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West Yorkshire Health and Care Partnership
Mental Health and Wellbeing Hub

West Yorkshire Health and Care Partnership

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Evaluation of the West Yorkshire Staff Mental Health and Wellbeing Hub

The West Yorkshire (WY) Staff Wellbeing Hub aims to support NHS, Social Care and Voluntary Sector staff. This evaluation has been conducted as a partnership between the WY Hub and the University of Leeds. It presents data reflecting user uptake and experiences.

Content Index

Preface

The West Yorkshire Staff Mental Health and Wellbeing Hub team came together in January 2021 and formally launched in April 2021. Our Hub, unlike most others is fully embedded within the Integrated Care System (ICS) partnership. As one of the Clinical Leads on the team of this new and important initiative I was keen to formally evaluate the impact of the work, capture our learning and understand the benefits and challenges of our innovative positioning of the Hub in the wider system.

The hub holds three key principles central to all aspects of its delivery. Firstly, it is delivered in partnership across the integrated care system (ICS) and its regional leaderships. Secondly, it is facilitative and embraces the "levelling-up" agenda. which means that it will not seek to replace what is working well but will aim to add value and connections. It will also pro-actively and consciously work to target those groups with the largest health inequalities and who have been disproportionality impacted by COVID. Finally, alongside the key NHS mandate of delivering therapeutic interventions to the staff and volunteers in need of specialist support it would work to understand and remove barriers that prevented staff from accessing the help they needed.

This report is the culmination of a year long collaboration between several Hub staff team members and a research team led by Dr. Judith Johnson at the University of Leeds. It aims to capture and collate the data and research findings generated from a number of different work streams to describe and evaluate the work of the hub to date as well as extract recommendations for future work and directions.

Dr Kerry Hinsby

Consultant Clinical and Forensic Psychologist; Clinical Lead for the West Yorkshire and Harrogate Staff Wellbeing Hub

Overview

The West Yorkshire (WY) Staff Wellbeing Hub is one of 40 regional dedicated staff support mental health hubs which were commissioned in January 2021 in a response to the impact of COVID-19 on the workforce. The WY Hub supports over 100,000 staff including those based in the NHS, social care and voluntary sector. The Hub delivers services based on a four-level framework (Figure 1). The first two levels are prevention focused; they involve interventions and measures designed to support 1) a positive staff culture which engenders wellbeing and help-seeking and 2) the embedding of formal and informal structures to ensure that all teams and individuals can access mental health focused conversations to support their wellbeing. Levels 3 and 4 are proactive. Level 3 is focused at the teams level, ensuring that teams impacted by work stressors can access resources to support them and help them recover from the impact of acute stressful events. These teams can also access ongoing support to identify individuals who may need referral for further, individualised interventions. Level 4 is focused at the individual level, enabling the provision of timely access to high-quality, culturally sensitive and evidence-based interventions.

This report has been prepared as a collaboration between the WY Hub and the University of Leeds. It presents a comprehensive evaluation of the hub and its services offered during its initial commissioned phase from January 2021 – March 2022. In particular, this report aims to evaluate 1) access to the hub and 2) experiences and effectiveness of the services it provides. The findings are reported in line with the tier structure presented in Figure 1.

At the time of commissioning the work, the geographical boundaries included Harrogate. However from April 2021 the geographical commissioning boundaries changed and Harrogate moved to a neighbouring ICS. Some of the early data includes Harrogate but the later data excludes Harrogate and represents the current picture.

Figure 1

Executive summary

The West Yorkshire (WY) Hub was one of 40 hubs created in the wake of the COVID-19 pandemic to support staff and volunteers. Recognising that the systems which support public health and wellbeing are much broader than the NHS alone, the Hub serves third-sector and social care staff and volunteers in addition to those working in healthcare services.

The remit of the Hub is broad; in addition to supporting staff and volunteers who self-identify as struggling with a mental health problem, it exists to support positive culture change. To do this, the hub has created a multi-level approach, which also 1) supports workers to develop basic mental health skills, so that they can support their colleagues; 2) raises awareness of mental health problems and solutions, to start 'the conversation' about mental health in teams and 3) reduces barriers to accessing help, supporting workers to identify when they need to access help and providing the necessary information so they can reach help when they need it.

The findings from this report indicate that in its first 15 months, it has delivered services and initiatives targeting each of its originally identified levels. To do this, the Hub has partnered with a range of external organisations and partners to ensure that specialist skill sets are acquired.

These services have been well-utilised: the therapy service has received 450 referrals; 36 participants have been trained in Critical Incident Stress Debriefing; 29 participants have received coaching skills training; 46 participants have joined peer-led mental health training workshops; 59 participants have attended self-help mental health webinars and 125 participants have joined Hub-facilitated Schwartz Rounds.

Feedback from these initiatives has been overwhelmingly positive, with qualitative comments indicating that participants have benefited from the Hub-provided support with their own mental health problems. They have also welcomed the opportunity to be trained and equipped to prevent mental health problems both in themselves and their colleagues. Moving forwards, feedback indicates that a hybrid approach to delivering these offers may be beneficial, with some participants preferring offers to be made available online and others expressing a preference for in-person delivery.

Pre-and-post quantitative data was only available in the evaluation for the Level 3 Critical Incident Stress Management training. Results from this were also positive, indicating that the training was associated with improvements in participants' confidence in facilitating discussions and supporting their colleagues after incidents.

These data also indicate areas where the Hub can improve its practice. In particular, these data identify a need to reach a more ethnically and gender diverse group of staff and volunteers. Findings from the qualitative research indicate that this could be supported by consistent messaging and advertising over time, and signposting from in-service managers.

Evaluation of Level 4 Services

Background

The Level 4 services offered by the Hub comprise the Level 4 Psychological Therapies Service and a Telephone Support Service. The Level 4 Psychological Therapies Service offers 1:1 psychological therapy with a trained and qualified therapist. The Telephone Support Service offers a 8am-8pm/7 days a week telephone line manned by trained listeners offering immediate low-level psychological support. All eligible staff and volunteers can use either service without needing to notify their manager; as such, access is confidential.

Unlike psychological services which are offered to the general public by NHS primary care services, the Level 4 Psychology Service does not use a stepped care design; service-users can access 1:1 therapy without first accessing lower-intensity psychological interventions (e.g., bibliotherapy; group interventions). The waiting list to see a Hub therapist is also shorter.

This element of the evaluation included two parts. In the first part, service-user experiences of accessing the hub were explored. In the second part, access to the both 1:1 psychological therapies and the telephone support service were evaluated.

Evaluation of Level 4 Services

Part 1: Experiences of Individual Psychological Support

Aim

To understand the experiences and perceptions of staff and volunteers who used Level 4 services.

Methodology

A qualitative exploratory research design was used. A semi-structured interview schedule was developed, consisting of open-ended questions with additional probe questions. We used an opportunistic sampling strategy, recruiting participants who received a Level 4 service, until we had sufficient information power to address the stated aim. Interviews were conducted by researchers at the University of Leeds, via Teams or Zoom. Interviews were transcribed verbatim and analysed using Thematic Analysis.

