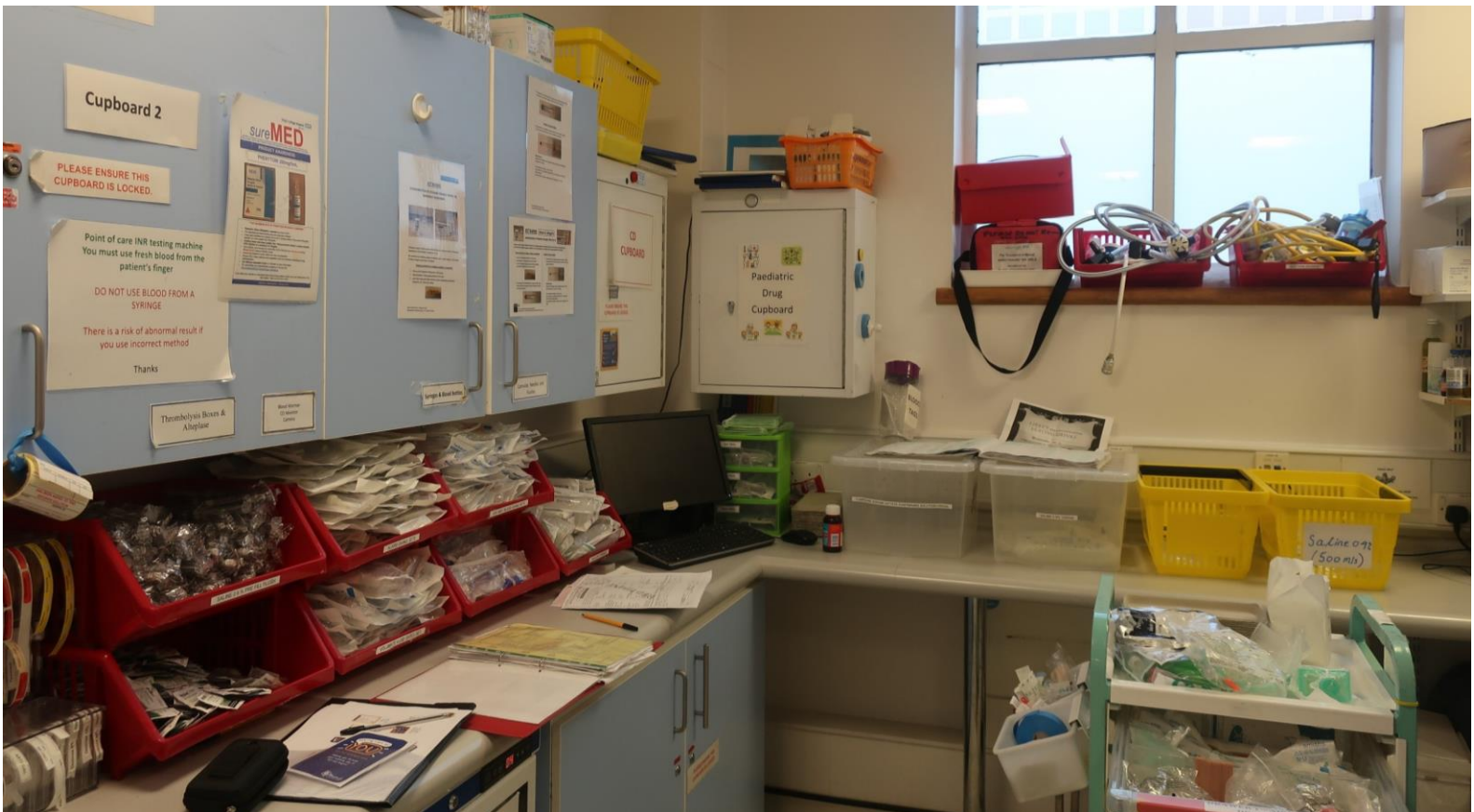
There were also people who felt excluded from the ED team. These staff were often people on the fringes of friendship groups, part-time workers, locums or bank staff, who were not part of the 'team'.

Being part of the team often meant it was difficult for staff to see when others weren't included. In all the hospitals there were staff members who felt they didn't fit in or felt left out. One psychiatric liaison nurse commented on not being invited to the Christmas party. In another hospital, a Facebook group was used to organise social events but not everyone was invited to it. For some, the arrival of new staff meant their feeling of belonging to a team was jeopardised.

> *"We don't feel part of the team, the new young nurses arrived and it's not the same as before, new era, hard to bind. They're younger, we're older"*
> Porter

Senior staff, in particular those at a trust-level, were also often seen as separate from the broader ED 'family', or weren't always part of close knit groups.

> *"We get occasional emails from management but I wouldn't say I know them"*
> Nurse



4. How staff talk and feel about their mental health

Staff operating in this high-stakes, high pressure culture generally see themselves as high performers, which can influence the way they think, talk and act in relation to their own – and their colleagues' – mental health.

They described a range of experiences of mental health of varying degrees of severity.

Staff tend to understand mental health in binary terms

ED staff were often guarded about expressing their emotions while working, concerned about the potential repercussions for their reputation.

One reason for this was binary thinking surrounding mental health. It was noticeable that, like many of the other narratives used by ED staff to conceptualise their working lives, mental health was often initially expressed in binary terms. Staff seemed to think of themselves – and others – as either mentally fit or unfit, seeing nothing in between.

This might have been exacerbated by their views of the mental health conditions staff saw their patients experiencing. Being exposed to severe cases of mental ill-health on a regular basis meant that staff did not put less extreme mental health problems into the same category of thought – patients may have mental health conditions, but staff do not.

> *"Sometimes it feels like we're in an acute psychiatric unit that happens to have sick patients"*
> Nurse

> *"Dealing with mental health patients is the most stressful thing"*
> Consultant

Even among patients, those with less severe mental health problems were sometimes labelled 'time wasters' by staff. There was a general tendency to trivialise less extreme manifestations of poor mental health, which likely influenced staff perceptions of their own mental health or led them to fear colleagues' reactions.

This understanding of mental health may make it particularly difficult, especially in more pressurised city hospital environments, for staff to express vulnerability and fostered a stigma associated with mental health problems.

While some members of staff across the trusts tried to raise awareness of these issues, most seemed to be concerned about people knowing they were struggling and defaulted to the 'I just cope' narrative.

