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'I never leave my house without praying': a qualitative exploration of the psychospiritual experiences of ethnically diverse healthcare staff during the COVID-19 pandemic

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ABSTRACT

Objectives The study aimed to understand the psychospiritual experiences and support needs of ethnically diverse healthcare staff during the COVID-19 pandemic.

Design A qualitative study using focus groups conducted remotely on Microsoft Teams.

Setting The study took place across 10 National Health Service Trusts in England: 5 were Acute Hospital Trusts and 5 were Community and Mental Health Trusts.

Participants Fifty-five participants were recruited to the study across 16 focus group meetings. Participants were all National Health Service staff from ethnically diverse backgrounds.

Results Psychospiritual concerns were central to participants' understanding of themselves and their work in the National Health Service. Participants felt there was limited recognition of spirituality within the health service. They described close links between their spirituality and their ethnicities and felt that the psychospiritual support offered within the healthcare setting was not reflective of diverse ethnic and spiritual needs. Improved psychospiritual care was viewed as an opportunity to connect more deeply with other colleagues, rather than using the more individualistic interventions on offer. Participants requested greater compassion and care from leadership teams. Participants described both positive and negative changes in their spirituality as a result of the COVID-19 pandemic.

Conclusions Culturally sensitive psychospiritual support is a key aspect of healthcare staff's well-being, despite identified gaps in this area. Aside from affecting physical, psychological, social and financial aspects of healthcare staff's lives, the pandemic has also had a significant impact on the ways that people experience spirituality.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study has generated rich data through qualitatively investigating the well-being needs and experiences of ethnically diverse healthcare staff within the workplace.
⇒ The study recruited participants from a broad range of national locations, professions, religious affiliations and ethnic backgrounds.
⇒ A study limitation is that only people who could access computers and online working were able to participate.

INTRODUCTION

Internationally, the COVID-19 pandemic has highlighted significant well-being concerns for healthcare staff.[1–4] Healthcare staff are, for the most part, psychologically resilient professionals, trained and experienced in dealing with illness and death.[5] However, the COVID-19 pandemic has had an exponential impact on the mental health of healthcare staff with global reports indicating elevated rates of depression, anxiety, post-traumatic stress disorder and suicidality.[6–9] From death and bereavement, to staffing and personal protective equipment (PPE) issues, as well as family pressures, COVID-19 has put frontline staff under extreme stress from both direct traumatic experience and secondary, sustained stressors.[10]

In the UK, ethnically diverse National Health Service (NHS) staff have been experiencing these pandemic-related pressures even more greatly than their white British ethnic colleagues, experiencing higher levels of mortality[11] and expressing concerns about unequal access to PPE.[12] They have also expressed perceptions about ethnically diverse staff being over-represented in the NHS frontline,[13] and concerns about safety being dismissed by leaders and managers as a result of 'institutional racism and bullying'.[13] The impact of the pandemic, specifically the disparities in infection and mortality alongside the high-profile killing of George Floyd, resurfaced conversations around

systematic racism and experiences of racism. For many ethnically diverse healthcare staff, there were reports of experiencing retraumatisation through recalling past experiences of racism.[14] This is particularly important to acknowledge as experiences of racial discrimination are stronger predictors of adverse mental health outcomes and burnout in comparison with other pandemic-related stressors.[15] This highlights the need to better understand the experiences of ethnically diverse healthcare staff during the pandemic so that more appropriate interventions that support their specific needs can be developed.

One mechanism that may guard against the experience of burnout is through the provision of 'psychospiritual support'. This can be defined as 'psychologically informed support which responds to people's need to find meaning, purpose, relationship and hope, and may include transcendent understanding of the Divine or of ultimate meaning'.[16] There is some evidence that psychospiritual interventions improve patient–practitioner relationships and reduce stress in healthcare staff.[17] However, although psycho*social* support interventions are commonly identified and implemented to support healthcare staff with their health and well-being needs,[1 18 19] the provision of psycho*spiritual* support is less evident in NHS settings.

Spirituality is an integral aspect of health and well-being,[20] yet it has been suggested that spiritual support to help individuals cope with the impact of COVID-19 was drastically reduced in both quality and quantity during the pandemic.[21] Psychospiritual support is acknowledged to be important in building a resilient and compassionate workforce[22]; however, there remains a lack of opportunity for spiritual development within the structures of the NHS outside of chaplaincy settings. It is not known how staff from a broad variety of backgrounds are conceptualising, experiencing and using spirituality during the pandemic, or what their spiritual training and support needs are.