Key findings

Ten participants took part in the interviews for this element of the evaluation. All were women and the mode age category was 31-40 years. All participants were offered 6 sessions of therapy as a minimum.

Analysis of the qualitative data indicated that participants experiences of the therapy could be described in three themes: 1) environment; 2) therapy modality and relationships; and 3) impact of Covid-19. These are explained further below.

Theme 1: Role of the manager

Participants described how important their manager was in shaping their experiences of accessing and using Level 4 therapy services, including their experience in the workplace after therapy was finished. A supportive manager helped to facilitate access to Level 4 services and also provided an understanding and encouraging environment to work in after their therapy journey ended.

"The manager of that charity manages the space and she was a little concerned. And she organised the...I don't know what.. What to call them. The counselling sessions is what I've been calling them.... I would not have been able to have done that without the support of somebody else"

She's [manager] very... very keen to... Like take work off me now that she knows it. She said quite a few times that... The new staff member we've got. She's been training him so that he can take more work off me so that she don't want me to worry about work or anything, so yeah, she's really supportive and really understanding.

Theme 2: Therapy modality and relationships

Having a positive relationship with their therapist improved both their experiences of therapy and the benefits they perceived they had gained afterwards. Participants receiving therapy online said that this modality initially made it harder to bond with their therapist but over the time, the greater flexibility afforded by online access outweighed any negatives and it did not impact the therapeutic relationship overall. The main concern for receiving online therapy was ensuring that they had a private space at home or work in which to talk.

"If you have to physically go somewhere, even though there are, you know definite benefits to doing things face to face. But I think because we could still see each other and it it went really well. And I liked doing it online. I found it very easy to access. I'd often sort of, you know, work right up to just before I have my session 'cause meetings will often, you know, run over and if it had been face to face I wouldn't have had that."

"Uh I think I was a little apprehensive because it can be difficult and there were times when we did freeze a little bit, but generally that was OK. I think because the therapeutic relationship worked quite well. Actually it didn't feel like it was such a barrier."

Theme 3: Impact of Covid-19

Pressures associated with the Covid-19 pandemic were the main reason reported for participants needing to access Level 4 services. However, participants also described positive effects of the pandemic on their organisations' workforce wellbeing agenda. Participants believed their organisations were now more aware of the challenges of their work on their mental health and offered a better range of support, including the possibility of using Level 4 services.

"So I think there's two sides to that. One is that it's definitely opened up that culture to talk more openly to check in with each other, and to be, try and be a bit kinder to each other.....But at the same time, I think the staff's wellbeing and even though we were openly talk about it, it has been....And I do think that, um, some staff are quite exhausted. Um, both physically and mentally."

Evaluation of Level 4 Services

Part 2: Understanding Access to Level 4 Services

Aim

To understand access to the Hub support services including the telephone support service, and the Level 4 psychological therapy service. This included personal and occupational demographics, the nature of difficulties people are seeking help for, type and duration of interventions, and outcomes relating to contact with the service.

Methodology

Level 4 therapy service: Case data for individuals referred to and who received therapeutic intervention from the service was routinely collated and stored on the ACORN clinical information system. This included personal and demographic data, information relating to organisation and role, nature of problems seeking help for, modality and duration of therapy, and routine outcome measures. For individuals seen within the Hub's independent provider partner (Oakdale CiC), this data was stored on ACORN but not directly accessible to the Hub service. In this case, a monthly summary report relating to access and including all the aforementioned data was sent to the therapy service Clinical Lead. This was then shared with the Hub Assistant Psychologist. For people seen within the Hub's therapy service, this data was held on ACORN and was accessible to the Assistant Psychologist. The Assistant Psychologist completed descriptive statistics on this data, which included information from routine outcome measures indicating reliable and clinically significant change, on a monthly and quarterly basis.

Key findings

Between when the therapy service began in April 2021 and February 2022, 450 referrals were received (Figure 2). The majority of individuals accessing the therapy service were female (n=165; 67%), most of whom identified as being from a White British background (n=327;74%). Gender data is highlighted in Figure 3 and ethnicity data detailed in Figure 4.

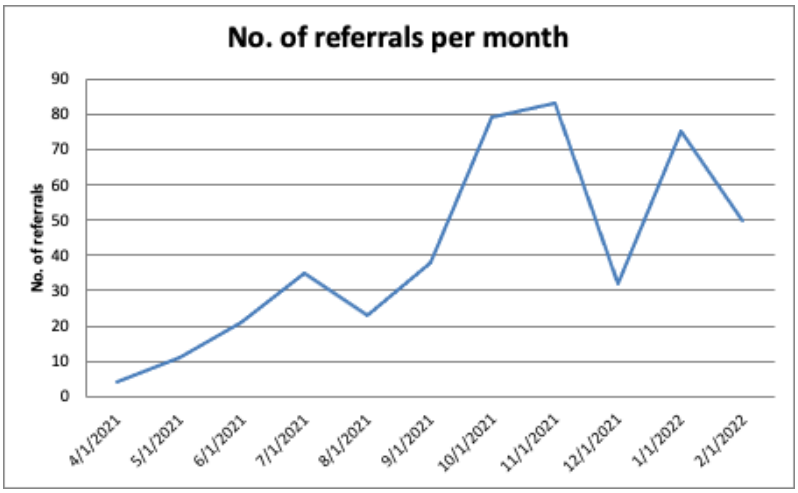
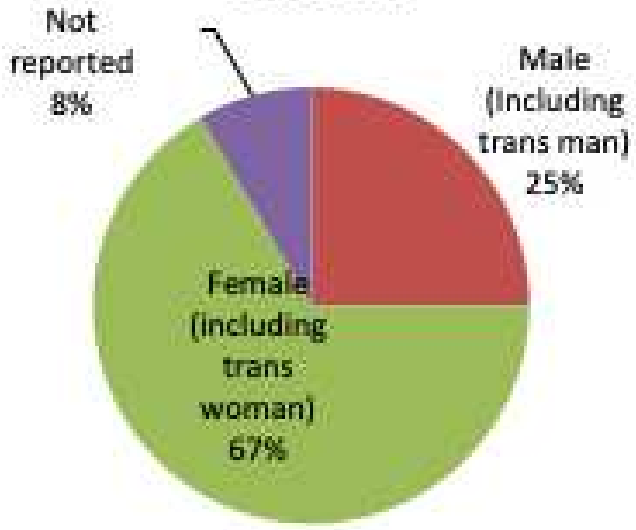