Staff openly shared their feelings about particularly traumatic cases

Though unwilling to be seen as mentally unfit by revealing mental health problems, there were some cases in which staff would talk openly about mental health. Across EDs it seemed acceptable for staff to be affected by particularly harrowing cases and to speak openly about situations that were profoundly sad or tragic.

In one of the hospitals, a few of the nurses were visibly upset following the death of a four-year-old who had been brought into the department in a severe condition earlier that morning. There had been four deaths in total that day, so the reaction to the child's death may also have been exacerbated by the build-up of a difficult day.

Traumatic cases sometimes appeared to deeply affect staff in all roles – sometimes so much so that they did seek out support. These seemed to be either particularly tragic experiences, which touched everyone involved, for example major disasters or children's emergencies, or episodes that resonated with an individual on a personal level, for example by reminding them of their own family.

One receptionist said she had been particularly affected by the sight of a woman her mother's age being resuscitated with a defibrillator.

> *"The mood in the department is just a bit shit at the minute"*
> Consultant

> *"We lost two patients that afternoon and of course it's jarring"*
> Senior sister

Strong emotional responses by staff could also be caused by abuse from patients' family members. One nurse was traumatised and still visibly shaken recalling a relative using strong language against her, which led her to take time off work.

> *"One starts going, and then the others [in the waiting room] see him and they all turn against you"*
> Receptionist

In such a performance-driven culture, where staff often didn't want to talk about their mental wellbeing, traumatic events seemed to present an opportunity to take a break and acknowledge the psychological pressures they faced.

It also seemed more acceptable for staff, whose identity was often strongly linked to the high pressure, life-and-death narratives around working in the ED, to talk about how they felt in response to the most dramatic, tragic or extreme occurrences.

This might be linked to the fact that debriefs are more common when serious incidents occur, setting in motion a distinct process which reinforced the particularity of these situations.

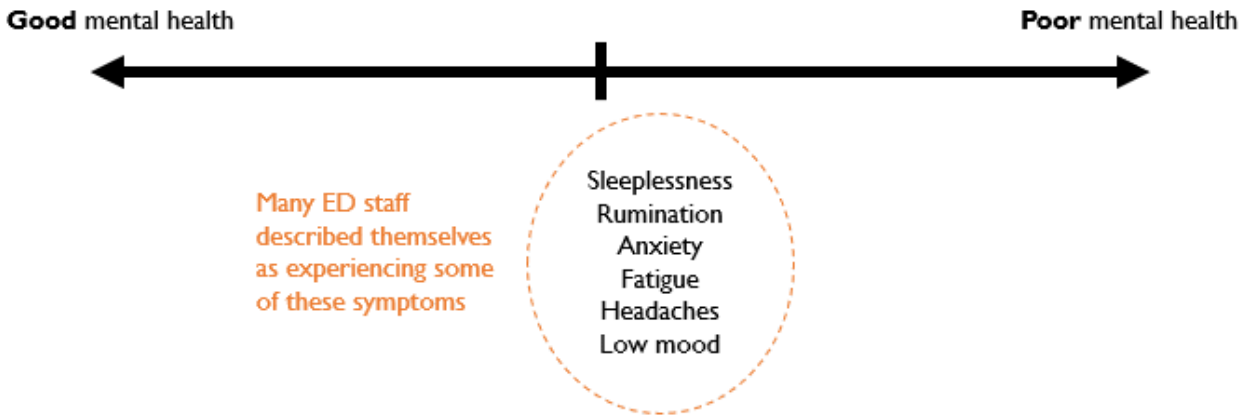
In these cases, staff generally seemed sympathetic to colleagues' struggles, and if they were present at the time they often suggested to affected staff that they should take a moment for themselves.

After a series of particularly hard shifts, a senior nurse decided to talk about her panic attacks to a colleague, starting a conversation around mental health and wellbeing in the department and how to encourage similar discussion among other staff. After she opened up to her colleague, the colleague admitted how hard she was finding things too and that hearing her talk about it made her feel more able to open up as well. Now, they meet up every six weeks to talk.

When staff did talk about their mental health, they described experiencing a range of stress-related symptoms

Upon further probing, it was clear that the experiences of mental health described by ED staff varied in nature and severity across individuals and roles. Just as in the rest of society, emergency department staff could be thought of as each being somewhere along a spectrum representing good to poor mental health.

Staff reported experiencing a range of mental health symptoms that contributed to poor mental health



Individuals' position on the spectrum was not fixed and staff moved forward or back along the scale at different points in their day, week or professional life. At some points, staff members might have a formal diagnosis of mental illness.

Most staff reported experiencing sleeplessness and rumination as a result of stress. Other symptoms were anxiety, palpitations, low mood and mood-swings, tiredness or fatigue.

For instance, a staff nurse described her problems with sleeping. She often had nightmares about cases that had resonated with her personally. As a result, she often felt fatigued and distracted at work, and worried that it affected her performance. Others described similar experiences of scenes replaying in their mind, delayed recall of tasks they had missed or an inability to switch off.

> *"I keep a mental check list, it all goes around in circles in my brain"*
> Junior doctor

> *"Sometimes I find it very difficult to unwind, the events play on my mind, and the next day. I'm not very good at switching off. I will replay it. It will take me a couple of days. I get a knot in my shoulders. It manifests in physical pain"*
> Senior nurse

Many people described feelings of anxiety about coming into work, sometimes after having taken a break. This was particularly accentuated for junior members of staff, especially during nights with less supervision.

> *"During December and the first weeks of January, it was genuinely awful. I would talk to other nurses and say, 'I feel anxiety about coming back to work, I'm worrying before I'm even there about what I am going to face when I'm there.'"*
> Student nurse

> *"Sitting at home picturing scenarios in your head, thinking anxiously, what if this happens? Or what if that happens? You can't know what the situation of the department will be like, so that is madness"*
> Nurse

Senior staff could at times forget the experience of being junior or struggle to spot when people were reaching breaking point. Some senior staff described it as fairly commonplace for staff members to end up crying in their offices – and felt bad it had got to that point before anything was said.

> *"When something bad happens, no one talks about it. There's no follow up, it's just 'OK, see the next patient.' There is lots of shame, you have to keep going"*
> Junior doctor

> *"As senior team members, we have a clear sense that progress is being made. If you are junior, you probably don't see that at all"*
> Consultant

> *"I remember being a junior and being petrified of coming in. You overthink it all and obviously you don't want to kill someone"*
> Registrar

The open spaces in the ED meant that staff at times openly showed frustration with those who were not performing or were nervous around each other, intensifying the stress. What's more, if people experienced an emotional 'crash', it often happened in front of others.

