Health Services Safety Investigations Body

## Interim bulletin 3

# Harm caused by delays in transferring patients to the right place of care

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Emergency care

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# Introduction

The aim of this third interim bulletin is to provide a further update on the investigation's findings. Two previous interim bulletins have been published and can be found here (Interim bulletin 1, Interim bulletin 2). The first interim bulletin included a detailed background to this investigation and discussed patient flow through the urgent and emergency healthcare and social care systems, concluding with two safety recommendations. The second interim bulletin focused on patient safety risk accountability. This third interim bulletin focuses on staff wellbeing across the urgent and emergency care systems and its impact on patient safety.

## Background

The research literature shows that optimal staff wellbeing is important for the patient experience and safe care (Maben, 2012), and that poor staff wellbeing can lead to patient harm (Hall et al, 2016; The Health Foundation, 2016). Staff wellbeing is affected by work-related factors, including workload, autonomy and the work environment (NHS Employers, 2022). Before the COVID-19 pandemic, one of the biggest challenges facing the NHS was workforce resilience (ability for employees to stay at work while remaining engaged and motivated) and wellbeing, with more than a third of NHS staff saying they felt unwell due to work-related stress (Health Education England, 2017). Data shows that, for NHS staff, 'anxiety/stress/depression/other psychiatric illnesses' is consistently the most reported reason for sickness absence, accounting for more than 476,900 full-time equivalent days lost and 23.2% of all sickness absence in June 2022 (NHS Digital, 2022).

Reports in the media relating to staff speaking up about their workplace stresses, and information gathered during this investigation, show that the current increased pressure placed on NHS staff is resulting in patient and staff harm.

## Emergent findings

The investigation engaged with a broad range of staff, including staff who deliver care and those responsible for making decisions about staffing and the place of care for patients being treated by the NHS. Discussions with staff focused on the impacts on patient safety of:

- staff wellbeing
- staff providing direct care to patients in ambulances waiting outside of hospitals
- staff providing direct care and indirect care (such as roles in decision making, management, administrative) to patients in urgent and emergency care settings for extended periods of time and in unfamiliar places (such as in a hospital corridors or not the correct specialty ward for a patient's condition).

The findings presented below were identified following:

- discussions with integrated care boards
- observational visits to ambulance services and acute healthcare settings
- focus groups with a broad range of staff working in the ambulance service and NHS 111 call-handling centres
- engagement with national organisations
- engagement with senior operational staff across the NHS and social care system.

## Approach

The initial approach for this stage of the investigation into the impact on staff wellbeing across the urgent and emergency care systems was to use ‘appreciative inquiry’ (Trajkovski et al, 2013; Whitney and Trosten-Bloom, 2010; Cooperider and Srivastva, 1987). An appreciative inquiry approach brings together diverse groups of people to explore and improve upon the best in an organisation, focusing on what is working rather than what is not working.

However, the structure of the investigation’s conversations with staff quickly changed as the investigation saw, felt and heard the significant distress. This resulted in a more free-flowing conversation about the emotional impact of their work. A subject matter advisor (a health psychologist with a special interest in moral injury; see below) reflected on this need to adapt the conversation approach as important and demonstrated the emotionally charged feelings of staff in the system.

## Findings

The investigation was given many accounts, across the healthcare system, of wellbeing impacts on individuals and teams. Staff at all levels described the challenges they face each working day. Staff told the investigation that not being able to help the sickest of people had an impact on their personal health and wellbeing.

Many staff cried or displayed other extreme emotions as they described their working environment, their personal feelings on their own decision making and that of others in relation to patient care, and the burden of moral distress.

The following examples were heard:

- Emergency (999) call handlers related receiving repeated calls from patients waiting for an ambulance. In some cases, the patient was heard to be deteriorating and staff were unable to respond, other than offering telephone advice.

- Emergency (999) ambulance dispatchers have electronic systems that give them live information on the waiting time for an ambulance. The investigation heard there had been occasions when more than 100 Category 2 calls (the second most urgent category of emergency call (NHS England, 2018)) were waiting, with no ambulances available to respond. Dispatchers told the investigation that it was common to worry about “How many people are we going to kill today?” due to their frustration and sadness at not being able to send ambulances to patients.
- Emergency department staff described making challenging decisions on which patients in queuing ambulances to take into the emergency department for treatment. Staff described this as often being “the most unwell, unwell patient”, and said they experienced moral distress when they were unable to “do the right thing [by all patients]”.
- Ward staff described being unable to discharge patients from hospital to an appropriate place of care. They explained that the longer a patient stays on a ward, the more likely they are to either fall or develop a new infection, resulting in further medical intervention and an extended stay in hospital.

In addition to impacting wellbeing at work, the investigation was told about the secondary effects on staff beyond their working day – including on their ability to switch off from work and how they interact with friends and family. Some staff spoke of isolation and despair at going home to an empty house after a difficult and challenging day at work, without support structures in place.

Some of the common words that the investigation heard from staff during interviews are displayed below:

**Figure 1 Common words used by staff during interviews with the investigation**




Staff told the investigation that wellbeing is prioritised by healthcare organisations only when there is time to do so. In addition, staff said that their wellbeing was only considered fully when it had deteriorated beyond the point at which they could be supported by colleagues or their local professional health and wellbeing services. The subject matter advisor told the investigation that if staff are not proactively supported then wellbeing concerns can lead to longer-term mental and physical health problems that will need professional interventions and time off work. Senior NHS staff told the investigation that this, in turn, increases pressure in the system as the remaining staff must fill the resulting gaps.