Figure 2



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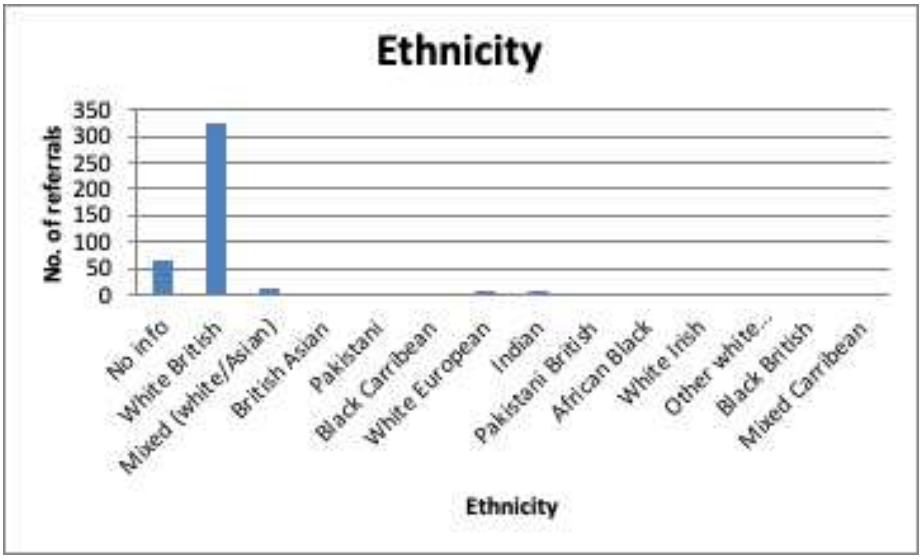


Figure 4

The majority of individuals who accessed Level 4 psychological therapy were employed by an NHS trust (n=336;89%; Figure 5). The main primary problems identified were anxiety (n=88) and post trauma symptoms (n=57). The main secondary problems were anxiety (n=63) and stress (n=53; Figure 6)

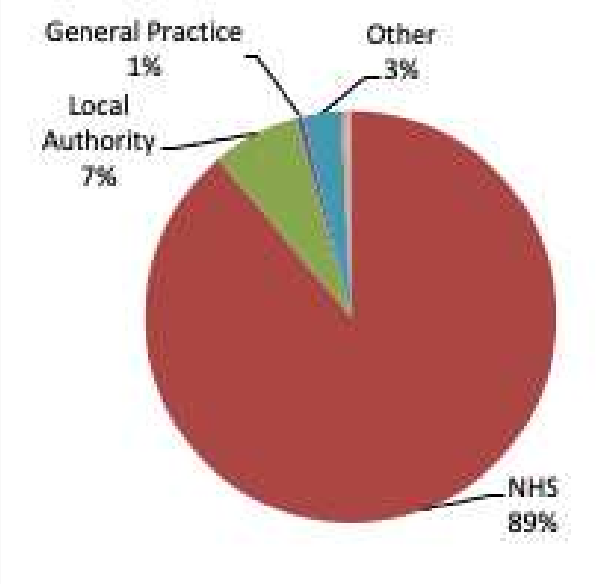


Figure 5

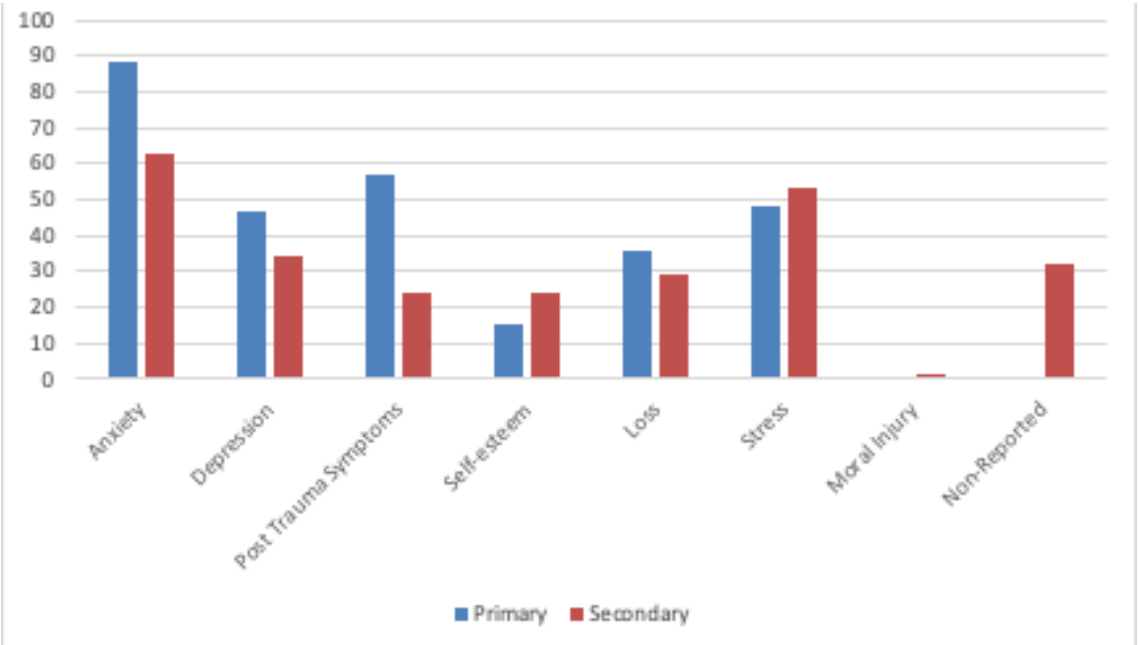


Figure 6

Summary

Participants described generally positive experiences of receiving psychological therapy from the Level 4 Psychology Service. Their experience of using the service was more positive when their line manager and work environment was supportive. Participants who used the service via a video platform found that once initial awkwardness had been overcome, this was a beneficial modality which supported their engagement. Participants described mixed experiences of the pandemic; whilst this was often a factor in their requiring extra support, they also appreciated the way in which this had highlighted pre-existing problems with employees' wellbeing and had led to improvements in the support available to them.

The findings of the Level 4 psychology service indicated the primary and secondary concerns of those accessing the Hub included anxiety, post-traumatic stress and stress. As a result of these concerns being highlighted, the Hub tailored other wellbeing offers to reflect the need of the system. This included, for example, the Level 2 wellbeing offers on the topic of stress and the development of the CrISSP pathway.

The had originally aimed to collect clinical outcome measures of the Level 4 psychology services. However, it was difficult to obtain the clinical outcome measures due to the nature of partnership working and utilising different systems. To develop the collation of outcome measures, the Hub is moving towards utilising the online clinical system of ACORN.

Evaluation of Level 3 Services

Background

Critical incidents which occur in healthcare delivery settings can have significant negative impacts on professionals' mental health and wellbeing. Research suggests that while immediate psychological debriefing after such events cannot be regarded as a tool to prevent Post-Traumatic Stress Disorder (PTSD), structured, group discussions coordinated by trained facilitators can support natural coping processes and may help reduce reliance on unhelpful coping behaviours such as substance misuse (Richins et al., 2020; Tuckey & Scott, 2014). These discussions should form part of a comprehensive organisational support system which is endorsed by senior management and which draws on the social cohesion already present within teams (Richins et al., 2020)

In order to deliver pro-active support for teams affected by critical incidents, the WY hub established the Critical Incident Staff Support Pathway (CrISSP; Figure 7). This follows the ASPIRE Framework, which outlines key elements of the organisational approach to supporting staff involved in incidents (Figure 8). As phase one of developing this framework, the WY hub has delivered training to staff in order to enable them to facilitate post-incident team discussions. The evaluation of Level 3 reports quantitative and qualitative results from this training, first aiming to understand participants' experiences of the training and second, aiming to understand the characteristics of staff and organisations accessing the training.