> *"This environment can be quite unkind to people"*
> Consultant

A handful of staff said they had formal mental health diagnoses and had received medical or therapeutic interventions, usually in the form of counselling or medication. In these cases, staff had disclosed this to their managers and some of their peers.

> *"I have PTSD and my team know. They've been great but I'd rather not talk about it with them"*
> Nurse

> *"I've been taking medication for anxiety and depression for the past six years. I prefer to see a psychotherapist out of work"*
> Staff nurse

Day-to-day stressors

Despite severe, tragic cases being the most memorable and the ones staff referred to most frequently when asked about the impact of work on their mental wellbeing, it seemed that it was the effects of day to day pressures and inefficiencies that caused most stress.

Fear of making mistakes

Staff frequently seemed anxious about making mistakes. This could mean worrying about being sued for negligence or being negatively judged by colleagues.

> *"Mistakes are part of the job. Juniors need to recognize their limitations but they're currently not sharing their concerns with anyone"*
> Consultant

Consultants described their fear of committing mistakes, referring to recent court cases or stories of doctors losing their licences over clinical errors that had resulted in deaths.

Lack of or loss of control

While the unpredictable and intense nature of the work and the environment in the ED was generally accepted, much of the stress described by staff seemed to be linked to perceived structural and organisational constraints. Staff felt these prevented them from performing at their desired level or giving the standard of care they wanted. Many found it hard to prioritise work effectively.

One consultant spoke of how procedural changes had recently led to increased spot inspections from senior members of other departments. He felt the additional pressure of being assessed by people who didn't necessarily understand the realities of the ED led to increased frustration and despondency across his team.

One registrar said the most difficult aspects of the job were not traumas and challenging cases, but the things he could not control, such as bed space, getting results in time and being able to send people for scans.

> *"You can't tell them how long they have to wait for a bed. You don't have an answer, and they think you're being evasive. You can't do anything about it, you have no control"*
> Senior nurse

> *"We all want to deliver the best care, but we feel that sometimes we can't. You feel that you're not heard, ignored. You will escalate to operational managers, struggle with lack of space. You're not then seeing any action, or anyone doing anything. There's loads of limitations everywhere."*
> Senior nurse

Staff described feeling helpless in the face of staff shortages and pressure from managers about trust performance targets. Not being able to find beds elsewhere in the hospital to move on patients who needed to be admitted, or medically fit patients 'wasting' staff time in the ED contributed to a sense that they lacked control over the situation. Staff also reported disputes with other departments over transfers.

These factors significantly contributed to their stress and often fuelled a sense of fatalism, which could, in turn, make it more difficult for managers and colleagues to effect change.

> *"When you feel everything is out of control, over time it feels helpless, like a depression. It's like 'Groundhog Day' for years"*
> Nurse practitioner

Administration vs patients

There was pressure to meet targets in situations when, according to the clinical staff, ensuring the safety of the most critical patients should be prioritised. For instance, one nurse said that worrying about targets was increasingly becoming a pressure for her. As funding was dependent upon achieving the four-hour target, it could have a big impact on the work of the trust, but she felt this didn't account for clinical priority.

Some of the stressors described by ED staff were the same things employees tend to find stressful in many other jobs – IT systems failures, or the administrative burden. An ED registrar said they felt under pressure because of the need to fill in their electronic diary, which he described as "a whole other job on the side".

> *"Now it's a different stress. It used to be about dealing with young, fit people, sick children, but the stress now is more about staffing targets, things not working, the printer is always failing, it's frustrating"*
> Specialist doctor

Pressures outside work

Experiences of poor mental wellbeing didn't stem only from work-related issues. Events in people's personal lives, or often a combination of the two, were also talked of. Relationships, financial problems and life events such as moving house could all be a catalyst for stress, on top of the already stressful work environment.

A staff nurse described experiencing a nervous breakdown at work in response to a simple demand. This was shortly after her father's death, and the event prompted her to seek support from occupational health.

> *"We had a member of the team lose a family member and she didn't feel like she could reach out for help. We had to intervene"*
> Senior sister

Blaming others

These problems seemed mainly to be dealt with by complaining and/or blaming external forces. For instance, one experienced senior sister explained she had seen a great deal of change in patients since she started and said "society has had the biggest impact" on the pressures she faced.

> *"They've lost the older generation who could look after themselves, you know, WW2, stoic. Now, the older generation are the baby-boomers. They're used to having things when they want. They're more dependent than the previous generation. Sometimes their next of kin is abroad, and so we're their first port of call."*
> Senior nurse

At one hospital, the ambulance crew were unhappy with the area where they were offloading patients. The area quickly became congested with wheelchairs and trolleys. Nurses felt the crew were bringing everyone in on stretchers, leaving them to have to challenge them and assess if the person was 'fit to sit' in order to make room for other patients. If the crew had to wait longer than 60 minutes, they fined the nurses and would complain about how the nurses did their jobs. This blame culture was causing increasing friction between teams.

The cumulative effect

In cases where poor mental wellbeing was the result of work-related experiences, it was often the build-up over time of smaller, everyday stressors that staff found most difficult to deal with.

> *"The pressure is not so much the acute trauma coming in, that's normal, you learn to deal with that. It's more the insidious effect over years, day after day, every day, of the things that build up over time"*
> Senior nurse