Acknowledging that ethnically diverse NHS staff members faced greater psychological pressures during the COVID-19 pandemic, NHS England specifically commissioned this study to understand better the experiences of these staff and the role of psychospirituality in how some of their support needs can be met. This paper aims to report on the role of spirituality in the lives and work of ethnically diverse healthcare staff during the COVID-19 pandemic, and in turn inform the development of psychospiritual support interventions for staff. The NHS is one of the most diverse workforce in the UK[23] and the aim is to highlight the whole-person experiences of a group who have given a huge contribution to the nation's battle with COVID-19 and yet have received some of the greatest stress and pressure from the pandemic.

METHODS

Study context

Data for this study were collected as part of the 'Listen, Share, Hold, Respond' (LiSHoRe) Project, which was commissioned by NHS England. The project aimed to understand the psychospiritual experiences and support needs of ethnically diverse staff in the NHS during the COVID-19 pandemic.

Design

A qualitative study using focus groups conducted remotely on Microsoft Teams.

Patient and public involvement

None.

Setting

The study took place across 10 NHS Trusts in England: 5 were Acute Hospital Trusts and 5 were Community and Mental Health Trusts.

Participants and recruitment

Inclusion criteria for participants were English-speaking NHS staff members from one of the participating Trusts; any pay grade/band or profession; any gender; and any religion, belief or spirituality. Also included was any staff member from a self-identified non-white British background—in the UK, this includes anyone who is not white, but also anyone who is white but not white British; for example, 'white–Eastern European' or 'white–Gypsy/Traveller.' In this paper, we use the term 'ethnically diverse' to describe non-white British people, acknowledging current difficulties with terminology.[24] Excluded was anyone from an exclusively white British background, and anyone who did not have access to Microsoft Teams. A total of 10 Trusts were approached from a range of geographical locations within England, and within each participating Trust a 'gatekeeper' was identified who assisted with local advertising. This 'gatekeeper' was often the Equality, Diversity and Inclusion Officer for the Trust, or was influential within the Trust's black, Asian and minority ethnic support networks. Staff who heard about the project and wished to participate, then voluntarily initiated contact with the researchers, were assigned to a focus group with other participants from their Trust. Snowballing sampling methods were also applied to support recruitment into the study whereby previous participants suggested other staff members who may be interested. In one of the focus groups, some of the participants were known to one of the researchers (GH) but we proceeded with the group as this had assisted recruitment and the researcher was not one of the group facilitators. Members of the public were not involved in the design or conduct of the research.

Data collection

Data collection occurred between June 2021 and January 2022, during the UK COVID-19 lockdown. Two experienced facilitators (RP, BN, HKG, JC), at least one of whom was from an ethnically diverse background, ran the focus groups. The average group size was three to four participants, and the focus groups lasted approximately 90 min. The focus groups took place predominantly during working hours, were held online and followed a topic

guide (online supplemental appendix 1), which acted as an *aide memoire* to facilitate discussions around psychospiritual perceptions, experiences and needs in relation to the COVID-19 pandemic. Facilitators were aware of the need to recognise that participants may be at increased risk of distress when discussing certain issues and understood how to offer practical and emotional support during the sessions and afterwards, for example, by signposting to relevant support services. Sessions were audio-recorded and transcribed by a transcription company with the relevant confidentiality agreements in place. Focus groups (16 in total) continued until data saturation was reached, which became apparent when no new data were being generated. All transcripts were anonymised at the point of transcription.

Data analysis

Data were analysed using thematic analysis[25] of recorded material using the framework approach.[26] The data were generated into codes and categories and entered into the framework matrix via a Microsoft Excel spreadsheet. Narrative summaries were written to detail the findings relating to the individual categories and themes were generated relating to the codes and categories that were summarised. The research team held regular meetings to discuss the themes that were emerging and at this point the themes were further refined, adapted and modified to reflect the interpretations generated from these meetings.

Findings

Fifty-five participants across 10 NHS Trusts in England (5 Acute Hospital Trusts and 5 Community and Mental Health Trusts) were recruited into the study. A total of 16 focus groups were conducted until data saturation was reached.[27] See table 1 for demographic characteristics.

Thematic analysis identified six overarching themes relating to the psychospiritual perceptions, experiences and needs of ethnically diverse staff members: (1) spirituality as connecting to something beyond oneself; (2) spirituality's influence on role within the NHS; (3) recognition of spirituality in the NHS; (4) the connections between spirituality and ethnicity; (5) spirituality and leadership; (6) spirituality during the COVID-19 pandemic (online supplemental appendix 2 shows themes and subthemes). The six themes are expanded on below with relevant, illustrative quotes.