Evaluation of Level 3 Services

Part 1: Evaluation of the Critical Incident Stress Management Training

Aim

To evaluate and explore the training and implementation of skills developed through a training package in Critical Incident Stress Management (CISM).

Methodology

Questionnaires measuring confidence and implementation views were collected for all three training cohorts via an online questionnaire before and after the training.

The first two cohorts were followed up for semi-structured interviews regarding their experience of implementing the skills in their host organisation and work on behalf of the hub. A qualitative exploratory research design was used. We used an opportunistic sampling strategy, recruiting participants from the first two cohorts, until we had sufficient information power to address the stated aim. Interviews were conducted by researchers at the University of Leeds, via Teams or Zoom. Interviews were transcribed verbatim and analysed using Thematic Analysis.

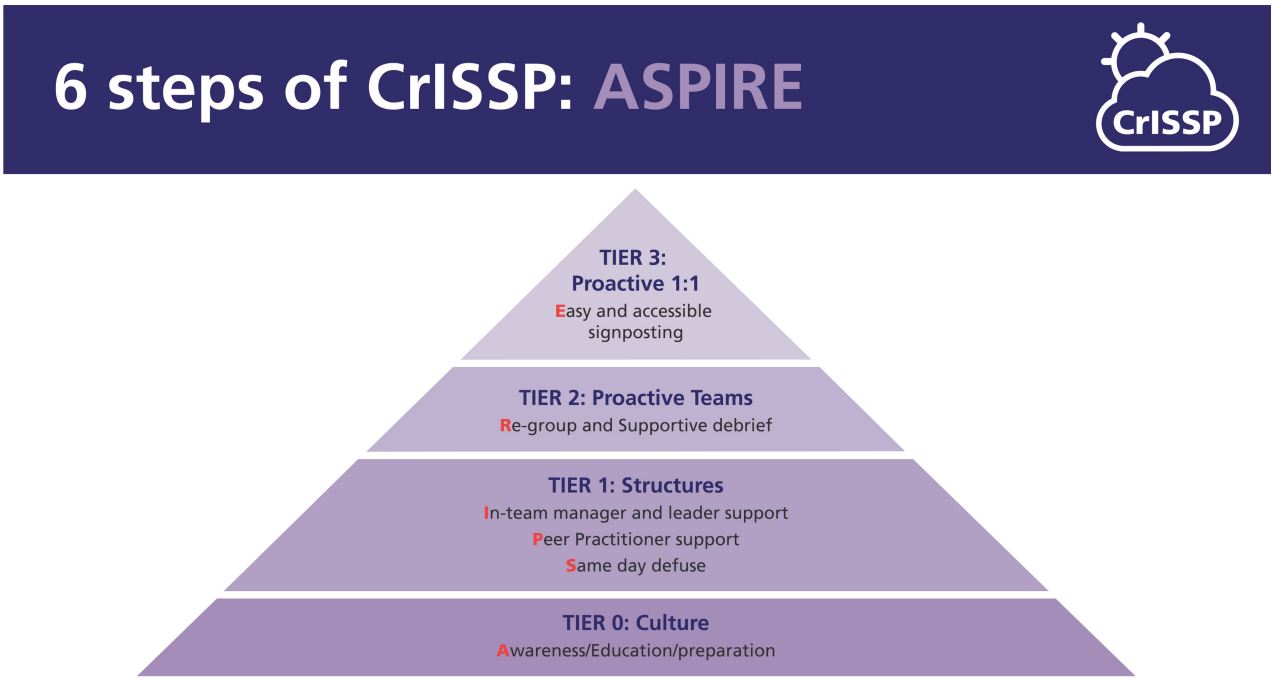


Figure 7

Key findings

Thirty-four participants completed either the baseline or the follow-up questionnaire and 28 completed both time points. They included 24 women, nine men and one unspecified and the mode age category was 41-50 years. All participants completed the Critical Incident Stress Management training package.

In response to the statement, 'I am confident I would know how to support my colleagues if we experienced a critical incident in our team or unit', scores increased from a mean of 3.18 (on a scale from 1-5) prior to the training, to a mean of 4.14 afterwards. This increase was statistically significant, $t(27)=-5.11$, $p<0.001$.

In response to the statement, 'I am confident I could facilitate a team discussion after a critical incident in my workplace', scores increased from a mean of 3.29 (on a scale from 1-5) prior to the training, to a mean of 4.21 afterwards. This increase was statistically significant, $t(27)=-5.73$, $p<0.001$.

100% of respondents agreed or strongly agreed that skills were learned in the training which would be useful for their organisation; 97.1% agreed or strongly agreed 1) that the training was relevant to their role; 2) there was adequate time to cover the material and 3) the training was engaging.

83.3% of respondents said they found all aspects of the training useful. The remaining participants indicated that they experienced video platform fatigue, they felt there was too much health and safety information or that they did not enjoy the role plays.