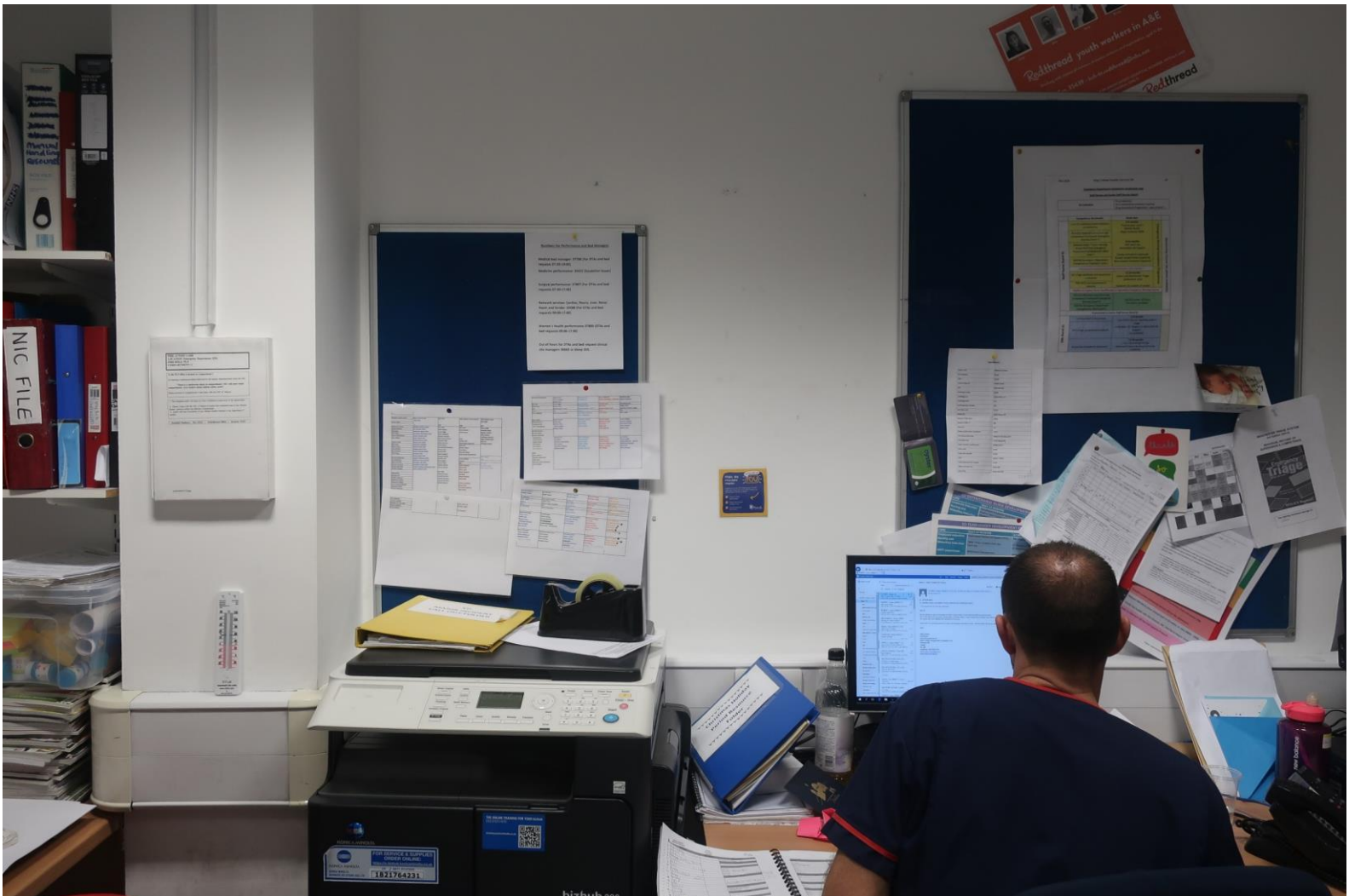
The cumulative effect of day-to-day stress was often subtler than the trauma of a tragic event, but no less detrimental to wellbeing.

> *"Sometimes you just think: 'I can't do this today', and you don't know what it is that's triggered that, but sometimes you just can't"*
> Senior nurse

For instance, a porter described the stress he felt because he could not sit down. Porters could only officially access one meeting room close to the staff room after midnight. From time to time they could sit informally in the staff room or at a nurses' station, but that was in the main space, in front of everyone.

"It's the little things that add up, like parking is miles away, so you're already stressed when you get here"
Specialist doctor

"Sometimes there is a build-up, say after a difficult three consecutive days, it may take something very small to move you from one side to another"
Senior nurse



5. Support and interventions: Current provision

Emergency departments do offer some formal and informal support for mental health. In particular, there are opportunities to engage with occupational health in response to particular events and often there are debriefs for ED teams after particularly traumatic experiences.

Formal support focuses on traumatic events and 'return to work'

When asked about the mental health support on offer, ED staff often defaulted to post-traumatic event debriefs. The traumatic events varied in nature, but included events such as a child's death, or large-scale, multiple casualty incidents such as fires or terrorist incidents. On top of informal support, such as being offered a 'shoulder to cry on' or someone stepping in to cover other duties, more formal interventions included team debriefs or counselling and were considered a core part of the departmental response to larger traumatic incidents. However, these weren't always automatically enforced for ED teams.

> *"We all had a debrief after the London Bridge attacks. Everyone was there, and it was an opportunity to share how people were feeling"*
> Consultant

> *"There was an incident where the ambulance team brought in a drowned child. The ambulance team had support, the nurses were expected to just continue with no downtime"*
> Nurse in charge

Some staff also associated 'mental health support' with the 'return to work' process for someone who'd been signed off sick by occupational health. In contrast to the way in which staff talked about support around traumatic events, this was considered a much more private matter and not something to be shared openly with colleagues.

There was some wariness about the way mental health problems had been dealt with by trusts, particularly associated with the 'return to work'. Some held the view that time off may not be best for the individual in the long term and expressed frustration about the lack of other forms of support to help staff cope while continuing their duties. Some expressed frustration that return to work recommendations were naïve and not practical for the way in which ED works.

> *"If you go off, it's sometimes difficult to come back. It singles you out as someone who hasn't coped. People will treat you differently. It shouldn't come to that. We should have other ways of helping people"*
> Senior nurse

> *"I just came back from sick leave. I'm meant to be starting on six-hour shifts but I ended up doing eight hours yesterday and no one said anything"*
> Receptionist

Despite many experiencing symptoms associated with poor mental health, few staff spontaneously described interventions or support on offer to help with everyday stress.

> *"I had three juniors out on stress. They can't possibly think they're the only ones who are stressed. Going off sick doesn't depend on that, it depends on getting a replacement"*
> Consultant

Preventative mental health strategies aren't a priority

The formal and informal wellbeing strategies seen in emergency departments were almost entirely reactive, with very little – if any – preventative work being done.

Half of the ED staff who responded to the survey in phase 2 of the research had thought about their mental health several times in the past month[2]. However, 68% said they did not regularly do anything to help with their mental wellbeing[3]. This can be attributed to the fact that both staff and senior leadership do not see self-care intended to address everyday stressors as essential to working in the ED. The idea of needing to 'carry on' is seen as an inevitable part of working in a high performing, patient-centred culture. Whereas reactive support around traumatic cases was not at odds with the ED's culture and staff identities, preventative strategies were seen as ill-suited to the context.