The evidence gathered suggests that those staff who engaged with the investigation showed strong elements of stress, moral injury, harm from incivility and burnout (see table 1).

**Table 1 Definitions of mental health concerns identified in NHS staff**

| | |
|---|---|
| **Stress** | Any factor that threatens the health of the body or has an adverse effect on its functioning, such as injury, disease, overwork or worry. (Martin, 2015) |
| **Moral injury** | The suffering people experience when they are in high-stakes situations, things go wrong, and harm results that challenges their deepest moral code and ability to trust in themself or others. The harm may be something that a person does or witnesses, or something that is done to them. It results in moral emotions such as shame, guilt, self-condemnation, outrage and sorrow. (Shay, 2014) |

| | |
|---|---|
| **Incivility** | Rude and unkind behaviour that can have a detrimental impact on staff wellbeing and patient care. (NHS England, 2022) |
| **Burnout** | A state of physical and emotional exhaustion. (NHS Employers, 2022) |

When staff experience stress, moral injury, incivility and burnout, the investigation found these can have significant impact on patient safety from both individual and team perspectives.

Impacts on individuals:

- Reduced ability to process information as a result of continually thinking through the same events and worry, whether a result of incivility or moral injury.
- Reduced available emotional resources to undertake work safely and well, as a result of burnout, moral injury or stress.
- Loss of trust and sense of psychological safety at work, meaning that staff are less likely to raise concerns, as a result of moral injury.
- Physical exhaustion due to effects on sleep from stress (also the effect of lack of sleep on decision making and information processing).

Impacts on teams:

- Loss of team cohesion (that is, being able to function efficiently, raise issues and communicate well) due to burnout and moral injury.
- Lack of time for emotional repair and support, and no ability for staff to ‘fill their cup’ (emotional resilience) as a result of burnout and stress, as there is no additional staff cover to draw on.

The subject matter advisor told the investigation that increasing challenges in getting patients to the right place of care, including ambulance handover delays and patients having extended stays in the emergency department (described in interim bulletins 1 and 2), will lead to further deteriorations in staff wellbeing.

Under section 2 of the Health and Safety at Work Act (1974), employers have a general duty of care to ensure the health, safety and welfare of all employees, and this includes employees’ mental health. Employers have to try to remove or reduce stress as far as reasonably practicable. However, current approaches to staff wellbeing within the NHS are inconsistent and depend upon local initiatives, leadership and personalities. This means that not all staff receive the same level of wellbeing support.

NHS staff can access support in several ways, including through employee assistance schemes, occupational health and other professional services. Staff told the investigation there are “significant” waiting lists for these services. These services are a reactive approach to maintaining staff wellbeing and rely upon staff seeking support when they feel they need it, or when wellbeing has been clearly impacting an individual and they have been signposted or referred to them.

The Health Service Journal recently published an article about funding cuts to staff mental health support services that were put in place during the COVID-19 pandemic (Moore, 2023). The article describes that these services have been underutilised and might therefore be removed. Staff told the investigation there is a need for such services, but that staff do not have time to access them because of a high workload and ongoing pressures in the system.

The investigation heard that while staff are trying their very best to give good care, harm is happening, and that this is affecting both patient outcomes and the ability for staff to stay well at work. The subject matter advisor said that healthcare staff who deliver direct and indirect care to patients may benefit from having the time and space for reflective practice – that is, giving staff a protected time to come together to talk about the emotional impact of their work. Staff told the investigation that the opportunity to speak openly, confidentially and within the safety of a facilitated discussion was incredibly helpful and ”cathartic”.

NHS England told the investigation that it believes there is a link between staff wellbeing and patient safety, and that it is considering directly linking the staff health and wellbeing work (part of the People Plan) to its Patient Safety Strategy (NHS England, 2019, 2020). It told the investigation that:

“We know that staff need to have time and support in order to provide safe, high-quality care. That is why in the 2022 refresh [of the NHS Patient Safety Strategy] the NHS England patient safety team are working with the NHS England’s People Directorate and partners across the system to develop a joint patient and staff safety plan. Positive patient safety and [a] healthy organisational culture are two sides of the same coin. A culture in which staff are valued, well supported and engaged in their work leads to safe, high-quality care. This means both psychological safety and physical safety, including considering staff engagement, fatigue, burn-out [and] presenteeism, and the impact these can have on risks to patients and staff alike."

The NHS People Plan, which was published in 2020, aims to improve the experience of working in the NHS for all staff members and sets out a range of actions to deliver this. Supporting the plan is The Promise that states:

‘We look after ourselves and each other. Wellbeing is our business and our priority – and if we are unwell, we are supported to get the help we need.’ (NHS England, n.d)

NHS England told the investigation that the NHS England People Plan focuses on staff wellbeing, while the Patient Safety Strategy focuses on patient safety. They are not currently interlinked.

### Conclusion

The investigation found strong links between patient safety and staff wellbeing. The investigation heard that while staff are trying their very best to ensure safe care, harm is happening, and this is affecting patient outcomes and staff wellbeing. This further impacts the ability of staff to stay well at work.

**Safety recommendation R/2023/219:**

HSIB recommends that NHS England includes staff health and wellbeing as a critical component of patient safety in the NHS Patient Safety Strategy.

**Safety observation O/2023/207:**

It may be beneficial for NHS organisations to provide time and safe spaces for staff to engage in reflective practice and talk about the emotional impact of their work, with support from people with expertise in staff wellbeing.

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