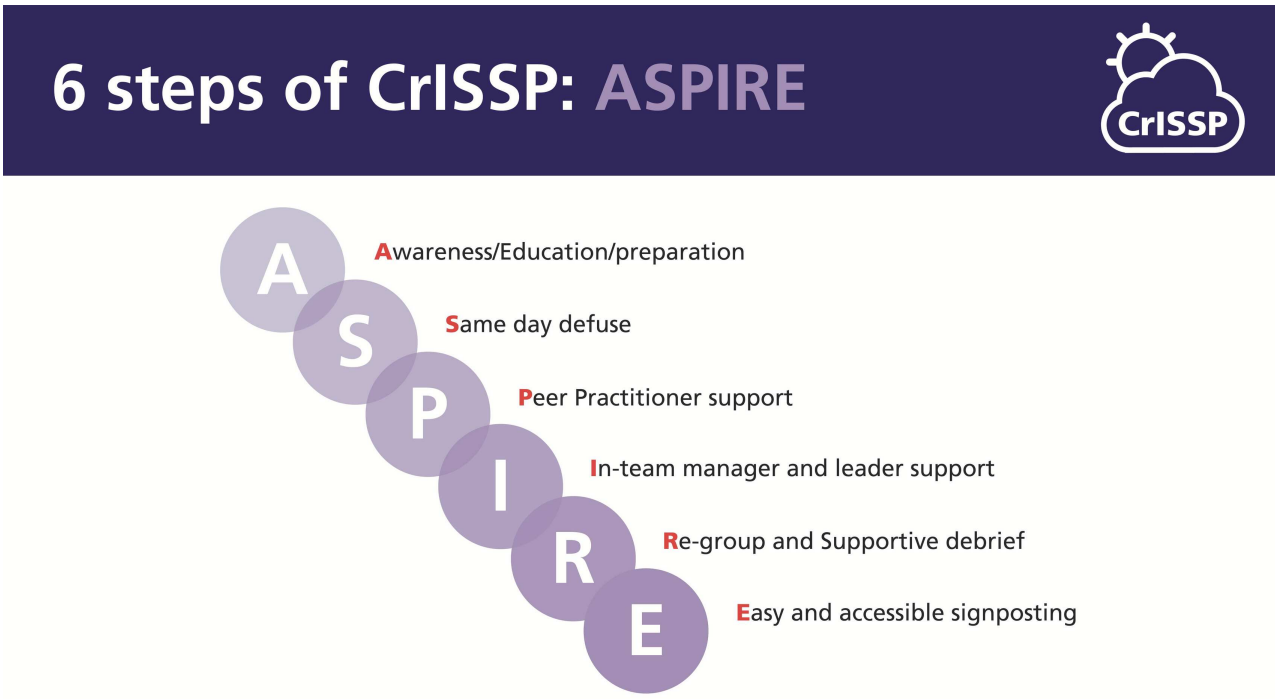


Figure 8

100% of respondents said that they would recommend this training to other staff or volunteers. However 72.4% of respondents said that they would like additional support from the WY hub to implement the training in their organisation. Respondents indicated that they would like support with regular refresher training or peer support from other CISM trainers to continue developing their skills, they would like support in approaching their organisation or management to help implement delivery of CISM and to be made aware and kept up to date with the wider range of services the Hub provides.

Fourteen participants took part in the interviews for this element of the evaluation. They included 10 women and four men and the mode age category was 31-40 years.

Analysis of the qualitative data indicated that participants' experiences of the training produced three themes, 1) Diversity in trainee backgrounds; 2) Modality of training and delivery of CISM; and 3) Systematic and organisational obstacles to training access and delivery. These are explained further below.

Theme 1: Diversity in trainees' professional backgrounds

Participants indicated that this was both a positive and negative aspect. Participants thought that including staff from different organisational and expertise backgrounds was very helpful for gaining new insights, however this also meant that for participants from certain clinical backgrounds the training was more generic than originally anticipated. This led them to believe that for them, some of the training was unnecessary.

"So it was quite nice welcome surprise that it was people from a range of different backgrounds and working areas. So I think it made the day better 'cause everyone could draw from their different experiences."

"The first few days are quite slide heavy, but he [instructor] introduced himself, it was covering stuff that I think going in as completely no knowledge you'd need, where some of the stuff I'd come across previously, so some of it for me personally, like I'd come across some of this stuff from my academic history, but I understand not everyone would have done so."

Theme 2: Modality of training and delivery of CISM

A return to face to face training was suggested as a key improvement for future delivery. A number of participants indicated that having training face to face would have improved the bonds between the group especially during the role play sections as this would have helped to increase and develop empathy for the situation. This was also indicated as a concern for those that had been able to deliver the intervention after an incident as they indicated that the online delivery was problematic for the same reasons as it was for attendance.

"I think that was the thing about the zoom that because the topic was just so emotive for people, but then you haven't got that connection with people like that physical connection. Not that we'd be cuddling each other or whatever, but they talk about it don't they? They would like their evidence about zoom, that you're always sort of searching for that eye contact, that physical connection with people and that didn't exist. So yeah, I think that's what I found quite draining from it."

"But the problem that we had is a couple of the girls got quite upset following it [CISM debrief] and we couldn't go speak to them after it, which as per the training you should check in with each individual one to one and have coffee."

Theme 3: Systematic and organisational obstacles to training access and delivery

Participants indicated that the key issues for concern in accessing CISM training was the ability to attend a five-day course due to their workload, availability and managers or organisation support to take this time away from their work schedule. Also that they felt that from a delivery standpoint there may be issues with inadequate system or organisational support to delivering CISM interventions. This was indicated as an issue especially for clinical staff as time and attitude may be problematic to change.

"And so I think I think my manager did initially say; you probably haven't got five days to go on that, but not from the point of view of, you know I don't want me to do it more. I think more of a concern from knowing that I was already incredibly stretched."

"t's just the the the main barrier would be. Uh.... Time and attitude....Can you be bothered?"

Summary

Participants showed increased confidence after receiving the training, indicating that the training was associated with participants feeling more able to support their colleagues and facilitate team discussions in the wake of critical incidents.

The training was reviewed favourably overall, with participants reporting that it was relevant for them, engaging and beneficial for building their professional skillset. All participants said they would recommend the training to others. Some participants identified elements of the training they would prefer to be changed; some did not enjoy the role plays and would have preferred in-person delivery, rather than online.

In addition, the qualitative interviews identified that there were challenges and benefits to including trainees from a wide range of professional backgrounds, with some trainees finding aspects of the training repetitive. Trainees expressed concerns that the length and intensity of the training could prevent some professionals being able to engage with it.

Evaluation of Level 3 Services

Part 2: Access to the Critical Incident Stress Management Training

Aim

To understand interest in the CISM training and characteristics of the professionals who chose to take this up.

Methodology

Participants who attended the training provided information about their demographic, professional and organisational information via an online questionnaire.

We also recorded metrics taken from our micro-site content linked to CrISSP, to understand interest and visibility of the site.

Key findings

Thirty-six attended the training and 22 returned questionnaires. Of these, the majority were female (n=15; 68%), heterosexual (n=22; 100%) and White British (n=20; 91%) with the remaining from other White backgrounds (n=2; 9%). None described themselves as having a disability.

Ages ranged from 26-35 to 66-75 (see Table 1) and came from five of six possible localities (see Table 2 and Figure 9). Participants worked within three different employment sectors (see Table 3 and Figure 10).

Age	Number	Percentage
18-25	**0**	**0**
26-35	**4**	**18**
36-45	**6**	**27**
46-55	**11**	**50**
56-65	**0**	**0**
66-75	**1**	**5**
76-85	0	0
Prefer not to say	0	0
Total	22	100

Table 1

Locality	Number	Percentage
Leeds	12	35
Wakefield	13	38
Bradford District and Craven	5	15
Calderdale	0	0
Kirklees	2	6
Harrogate*	2	6
Total	34	100