> *"I don't really have any coping mechanisms – I just try to carry on"*
> Registrar

> *"Part of our job is to cope with stress"*
> Staff nurse

This was exemplified by an aversion to preventative mental wellbeing strategies among many senior staff. As staff members at the top of a performance culture, they saw sharing the fact they used mental wellbeing techniques as particularly inappropriate for their position, more to be used by junior colleagues and particularly "nursing staff".

> *"As you grow old you learn how to do these things. It takes experience"*
> Consultant

Some staff members had accessed mental health support via their GP and were taking medication or receiving support such as counselling and psychotherapy outside of work. Sometimes these people had made their situation known to line managers but were not expecting direct support from them or the trust. Mostly these individuals did not see mental health as related to their professional role and kept it hidden from their colleagues.

> *"I've been visiting the same counsellor for five years now and feel I have a good grasp on what I need to do to manage when I'm feeling anxious at work. I've never been to anything they put on for people there"*
> Nurse

When formal support did focus on preventative work, staff often found it unappealing. Some hospital trusts were running 'wellbeing' or 'stress management' sessions to help build resilience in staff. However, these quickly gained a poor reputation among staff. Very few had been to this kind of session, but many had heard that they weren't useful, offering only basic, obvious advice, not tailored to the reality of the ED. Others had tried to book onto sessions but had been unable to get a place. When they found these kinds of interventions unhelpful, word quickly travelled across the department and resulted in a growing reluctance to attend.

> *"There was a resilience training course, and someone went after a long shift at work. They thought it was a complete waste of time"*
> Senior nurse

---

[2] Base 199 – See Pilot Findings Summary, Question 1

[3] Base 170 - See Pilot Findings Summary, Question 3

"Yeah I heard about that, I couldn't even book onto it"
Matron

There were often strong assumptions that mental health interventions would include talking therapies and mindfulness, which ED staff perceived as "fluffy" and "not their kind of thing".

"As a group of people, we aren't that into colouring in"
Consultant

Staff faced significant barriers accessing formal support

Commonly staff didn't know where to go for support at work, citing their managers as first port of call without really knowing what they could do to help them.

Most were aware they could go to occupational health, although they typically found this route unappealing, associating it with long delays and poor quality advice. One senior staff nurse had recently been referred to occupational health and was told that she had been put on a list, but then never received an appointment.

There's a waiting list for bereavement counselling and a waiting list for hospital wellbeing – there are things in place but it's hard to get to them when you need them"
Senior sister

For some, 'being sent' to occupational health was the ultimate confirmation of professional failure.

"They [OH] are there for needlestick injuries and special eczema gloves. I would never consider sending anyone in my team to occy health"
Lead consultant

"You only go to occ health when you need time off work. They don't really do anything except sign you off"
Reception

Most staff were also sceptical that formal support options, such as occupational health, would be tailored to the kind of work they did in the ED.

"Wellbeing is pointless. They don't have any concept of what goes on here. They wouldn't understand, what could they do? Once you see something you can't un-see it"
Senior nurse

"The wellbeing team [occupational health] aren't a face on the floor. They don't know about the ED environment. You would reach out and wait days for a phone call back"
Senior sister

They were also concerned about confidentiality and the potential impact on their career of disclosing any kind of mental health issue. As such, there was some concern about group sessions where people were encouraged to disclose any mental health concerns.

"If I needed help I would just go to my GP. I would never access support through work, you just don't know what would happen"
Nurse

"As a doctor, if I report that I might be unfit for work I could be told to stop working. You might even lose your job. That is not something most people are willing to take a risk on"
Lead consultant

"You would worry about any legal risks if you made a mistake at work and then it came out that you had depression"
Nurse

Some staff thought they might be thought of as timewasters by their colleagues, a perception that was reinforced by negative attitudes towards patients who had mental health problems themselves.

To overcome confidentiality concerns some staff managed to find their own way to access support, without help or guidance from the trust. Some used professional helplines such as the BMA (British Medical Association), which they favoured as the service was anonymous and run by experts in the field. This made them feel safe, and that the service was credible and reliable.

Staff lack informal coping strategies, and rarely share the techniques they do have

Informal support comprises strategies that are outside institutionalised structures. Informal support was often provided by colleagues who had become close to one another, with professional relationships sometimes becoming personal friendships. When formed, these attachments were frequently strong and considered to be "lifelines" or "crutches" for those involved.

> *"Having colleagues you can depend on is the most important thing. We're quite a close-knit group here"*
> Staff nurse

Most people found it hard to talk to family members who didn't have experience of trauma or emergency medicine. Many also felt it wasn't appropriate to burden their families with their work experiences, which could be distressing or upsetting for them.

> *"You have to just leave work at the door. One time I tried to talk to my husband about it and we got into a row. He just doesn't understand. It's better if I just leave things at work"*
> Senior nurse

> *"I was always thinking about work at home and it was causing problems with my boyfriend"*
> Nurse

Some had personal relationships with people who worked in other emergency services and found these friendships useful ways to download and debrief.

Staff also accessed informal support online, including WhatsApp groups, or Facebook pages. These were mainly used for practical issues such as swapping shifts, however they could also be a space for staff to let off steam.

> *"There's a group of four of us and we have a WhatsApp group. The rule is, if things get really tough we'll send the emergency emoji. Then we'll call that person straight away to check if they're okay"*
> Consultant

The relationships ED staff had with each other were a key part of these strategies. Often drinking alcohol, black humour or moaning about management were a part of these relationships and perceived to be an important way to "let off steam".

> *"Black humour gets them through, it's a coping mechanism which helps to build the relationships, it's not degrading, sometimes it's the only way that gets you through. It's only when you're in it that you'll get it"*
> Senior nurse

Sometimes, informal support would find staff members who were showing visible signs of distress.

> *"When my dad was dying, someone noticed that I wasn't my usual self. They took me to one side and we had a chat. It made me feel so much better"*
> Band 7 nurse, operations manager

> *"You do something if you see someone's about to start crying"*
> Staff nurse

Though in general ED staff weren't keen on the idea of mental health interventions, with prompting, staff did reveal a range of ways they coped with the intensity of working in such high-pressure environments, even if they didn't necessarily associate them with mental health or see them as part of their professional identity.

Some staff described personal routines they had developed to prepare for or wind down from their shift, such as taking exercise or listening to music.