Spirituality as connecting to something beyond oneself

This theme related to the different meanings that participants attributed to spirituality. Participants defined spirituality as a 'way of life' and 'the essence of the self'. It was reported as providing meaning and direction to life. Participants also described spirituality as transcendence or reaching for something larger beyond oneself, sometimes in pursuit of inner peace. Importantly, it was argued that spirituality was personalised in accordance with one's ethnic background, life history and life circumstances.

Table 1 Demographic characteristics of participants

Domain	N=55
Gender	
Female	41
Male	14
Age group (years)	
18–29	7
30–39	12
40–49	17
50–60	16
Over 60	6
Ethnicity	
Asian or Asian British–Indian	14
Asian or Asian British–Pakistani	8
Asian or Asian British–any other Asian background	5
Black or black British–African	17
Mixed–white and black African	2
Black or black British–Caribbean	5
Mixed–white and black Caribbean	1
'Dutch Somali'	1
'Russian British'	1
Tunisian	1
Religious affiliation	
Buddhist	1
Christian	22
Hindu	5
Muslim	16
Not religious	4
Sikh	5
'Spiritual'	2
Pay bands	
B2	0
B3	2
B4	5
B5	7
B6	10
B7	10
B8a	6
B8b	5
B8c	1
B9	0
Unsure	6
Doctor payscales	3
Years working in job role	
<1	8
1–5	15

Continued

Table 1 Continued

Domain	N=55
6–10	12
11–15	4
>15	16
Profession	
Clinical roles (social work, nursing, pharmacy, chaplaincy, medical/doctor, healthcare assistant, physiotherapy, psychology)	36
Non-clinical roles (administration, Freedom to Speak Up guardian, human resources, volunteer, information technology, management, research)	19

People's spiritual beliefs—whether grounded in a specific religion, a mixture of various faiths or simply humanism—provided a moral compass, guiding their values and coexistence with others. One participant described it as:

> [Spirituality] makes you always want to live the right life, do the right thing. It makes you a more caring and a more considerate person. (black British Caribbean, Christian)

Most participants felt that it was impossible to separate their spirituality from their identities:

> How can you summarise something which is a part of you, which is the essence of you, which is a unique quality of you, which is the colour, the taste, and the experience that you have? (Asian British, Muslim)

Spirituality's influence on role within the NHS

This theme identifies how the meanings of spirituality make a difference in the participants' role in the NHS. Participants described how their spirituality or religious beliefs guided their interactions with patients and colleagues by providing an ethical framework for action, for example, reminding them to be compassionate and open-minded. One participant captured the essence of this; that their work in the NHS provided an avenue for putting spirituality/religion into practice:

> I have the calling to become a nurse and it's a devotion, it's my spirituality giving the helping hand. That is the way I meet my spirituality, that is the way I fulfil it. (black British African, Christian)

Participants shared that they found strength, patience and hope in their spiritual beliefs during challenging times, such as when encountering discriminatory practices at work:

> Spirituality has helped to have inner joy despite what is being thrown at me, and I carry on. So, I'm always happy in my heart regardless of the challenges. (black British African, Christian)

Spirituality also provided the motivation to endure the exhaustion of working overtime during the COVID-19 pandemic out of compassion for patients and colleagues:

> I did more, not that I needed the money most, but doing more because I thought, 'how can I leave these people dying when we are short-staffed and my colleagues are on quarantine?' (black British African, Catholic)

Recognition of spirituality in the NHS

This theme alludes to the perceived unrecognition/recognition of participants' spiritual beliefs in the NHS. Most participants perceived that they had to hide their spiritual orientation at work, with one participant stating that spirituality or religion is similar to 'race', a topic 'that causes incredible amounts of conflict'. As a result, many felt that they had to be cautious about discussing their spiritual beliefs with colleagues and described how they felt they were concealing an essential aspect of their being:

> At first it was difficult, because it's [spirituality] something that you are not allowed to share with anyone. You might maybe share with colleagues, depending with what relationship you've got. (black British African, Christian)

In contrast, there were also participants who felt that provisions for their faith had been made at work and that their spirituality was supported by their line managers. They perceived being unrestricted in their thinking and in expressing themselves spiritually. However, alongside this, there was a strong feeling that spirituality, despite being welcomed at some staff members' NHS Trusts, still needed to be better integrated at work. Overall, participants felt that the topic of spirituality lacked recognition in the NHS and needed to be better incorporated into the wider organisational culture:

> I'd like to see it with supervisors, taking the whole person and being interested in what you bring from that perspective. I'd like to see it in reflective practice sessions, in our client work, in our clinical work, I'd like to see it in appraisals and personal development reviews. That's when we know we're getting there… Rather than an exception to the rule, which it appears to be. (Asian British Indian, spiritual)

The connections between spirituality and ethnicity

This theme highlights the perceived lack of ethnic and religious sensitivity at the workplace, as well as the emotional effects this had on the participants. Most participants described how their religious and ethnic backgrounds were interdependent. This was especially the case for participants from Islamic religious communities. Some participants perceived that the available psychospiritual support was tailored to the needs of white British ethnic majorities, for example, in the form of

mindfulness sessions or one-to-one psychological interventions. These interventions were considered 'white' or Western European-centric because they were perceived as individualistic, where spiritual transcendence entails inward reflection, whereas many participants discussed how a helpful spiritual intervention for them would mean greater connection with others, for example:

> One of the things that we did within my team as a way of keeping an eye on people very, very closely was that we instituted daily meetings, short meetings, but they're daily. So, you get a snapshot, of how the person is, but then you also get [a snapshot] of how the group is thriving…If somebody is a bit quieter first thing in the morning, you can say to them, are you okay? Give me a buzz a little later on, or check in with me later on in the day. (black British African, Christian)

It was suggested that spiritual support could be better tailored to people's ethnic and spiritual backgrounds by having a more diverse spiritual support service which would bring an 'insider's' perspective to the spiritual needs of their communities:

> It took me years to get somebody from the Black churches to come in as a chaplain, because we just had Anglican White folk who were chaplains. (Asian British, Muslim)

Overall, participants agreed on the need to consider holistic well-being, for patients and staff alike:

> I think, what we're talking […] about, is general wellbeing […] and the broader recognition of human beings needing a more holistic shall we say, care package […]. And religion and spirituality are part of that, aren't they? (Asian British, Muslim)

Spirituality and leadership

In this theme, we address the participants' desire for more compassion from their leaders both on an organisational and local level. Participants expressed the view that ethnically diverse NHS staff need a safe, compassionate and holistic space to speak about their problems, and to be spiritually cared for. Spiritual care for them involved 'feeling comfortable around anybody to have a conversation'.

Some participants reported that some sectors of the NHS lacked leaders who appeared to genuinely care for their employees/team. It was suggested that to improve spiritual support, managers needed to become closer with their team through regular conversations that enabled an understanding of the ethnic, spiritual and individual differences between them:

> But it's really, really important just to check on people on a human level, how are you?… And I think that, to me, is a big part of what spirituality is, just looking after each other, that kindness, just seeing how we look after one another. (black British African, spiritual)

Some participants pointed out that because we 'now live in a world that's so politically correct', it might stop white British ethnic managers from asking questions out of 'fear for misinterpretation'. Participants empathised with their line managers because they perceived that the managers often wanted to connect with ethnically diverse staff members; however, due to the often uncomfortable nature of these topics, managers became reticent of raising certain issues. This is discussed in greater detail in a separate paper.[28]

Spirituality during the COVID-19 pandemic

The final theme describes how participants perceived their spirituality was affected by the COVID-19 pandemic, in both positive and negative ways. Some participants reported that their spirituality had been deprioritised during the pandemic; one of the most common reasons given was that they were too busy at work and thus had little time for self-care. Moreover, the pressure at the workplace and loss of loved ones who had contracted COVID-19 affected some participants' spirituality in a negative way, for example, reducing their faith in God or a higher power:

> During lockdown it made me question not just my own religion but all religions because you look at what's going on around you and you're just thinking, 'if there's a God, where is He?' (black British African, Muslim)

It was argued that the pandemic put a limit to 'compassionate action' due to restrictions on caring for others in person. Although participants could show their gestures of care for others online, it was felt to be difficult to fully connect emotionally, as this was usually easier when people were physically present. It was perceived that distant communication and a lack of face-to-face compassionate action weakened participants' emotional connections to friends, patients and colleagues alike, which for many participants were regarded to be the essence of their faith. This posed an obstacle in connecting with something beyond themselves:

> What I've said about not feeling as close to my spiritual side over the pandemic…That had a lot to do with connectedness, actually. Even though we're dealing with each other virtually, it didn't feel like compassionate action…How I behave with others in person…That distance that grew was also one of the reasons I felt a lack of connectedness, of not having the opportunity to be with each other and putting certain values in action. (British African Indian, Sikh)