Table 2

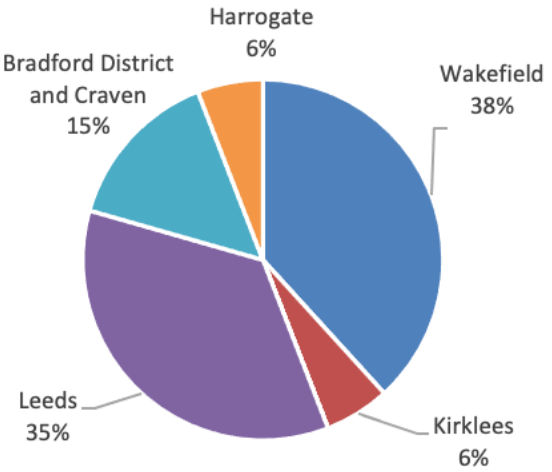


Figure 9

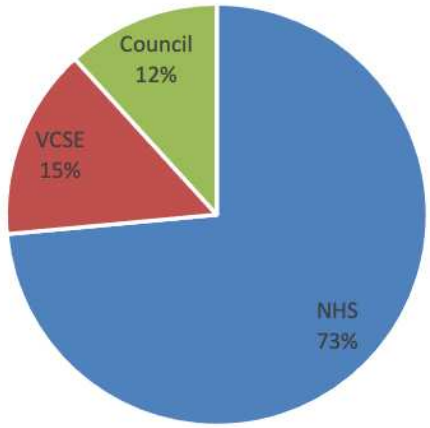


Figure 10

Organisation	Number	Percentage
NHS	25	73
VCSE	5	15
Council	4	12
Total	34	100

Table 3

The website analytics highlighted the CrISSP page had 15 page views and the secure resource for CrISSP facilitators had 4 page views. The website pages related to CrISSP were accessed only a small number of times, suggesting limited visibility. This may be due to the website pages being relatively new. A formal launch and promotional event is scheduled for May 2022 and it is hoped this will increase the profile of the work and website resource.

Summary

The website had limited access and visibility. The participants in the training had good regional, professional and employment sector variability. However, there was a lack of demographic diversity and diversity according to protected characteristics.

Evaluation of Level 2 Services

Background

In accordance with the Hub framework outlined in Figure 1, for Level 2, the Hub worked in partnership with three key delivery partners to offer a range of self-help, psycho-education interventions and training designed to improve self- understanding and the facilitation of everyday conversations around mental health. These smaller projects are summarised below.

These were designed and delivered responsively dependent on staff feedback about need. In particular the coaching skills programme, given its target audience was iteratively delivered. The co-design and co-created element was woven into every stage of the delivery.

Evaluation of Level 2 Services

Part 1: Coaching for under-represented pools of staff (minority ethnic communities and the voluntary sector)

Aim

To evaluate the experience, impact and output of a coaching skills training programme.

Methodology

All participants provided their locality and sector when they signed up for the training via email. Participant demographic details were collected via online survey for the first two cohorts. The demographic survey return remained low (n=4) and was not reflective of the group make-up. For cohort three, the data collection method was revised; only ethnicity data was collected and participants were asked to self-describe their ethnicity when they signed up to the coaching skills programme via email. Because of this, only ethnicity data was reported and this was only for cohort three.

The first two cohorts completed an online survey feedback questionnaire which asked participants to provide information regarding their views and experiences of the training.

The coaching skills trainer asked all participants to provide a story which reflected the impact of the coaching skills training. Participants provided this to him by email and this was forwarded on to the hub evaluation team. Four such stories were provided to the Hub team altogether.

Key findings

Thirty-five signed up for the coaching skills programme, with 29 attending the training. Of these, the majority were from the VSCE sector (n=25; 72%) and came from five of six possible localities (See Table 4 and Figure 11).

After the revision of the data collection method, out of the 12 participants in cohort three, nine participants self-described their ethnicity (See Table 5 and Figure 12) and three reported that they would prefer not to say.

Locality	Number	Percentage
Leeds	13	37
Wakefield	1	3
Bradford District and Craven	19	54
Calderdale	1	3
Kirklees	0	0
Harrogate	1	3
Total	35	100

Table 4

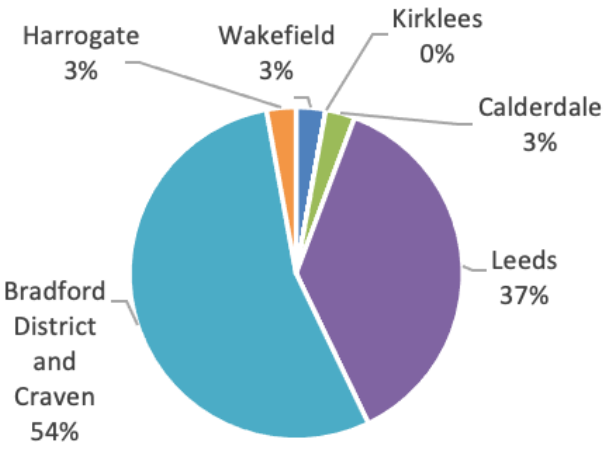


Figure 11

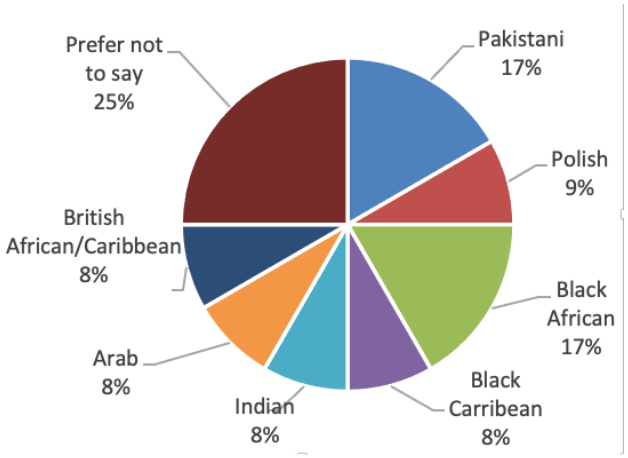


Figure 12

Ethnicity	Number	Percentage
Pakistani	2	17
Polish	1	9
Black African	2	17
Black Carribean	1	8
Indian	1	8
Arab	1	8
British African/Caribbean	1	8
Prefer not to say	3	25
Total	12	100

Table 5

All participants strongly agreed or agreed that the programme made coaching skills relevant and accessible to a diverse range of people and roles, with all participants seeing ways to use the skills within their roles and organisations.

87% of participant reported being more or significantly more able to encourage self-compassion when helping people review progress towards their goals and living their values as a result of the coaching.

83% of participants strongly agreed or agreed that the coaching was an important approach to developing inclusion, wellbeing and performance.

Quotes extracted from stories reflecting the impact of the coaching skill training:

“If we all had some coaching skills our lives, our relationships our communities and the world would be a better place. Taking time to understand our own behaviour and interactions develops self awareness and a greater understanding of those around us"

"I often remind myself I’m a human ‘being ‘ not a human ‘doing’ developing a coaching style has helped me to be more present in my interactions.”

"Although coaching is not part of my current role within my organisation, I have found the Coaching Skills course very valuable in helping me understand how to have more meaningful conversations with colleagues, project partners and those outside of work. "

"We often live our lives in the ‘fast lane’ with so many expectations of ourselves and others, but if anything the pandemic has shown me it is the quality of our interactions that count . I’ve lived my life at 100mph and I wouldn’t change a thing because wherever my path has taken me it has made me who I am . Like all of us I’m a work in progress ! "

Evaluation of Level 2 Services

Part 2: Peer-led learning in collaboration with MIND

Aim

To evaluate a series of peer led workshops delivered by MIND

Methodology

As part of requesting a place on one of the workshops, participants provided details about their role and organisation via email to the hub. Participants who attended the training provided information about their demographics, via an online questionnaire.