> *"Going to the pub. That's what I do. If in doubt, drink!"*
> Nurse

> *"Do you know what I do for stress? A pedicure"*
> Senior staff nurse

In some cases, informal wellbeing strategies included deliberately taking time off work.

> *"When I can't cope, I go on sick leave. I've taken twelve days of leave for stress in the last seven months"*
> Junior clinical fellow

Sometimes, staff were using more structured and targeted mental health interventions such as mindfulness techniques or meditation apps. Individuals who had these strategies in place often had a specific interest in mental health, personal experience of supporting a family member with a mental health issue or had received mental health support themselves. Some found information provided by professional associations through journals and trade magazines helpful. It was also common for some staff to share news articles and infographics, through Facebook and WhatsApp.

The impact of informal support often depended on membership of networks. Groups of similar ranking staff would tend to support each other by sharing their techniques, encouraging each other to take breaks or supporting one another in the event of a traumatic incident. Staff who were excluded from these sub-'families' were excluded from these strong informal support networks.

Senior staff did not see looking after the mental wellbeing of staff as part of their role

A majority of senior staff did not see looking after the mental wellbeing of their staff as part of their role. Senior staff did not take an active role in signposting existing formal support to more junior colleagues, nor did they share more informal coping strategies.

Few managers had received any specific training in how to ensure their team were resilient or how to deal with mental health problems if they arose. Across the board, managers raised concerns about not being able to support people effectively. Even those managers who were most engaged in thinking about staff mental health were relying on personal experience to inform the way they supported staff.

Staff described their experiences with managers as highly variable. While some staff felt the support they had received was extremely helpful, others found they were just told to 'get on with it'. One porter reported that his manager didn't ask anyone how they were until they had to take time off work. A junior clinical fellow spoke of his desire for "someone who you can open up with without going through seniors/supervisors". A healthcare support worker reported that when she had mentioned mental wellbeing to staff, she was treated like "an irritant".

> *"We rarely ask our line managers for help, but when we do they don't acknowledge it. If we ask for help it's because we really need it"*
> Occupational therapist

While most had a lot of admiration for their managers, some felt their manager could be doing more to look after their own mental health. Senior staff were very rarely open about their own struggles with mental health.

> *"Within the hierarchy of medical staff, very rarely would you have a senior consultant saying, 'I'm struggling.'"*
> Doctor

One consequence of senior staff not being open about mental health was that more junior staff felt they could not express their concerns about their own mental health. Though not the sole reason, this would have compounded the effect of the performance culture in encouraging staff reticence.

> *"Senior staff are very stoical, they don't really talk about it. I'd love a session to talk about the fact that you're not alone"*
> FY2 doctor

> *"Teamwork is key to this sort of thing, if everyone is doing it it's accepted"*
> Junior clinical fellow

Staff were seen to be much more likely to recommend mental health techniques if they had heard about them at work, as opposed to in their lives beyond work[4]. It's likely that if senior staff were open about struggles and their own coping mechanisms there might be greater uptake.

Without senior support, when more junior staff took responsibility for mental health interventions, the reach and impact of their work was limited. Without cross-level institutional support, new initiatives didn't make much of a splash.

In one ED, a senior nursing assistant had taken responsibility for promoting a number of mental wellbeing strategies. However, without buy-in or support from senior staff, the reach of this work was limited.

---

[4] See Pilot Findings, Questions 7 and 8

Awareness of the intervention was largely limited to nurses of a similar level, many of whom knew the nurse leading the intervention personally.

> *"I don't really know much about it to be honest – I think that stuff is mostly for nurses"*
> Junior doctor

This was compounded by the unwillingness of the nurse leading the intervention to spread the responsibility she had taken on, in part because of her own interest in mental wellbeing. But as long as the intervention remained solely her 'personal' project its impact was limited.

Similarly, in cases where there was very limited staff input and interventions were intended to emerge organically through, for example, the dissemination of resources, mental wellbeing initiatives failed to get off the ground. In these cases, what made the difference was input from leadership figures.

At one ED, taking care of staff mental health was a stated leadership priority. A senior consultant whose responsibilities covered clinical safety saw this remit as including staff wellbeing and she was active in supporting staff mental health. She promoted mentor schemes for junior doctors and campaigned for a wellbeing fellow to be a separate position in the ED. As a result of her involvement, staff thought of wellbeing initiatives as authorised and encouraged by senior staff members and considered the department to be particularly open about discussing stress and wellbeing.

Some hospitals had included mental health strategies at induction, inserting mindfulness resources in starting packs and setting up mentor schemes for junior nurses and doctors. Some senior staff also had ideas about where to include self-care initiatives but hadn't taken action to develop or promote them.

> *"At regional middle grade training, it should be pitched and explained to them (junior doctors)"*
> Consultant

6. Opportunities: How can we improve the mental health of ED staff?

Though they described themselves as resilient, many ED staff describe experiencing poor mental health.

As this research has identified, there are considerable opportunities to provide support and significant benefits to doing so. But initiatives and interventions need to take account of the culture within the ED, the performance mentality of most of its staff and the prevailing narratives around putting the patient first.

Mind developed the 'Taking care of you' toolkit and champions programme as a pilot intervention to help ED staff prioritise self-care and develop coping strategies to manage the challenges of their workplace. This chapter summarises the opportunities that emerged from the scoping research and this pilot evaluation, and how health and hospital leaders can put them into practice.

Opportunity 1: Encourage preventative strategies in line with the performance and patient-focused culture

Mental health support should be updated to make clear how taking proactive steps can prepare staff to do their jobs at their best. ED staff pride themselves in putting their patients first and therefore messaging will have a greater reach if framed around the impact on their own professional performance and the benefits to patients.

- **Encourage staff to appreciate the benefits of preventative wellbeing** – Staff should be encouraged to consider the benefits that preventative, rather than reactive, steps to manage their mental health would have, not only on their job performance but on the care they provide to patients. Prioritising self-care should not be seen as a failure, but as a means to attain a high-performing and patient-focused identity.
- **Frame mental health as essential to high performance** – Ensure resources or support frame the notion of looking after mental health as critical to improving staff's professional performance. Making the connection between effectively managing mental wellbeing and doing well at work will help staff feel motivated to engage and try the strategies.
- **Associate better mental health with putting patients first** – Mental health support should emphasise proactive steps as a means to go 'above and beyond' for the patient. This would make looking after mental health seem vital to their vision for their job and their caring identity. Just as clinical staff prioritise hand-washing to ensure patient safety, looking after their mental health should be seen as a means to provide better care.
- **Engage junior staff with wellbeing support during training** – Building mental wellbeing support into mandatory training encourages staff to feel comfortable engaging with their mental wellbeing and feel that they have senior backing.