Participants reported that the lockdown affected their spirituality in a negative way because they could not access worship places, for example, mosques, temples or

churches, regarded as essential for being in touch with their spiritual community:

> I think within the Pakistani community, people turned to their religion a lot more. But […] there were difficulties […] because […] places of worship are closed. (Asian British Pakistani, Muslim)

Other participants reported that the pandemic, especially the lockdowns followed by home-office working, affected their spirituality in a positive way, for example, strengthening it by offering them more time for spiritual practice. It was reported that the pandemic and lockdowns had been a real personal journey in learning to accept suffering, loss and death as a part of life. Moreover, for some, seeing sick and dying patients had brought an appreciation for the taken-for-granted aspects of life, for example, good health or life itself:

> I think the pandemic served the purpose of knowing that human life is temporary and to be patient when you're struggling and to know that one day, this will come to an end. (Asian British Pakistani, Muslim)

For most participants, their spirituality became a pillar of support and a source of strength and hope, often expressed in the form of meditation, online church/prayer sessions, music or daily prayers:

> I never leave my house without praying. I pray to God, I know that I'm going to work, which is His work. (black British African, Christian)

DISCUSSION

Summary of results

The findings confirm the importance of spirituality among some NHS staff and how spirituality can be regarded as inseparable both to them as people and to their work in the NHS. Having spirituality provided individuals with an ethical framework for action that they applied within their role in addition to their required professional and clinical ethical frameworks, and there was a clearly expressed need for an open recognition of spirituality within the organisational culture of the NHS. Specifically for ethnically diverse staff, spirituality and ethnicity were often interdependent, and so future psychospiritual support initiatives would benefit from reflecting this and being less individualistic and Western European-centric. To succeed in meeting the psychospiritual needs of staff and facilitate spaces to discuss spirituality, participants described the need for leadership to be more compassionate. The expression of and engagement with spirituality were affected by the UK national COVID-19 lockdowns, in particular the lack of connectedness with others, but for most, spirituality continued to be a positive coping resource.

Consistency of findings with the literature

The findings from this study indicate the centrality of spirituality to participants' healthcare work, which is consistent with other qualitative findings that physicians delivering palliative care use their own religious/spiritual beliefs to support families' spirituality, uphold hope and participate in prayer with patients, as well as have more compassion and to cope with their own grief.[29] Participants in the LiSHoRe Study also discussed their desires for greater psychospiritual support at work. Similarly to patients, healthcare professionals can experience existential crises (eg, why did my patient die, why did they get this terminal condition, why did this treatment not work?), and when encountering such clinical situations, they too can benefit from spiritual support; however, in many organisations, there is limited provision of spiritual support for healthcare staff.[30] There have been several calls from clinical academics internationally to provide spiritual support for frontline healthcare staff[31 32] and our findings are the first to qualitatively report on the psychospiritual support needs of healthcare staff from ethnically diverse communities in the UK.

Participants described how to them, spirituality means connection and shared compassion with other people, which implies that psychospiritual care for staff should reflect this. Participants described how their NHS Trusts had offered well-being support during the COVID-19 pandemic, but this was often in the form of individualistic approaches such as one-to-one mentoring or therapy. The NHS Check Survey[33] highlighted that effective interventions for healthcare staff are often informal, easy to access and draw on the potential of teams rather than mental health professionals. Therefore, ethnically diverse staff may be better served within group settings and via interventions where people can come and share their thoughts, feelings and experiences and connect with others, such as via well-being lunches, regular group meetings, multifaith staff networks or Schwartz rounds. Schwartz rounds were originally developed to help foster compassion in healthcare[34] and provide a structured forum where staff within a healthcare organisation can meet regularly and reflect on the human connections made with patients and the emotional impact of their work. A recent evaluation of this approach in acute and non-acute NHS Trusts and hospices indicated 'very positive' results.[35]

The human desire for connection is also apparent when participants described colleagues in leadership positions; it was felt that line managers and other senior management team members sometimes failed to bond with staff through not always actively demonstrating kindness and compassion. It is proposed that training or other means of changing leadership culture would do well to focus on softer, more humane skills, and talking with staff from a more holistic approach, rather than having procedural-driven conversations. 'Compassionate leadership' is an approach growing in popularity in the NHS and 'involves a focus on relationships through careful listening to, understanding, empathising with and supporting other

people, enabling those we lead to feel valued, respected and cared for, so they can reach their potential and do their best work'.[36] There is evidence from the UK that compassionate leadership results in more engaged and motivated staff with high levels of well-being, which in turn results in high-quality care.[37]