MIND delivered a range of sessions related to wellbeing with topics being chosen responsively to the needs in the system. Post session evaluation forms were collated by Leeds MIND and sent to the Hub team. There was one quantitative question which was collected across all groups; this asked participants to rate the extent to which they agreed with the statement 'Today's session has supported me to improve my knowledge'. The remainder of the survey requested qualitative feedback from participants.

Key findings

Eighty-one participants signed up, with 46 attending eight peer-led learning sessions. Twenty-five demographic forms were returned, which indicated that the majority of participants were female (n=23; 92%), heterosexual (n=18; 72%) and White British (n=18; 72%). Nineteen described themselves as not having a disability and ages ranged from 18-25 to 66-75 (Table 6 and Figure 13).

Participants came from all six places (Table 7 and Figure 14) and the majority came from NHS organisation sectors (n=52;66%).

Age	Number	Percentage
18-25	2	8
26-35	5	20
36-45	3	12
46-55	5	20
56-65	8	32
66-75	2	8
76-85	0	0
Prefer not to say	0	0
Total	25	100

Table 6

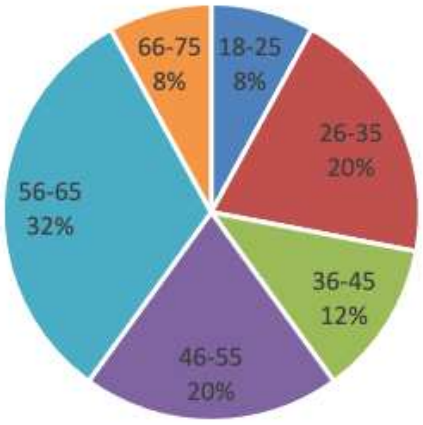


Figure 13

Locality	Number	Percentage
Leeds	35	45
Wakefield	9	12
Bradford District and Craven	10	13
Calderdale	5	6
Kirklees	11	14
Harrogate*	8	10
Total	78	100

Table 7

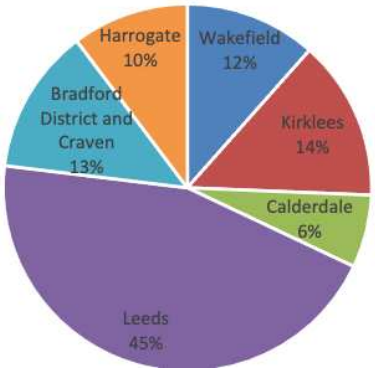


Figure 14

Gathering formal feedback was difficult as we relied on MIND's methodology. However of the ten feedback forms which were returned, six participants responded to the item, 'Today's session has supported me to improve my knowledge'. Of these, five [83%] reported the sessions had ‘definitely improved’ or ‘somewhat improved’ their knowledge of the session’s topic. Qualitative comments included:

“Learned from peers different viewpoints about coping and building resilience. Good to share ideas and challenges with others” – Participant from Building Resilience Workshop.

“The facilitator was brilliant so easy to talk to all the participants were honest and willing to share”- Participant from Looking after ourselves Workshop.

Evaluation of Level 2 Services

Part 3: Access to on-line self-help and webinars – developed by the Cellar Trust

Aim

The Cellar Trust is a mental health charity, primarily supporting people with mental health problems. The Cellar Trust provided a bespoke webinar to support mental wellbeing in the context of the Covid-19 pandemic. The aim of this aspect of the evaluation was to understand the reach and impact of the on-line self-help offer co-ordinated by the Cellar trust

Methodology

Participants' demographics were collected at sign-up via an online survey and collated by the Hub team. The Cellar Trust collated feedback data . As the year progressed it became increasingly popular to offer sessions to whole teams requesting support, rather than individuals attending generic sessions.

Key findings

Eighty-six participants signed up, with fifty-nine attending 24 sessions of Leading Mental Wellbeing Together. Thirty-four demographics forms were returned. These indicated that the majority of participants were female (n=28;82%), heterosexual (n=34, 100%) and White British (n=28;82%). Thirty-one described themselves as not having a disability and ages ranged from 18-25 to 56-65 (Table 8 and Figure 15).

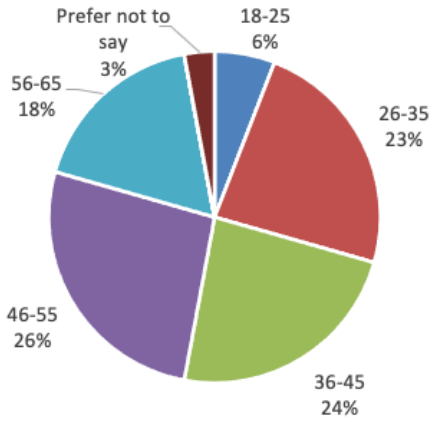


Figure 15

Age	Number	Percentage
18-25	2	6
26-35	8	23
36-45	8	24
46-55	9	26
56-65	6	18
66-75	0	0
76-85	0	0
Prefer not to say	1	3
Total	34	100

Table 8

Participants came from five out of six possible localities (Table X and Chart X) and from all three organisation sectors (Table X and Chart X).

Locality	Number	Percentage
Leeds	21	35
Wakefield	17	29
Bradford District and Craven	13	22
Calderdale	0	0
Kirklees	7	12
Harrogate*	1	2
Total	59	100

Table 9

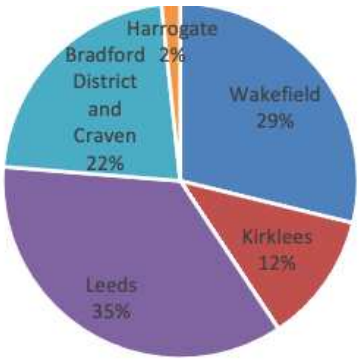


Figure 16

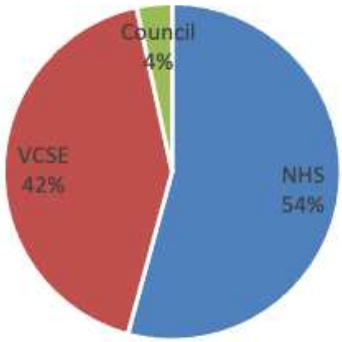


Figure 17

Organisation	Number	Percentage
NHS	32	54
VCSE	25	42
Council	2	4
Total	59	100

Table 10

Qualitative feedback provided from the Leading Mental Wellbeing Together Sessions included:

"The course was interesting, interactive and informative with lived experience speakers. The facilitator was friendly, knowledgeable and encouraged group contributions without any pressure. There were some good resources provided and useful tools that I will be using in the future"

"Brilliant course, expertly delivered and well worth investing the time. Thank you so much!"