Opportunity 2: Messaging needs to convey that mental health isn't binary.

The tendency for ED staff to think of mental health as a binary concept needs to be overcome with much clearer messaging about the spectrum on which mental health issues can sit.

- **Encourage a view of mental health as a spectrum** – Messaging, support and explicit interventions need to reinforce a wider message that mental health sits on a spectrum. The specific stresses that ED staff face can then be placed along this spectrum. Staff should be encouraged to acknowledge that lesser struggles due to day to day stressors have an impact on their work and wellbeing and they should be encouraged to address them.
- **Make clear which stressors interventions are aiming to combat** – It should be made clear to ED staff which stressors on the spectrum mental health interventions are intending to address, to avoid frustration at their limitations. Any materials, strategies, messages or tools also need to be explicitly clear on what part of this spectrum they are aiming to meet and to distinguish the different stresses that they are trying to overcome.
- **Distinguish interventions or support from specific 'return to work' procedures** – Any interventions which aren't part of the 'return to work' process need to be more clearly marked and marketed as focusing on another aspect of the mental health spectrum.
- **Provide techniques that staff can use without fear of repercussions** – Mental health interventions should include techniques for staff that they can use by themselves in a more discrete manner, without other people knowing, or 'off the shop floor'.
- **Small interventions can have a sizeable impact** – Even small interventions, if they demonstrate that the trust cares about the team's mental health, can have a positive impact in the ED. Some simple, clear resources shared around the department, with some communication, can increase the level of discussion about staff mental health and wellbeing within the department.

Opportunity 3: Staff wellbeing needs to be an integral part of the senior team's responsibility

Senior leadership, at both a trust and team level, need to be explicitly responsible for staff mental health and actively involved in the roll-out of any interventions, messages or resources. By doing so, they would explicitly show their approval and give active permission for staff to speak up about mental health and address their stresses early on.

- **Make looking after mental wellbeing a key part of the responsibilities of senior staff –** Senior staff should see prioritising the mental wellbeing of their staff as central to their role. This would encourage openness amongst staff and a permissive culture. For example, at least one trust director could be responsible for staff wellbeing. This must be complemented by senior staff at a team level making themselves available to respond to staff's mental wellbeing concerns – support should come both from the trust and from those who understand the specifics of working in the ED.
- **Involve senior staff in the implementation of mental wellbeing support** – Senior staff involvement would ensure interventions reached the whole ED and encourage understanding and buy-in from staff.
- **Proactively reach beyond informal networks** – Ensuring messages and resources get spread across teams by identifying the most appropriate senior on the shop floor who can act as gatekeeper to each group.
- **Senior teams can more actively share their tips for coping** – Senior teams on the shop floor, with their own approaches to managing their mental health, could be encouraged to better share strategies and resources for managing mental health and different type of stressors.

Opportunity 4: Tailor messaging to take account of the specific environment

The framing of any options to support mental health, as well as wider messaging, needs to acknowledge and be tailored to the realities of the ED environment. Messages and support that acknowledge the uniqueness of the ED are more likely to be considered and adopted by staff. Current resources are often dismissed as unfeasible

or not useful for the ED, particularly those which require a specific amount of time or are focused on the individual without acknowledging the context or surroundings.

- **Use explicit examples, language or imagery tailored for the ED** – Interventions should speak to the reality of work in the emergency department, for example by tailoring imagery or language to be ED-specific. Information needs to be adapted for people in different roles and interventions will be more successful if they reflect the rhythm or pressure of different shifts, for example the precise demands of working at night.
- **Location influences the success of wellbeing resources** – Wellbeing resources should be placed in strategic locations, where staff feel they can take time to think of themselves. These include staff areas, like the back of toilet doors, or in areas where staff take time to wait for samples or test results.
- **Size of text is key to success** - Resources should focus on large text that is easily processed as teams move quickly around the department and are processing information quickly.
- **Ensure support options fit the rhythms of the ED** – For mental wellbeing interventions to be effective, they should be targeted at moments during the shift where staff feel like they can think about self-care. This was often before or after their shifts, but some teams had success at other points (e.g. waiting for results). Interventions should speak to the fact that staff see themselves as in a high-performing 'adrenaline' mode whilst on the 'shop floor'. Interventions focused on 'going home' or 'preparing for work' appeal more to staff. Support should also recognise that shift patterns mean that interventions and options might need to be staggered to reach people across multiple shifts.
- **Consider how materials are shared around the department** – Interventions that include materials or resources should consider how these elements are given to each member of staff and what is told to people. This is a great moment to make it clear that these materials have been designed for them and the pressures of the ED.
- **Support should be promoted and made available to all parts of the ED** – Those running interventions need to recognise that communications and materials that are shared will not necessarily cascade to all staff members – some staff will feel excluded from close teams and informal networks of dissemination tend to be limited. This can be overcome with the involvement of multiple senior staff or careful dissemination through the gatekeepers of various teams. Mental health support should be actively promoted across all teams within the ED, with steps taken to ensure it is not limited to the clinical teams. Materials could be tailored to the specifics of individual roles to better encourage buy-in and interest from staff.

7. Conclusion

ED staff would benefit from specific, targeted mental health support. For any support to be effective, it needs to be designed specifically for the staff in this environment and needs to take account of the following factors.

ED culture focuses on performance and putting patients first

The pressures of working in an emergency department are real. There are high expectations of staff – from their managers, their colleagues and themselves. They need to perform to a high standard.

However, many of the pervasive narratives in EDs have some inherent tensions. Dramatic language and the prevalence of binary conceptualisations can mask nuance and detail.

For example, not all staff feel part of 'the team'. Similarly, while staff will always talk of putting the patient first, in practice this is not always equally strongly felt – certain patients, e.g. children, or cases that are more severe, are prioritised more than others. When it comes to the pressures they experience, ED staff tend to default to talking about trauma although a little unpicking reveals that more mundane pressures can in fact be just as significant.

This matters because language and shared narratives are one important way that the workplace culture is developed, maintained and passed on. They also affect and reinforce the way ED staff conceive of and articulate their own professional identities.

All these factors combine to create a powerfully felt performance culture for ED staff that affects the way they do their jobs, their consideration of and actions in relation to their mental health and how they respond, or might respond, to support or intervention. Within this performance culture, there is little room for what we call self-care, with staff feeling that they must put patients first at all costs.