Participants expressed the need to have spaces (emotional and physical) where they did not have to hide their spirituality, as well as better incorporation of spirituality into NHS organisational structures. An article by Graber *et al*[38] discusses how healthcare organisations in recent decades have largely excluded spirituality or religiousness, and make a case for a truly 'spiritual' healthcare organisation that supports patients' expressions of faith while fully respecting the views of non-religious staff and patients. Such an organisation would provide guidance and direction to staff on how to discuss faith, health and meaning in illness; encourage staff and clinicians to be warm, caring and sensitive; and would support individuals' search for meaning and fulfilment. There is limited literature on the impact of spirituality within healthcare organisations (as opposed to individual spirituality among healthcare staff), although there are some studies from Iran indicating that a high level of 'organisational spirituality' is linked to reduced chronic fatigue in nurses,[39] and raises general health and reduces occupational stress in faculty members of a university medical sciences department.[40] There is also a study from Portugal indicating that high levels of 'workplace spirituality' correlate positively with improved organisational performance in primary healthcare services.[41] This is a strong indication that there could be benefits for healthcare organisations that, in addition to chaplaincy services which already exist, consider spirituality within their broader structure and culture.

Our findings indicate that the COVID-19 pandemic had both positive and negative effects on participants' spirituality. There is limited literature describing changes in spiritual understanding or practices during the pandemic, although one study indicated that there was an increase in engagement with spirituality as people tried to make sense of the pandemic and its impact, and that even among those who were not religious, there were increases in prayer (Pew Research Center, 2020[42]).

Strengths and limitations

To our knowledge, this study is the first of its kind to the explore psycho*spiritual* experiences and support needs of healthcare staff rather than psycho*social* support needs during the pandemic. The need for this was reinforced by the study participants expressing the need for psychospirituality to be freely discussed and central to healthcare work. This study is also one of the first in the UK to qualitatively explore NHS staff well-being and the experiences of ethnically diverse staff, an arguably neglected area of study given the sensitivities around it as a topic.

A study limitation is that only people who could access computers and online working were able to participate. This is likely to have excluded among others, porters, cleaners and staff needed intensively on hospital wards.

CONCLUSION

This study is one of the first in the UK to report the role of spirituality in the lives of ethnically diverse healthcare staff working during a global pandemic. The findings reiterate that despite spirituality being of central importance to many staff (data from the 2021 Staff Survey indicate that around 56% of NHS staff members hold an active religious belief[43]) and perceived to have an important role in maintaining well-being, it is still a neglected area by NHS leadership. Spirituality was described as an integral aspect of an individual's identity, yet is still something that staff did not feel comfortable openly discussing. Staff wanted to have spaces where they did not have to hide their spirituality, as well as better incorporation of spirituality into NHS organisational structures. They also discussed how important connection with others was to their spiritual well-being, indicating that approaches such as Schwartz rounds or compassionate leadership may help address these concerns.

The topics of psychospirituality, staff well-being and experiences of ethnically diverse staff have potentially far-reaching consequences for job satisfaction, recruitment and retention of the healthcare workforce, as well as the quality of patient care; it is thus hoped that this study adds new understanding to the international literature and contributes to broader work in improving psychospiritual well-being of healthcare staff.

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Contributors All authors made substantial contributions to the conception or design of the work; or the acquisition, analysis or interpretation of data for the work; and were involved in drafting the work or revising it critically for important intellectual content. All authors gave final approval of the version to be published and have agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. HKG was involved in the data collection, led the data analysis process and co-collated the first draft of the paper. JC was involved in the data collection, data analysis process and the overall coordination and management of the study. She was also responsible for co-collating the first draft of the paper. RP and BN contributed to the study design and development,

were involved in data collection and the analysis and/or interpretation of the study data. CH and GH were responsible for the original study design and conception and were involved in the analysis and/or interpretation of the study data. GH, as the guarantor, is responsible for the overall content. All authors contributed to either the drafting or critically reviewing the manuscript.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Ethics approval Ethical approval was obtained from the local university prior to conducting the study (UREC registration no: 201475). In addition, written authorisation was obtained from each participating Trust. All participants were provided with relevant study information and were asked to provide written informed consent before taking part in the study.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. Data are available on reasonable request from the corresponding author (CH) (chenshall@brookes.ac.uk) and comprise deidentified focus group transcripts.

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