Support for mental health needs to challenge binary thinking

When asked about mental health, staff in the ED tend to default to talking about the impact of particularly traumatic cases. There is also a shared narrative that everyone on the team runs on adrenaline – with both positive and negative implications for mental wellbeing.

Mental health tends to be thought of – along with several aspects of ED culture – in binary terms. Either someone is mentally fit or they're not – and anyone who does not have severe symptoms might be thought of as a time waster.

Unpick these narratives, however, and it is clear that ED staff are affected by a range of issues, with some revealing stress or displaying symptoms that suggest they are not in the best mental health.

While staff themselves may struggle to do so, it is useful to think of mental health as a spectrum rather than a binary state, which individuals might move along across different points in time or under particular circumstances.

When probed, staff reveal that many of their stressors are the more daily pressures they feel – lack of control over the hospital system, pressure to meet targets, which build up cumulatively over time.

In many cases, staff have developed strategies to cope or help deal with these pressures.

There is appetite for improved support across the ED

The culture and working practices of the ED make it a uniquely challenging place to deliver mental health support to staff.

In line with staff's own default narratives, formal support tends to be around traumatic events or is a standard part of the 'return to work' process for someone who has been off sick. Beyond this, there appears to be low awareness of wider support options, few proactive steps being taken to manage their mental health and a scepticism of support options that are available. While some informal support does happen in many trusts, between staff groups, it is often not inclusive of all staff and ineffective.

Leaders and managers did not always know how to support their teams and many did not role model positive behaviours or share their tips for proactive management of their mental health.

However, even a small intervention, like the Mind 'Taking care of you' toolkit and champions programme can be seen to have a positive impact in the environment, encouraging greater conversation about mental health and less severe causes of stress and poor wellbeing.

There was a great appetite across the departments for proactive mental health support, with several departments building wellbeing sessions into their regular team catch-ups and staff training for junior and new clinical teams.

There are significant opportunities to improve wellbeing intervention and mental health support for ED staff. Interventions designed specifically for the staff in this environment, taking account of their working culture, their attitudes and the practicalities of their work can have a significant impact, as long as they are led and prioritised by those perceived to have credibility and authority.

All emergency departments could introduce changes such as tailoring wellbeing messaging to take account of the specific ED environment, encouraging preventative strategies in line with the ED performance culture and making staff wellbeing needs an integral part of the senior team's responsibility.

Appendix

Methodology

Both phases of research were primarily qualitative in nature, focused on exploring needs, motivations to and influences on staff experiences of mental health and support as well as engagement with the pilot intervention.

Key elements of the approach included ethnographic observation in several emergency departments (EDs) and both intercept interviews conducted on the shop floor and in-depth interviews with staff working in a wide range of roles, including medical, nursing, clerical and facilities.

Six sites were chosen for the initial scoping research, selected to include a range of EDs (regional, urban, trauma, etc.), workload (in terms of number of patients seen each day) and current performance rating (NHS performance statistics).

Five of these hospitals went on to participate in the pilot intervention. This meant the research team was able to explore behaviours and attitudes to the pilot intervention in the context of detailed knowledge about their culture, support available around mental health and staff pressures.

Phase 1: explorative approach

The research was designed to maximise understanding of staff experiences of mental health and its relationship to the working environment and culture. Key elements of the approach included:

- **15.5 days of ethnographic and observational fieldwork** across six sites to understand the reality of staff experiences. This included understanding the physical and cultural environment, staff base and shift patterns, perceptions of workload and language used and communications around mental health.
- **90 intercept interviews** with staff across the ED (clinical and non-clinical, including senior house officers, junior doctors, junior and senior nurses (matrons, emergency nurse practitioners, advanced nurse practitioners), healthcare assistants, administrative and clerical staff (for example receptionists), and facilities staff (including porters, cleaners and security).
- **15 off-site depth interviews** with ED staff in a range of roles, as covered above. Participants in these interviews were recruited as a result of intercept interviews or through contact points within the departments.

Phase 2: pilot intervention evaluation

The ambition of this phase was to gain a detailed understanding of staff's behaviours and attitudes around the implementation of the intervention and use of the materials. Key elements of the approach included:

- **9 days of ethnographic fieldwork** across five sites to understand staff awareness of the intervention, actions taken to encourage staff to engage with the toolkit and champions and the barriers to effective implementation.
- **100+ intercept interviews and in-depth interviews** with staff in a range of roles across the ED, and specifically with champions across three of the EDs. The ambition was to understand the experiences for different types of champions and other types of staff with the implementation of the toolkit.
- **Online staff survey** across all five EDs, with 200 responses from staff in a range of roles and at different levels of seniority. This helped us understand the scale of awareness of the toolkit after two months in each ED and the appeal of the different elements of the toolkit.

‘Taking care of you’ intervention materials

The ‘Taking care of you’ pilot intervention aimed to support mild-moderate challenges with mental health and provide proactive approaches to managing wellbeing. The materials were not intended to support people dealing with more severe mental health challenges or traumatic experiences.

The intervention had two parts. The first element was a toolkit of self-management techniques for ED staff to employ before, during, and after their shift (*see next page*). This comprised a portable guide of the techniques for staff members and resources designed to be placed strategically around the department to ‘interrupt’ staff at opportune times and encourage positive self-care habits.

‘Teaser’ postcard

Champions guide (booklet) + badge

Tips & techniques guide (booklet)

‘Ready for work’ checklist (business card)

‘Going home’ checklist (poster)

Stress scan (wall vinyl)

Stress scan (coaster)

Take a break reminder (wall vinyl)

Breathing window (wall vinyl)

Mindfulness reminder (wall vinyl)

Stickers

The second part established a network of volunteer ED staff ‘wellbeing champions’ to raise awareness, signpost to support, and promote positive mental health and wellbeing in the workplace. Three of the five EDs taking part in the pilot designated a group of volunteer ‘champions', including staff from different roles across the ED (e.g. consultants, nurses, porters, and receptionists).

Considerations about sensitivity of mental health

Across both phases of research, the project team was fully aware of the sensitivity of the subject matter and took care to find ways to enable staff to feel confident and comfortable talking about mental health. The researchers were careful not to force disclosure and put processes in place to ensure confidentiality, for example maintaining discretion within the department about those who had participated in the research and ensuring conversations could take place in private spaces or outside the ED.