Team Sessions

Sessions were offered to teams to help support and build team resilience. The teams came from two of the organisational sectors from a wide range of teams (Figure 18).

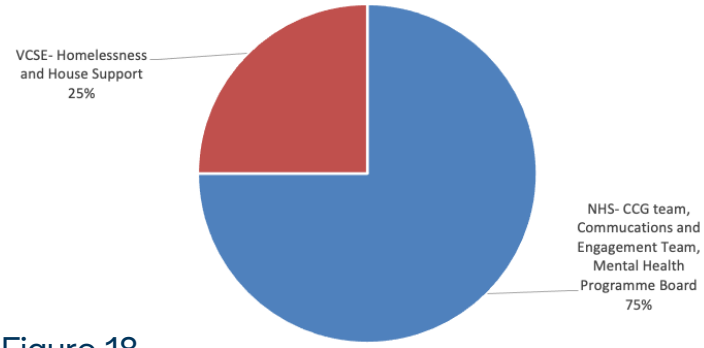


Figure 18

Summary

A total of 238 people signed up for the Level 2 wellbeing offers, with 170 people attending a range of different sessions between July 2021 and February 2022. Taking the findings together the lower-intensity support and training interventions offered a useful complement to the more intensive 1:1 therapy. Uptake has grown as the Hub has evolved and communication and reach of offers has improved. Being able to respond dynamically to feedback from the system and participants has improved the relevance of the sessions. Routinely collecting demographic data has helped the hub to understand the uptake of interventions. However, different partners have different collection methods which has made cross comparison data challenging. The data does not indicate a representative sample of the workforce are attending the sessions and more can be done to increase representative uptake.

Coaching has previously been well evaluated but usually in White participants; this study expanded out to target people from ethnic minority groups. Representative groups attended the cohorts however this was not demonstrated in the formal demographic return. The next step for the Hub is to explore a 'train the trainer' element, offer team coaching to VCSE partners and to develop a reference group for future developments.

The MIND workshops were proven to be popular with a number of the sessions being oversubscribed. The topic of the sessions evolved with the demand in the system. Due to the challenges of partnerships working, the evaluation data remained difficult to obtain as originally intended. The next step for the Hub is to produce communications through different modalities to share learning and to explore what topics would be beneficial for future sessions.

The Cellar Trust provided a wide range of sessions, with team sessions becoming increasingly popular to support team resilience. Similarly, the evaluation data remained difficult to obtain due to the challenges of partnership working. The next step for the Hub is to continually offer team sessions to support team resilience and to strengthen the offer to link into additional resources from the Cellar Trust.

Evaluation of Level 1 : Culture and helpseeking

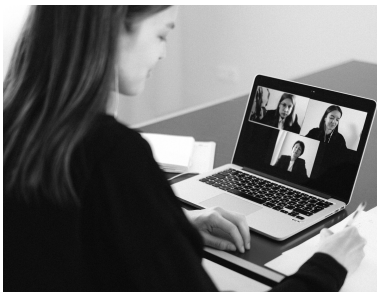
Background

Healthcare professionals suffer from disproportionately high levels of stress and burnout, the psychological syndrome characterised by emotional exhaustion and disengagement. Level 1 of the WY Hub services is prevention focused, and involves interventions and measures designed to support 1) a positive staff culture which engenders wellbeing and help-seeking and 2) the embedding of formal and informal structures to ensure that all teams and individuals can access mental health focused conversations to support their wellbeing.

Despite the wide range of services offered by the WY Hub, many staff do not engage with the support which it offers. Previous research suggests that employees are less likely to use workplace counselling services when their organisation is: perceived as psychologically unsafe, if they suspect it is not confidential, or that their organisation is only offering the services to avoid litigation.

The evaluation of Level 1 reports results from three projects designed to better understand and improve organisational culture. First, we report results from a qualitative investigation into barriers and facilitators for staff and volunteers in accessing hub services. Secondly, we report a preliminary evaluation of Schwartz Rounds. A third project, qualitatively exploring with key stakeholders and place based leaders about their perceptions of the WY Hub will be reported on later in the year.

Evaluation of Level 1



Part 1: Barriers and facilitators to accessing the hub

Aim

To explore the barriers and facilitators to staff accessing help. To explore both internal barriers such as shame and guilt alongside external and relational barriers such as team support and knowledge of what is available.

Methodology

An exploratory qualitative design was used. Semi-structured interviews included questions focused around 1) perceptions and views regarding the WY hub services specifically, 2) perceptions and views regarding help-seeking for personal well-being more broadly and 3) perceptions of wellbeing culture in their organisation and WY, including participants' perspectives regarding their role in supporting their colleagues. The interview schedule elicited information pertaining to participants' wellbeing practices, how they perceived their role as a care-giver in relation to their own care needs and their wellbeing ethos.

Advertisements were disseminated via email and posters in the organisations served by WY. Participants were invited to contact the University of Leeds research team directly if they were interested in participating. The research team screened out participants who had received WY hub services; retaining only those who had not contacted the hub and those who had contacted the hub but had not received a service. Sampling was purposive; we aimed to recruit participants from a range of professional roles, genders and ethnicities.

Key findings

Twenty-five participants took part in the interviews for this element of the evaluation. They included 23 women and 2 men and the mode age category was 31-40.

Analysis of the qualitative data indicated that participants' experiences of accessing the support services could be captured in four key themes, 1) Environment and Atmosphere in the Workplace; 2) Confidentiality; 3) The Impacts of COVID-19; and 4) Awareness and Communication of Resources. These are explained further below.

Theme 1: Environment and Atmosphere in the Workplace

The environment and atmosphere within the workplace played a key role in professionals accessing support. Having a supportive manager and team enabled participants to discuss their wellbeing concerns and seek support in an understanding environment; conversely, participants indicated that having an unsupportive manager was one of the biggest barriers to accessing support resources.

"She [manager] was happy to read [about an underlying health condition] and that was useful and trying to adapt where you know and refer me to occupational health where possible. So I think she's been really flexible and done done what she can do within the context of of yeah the current environment."

"Organisations that have third sector organisation managers who have different targets and different ethos. So contacting XXX NHS trust manager and they said all these things that you could do this and that. The third sector organisation don't have that support system, have no knowledge or other support system in general. And they... they kind of just discredited it. So it just seemed completely... Pointless asking for help because nothing was done."

Theme 2: Confidentiality

Participants discussed confidentiality as a key concern of theirs when seeking and accessing support services. Participants indicated a fear for the impact on their career progression if their colleagues found out about their wellbeing concerns. This is further highlighted by the participants' general preference for accessing support that was separate to their workplace, as this was deemed to be more confidential and pose less of a risk of meeting a colleague.

"I think something could.... have to be anonymous, that isn't directly connected to work. I think it would make a big difference."

"I do think career progression is one of them. Uh, massively, that's probably. When I had a little think why I've not really mentioned that it is that because. I think you don't. You don't want to be labelled as um... I don't know."

Theme 3: The continuing impact of COVID-19

The significant changes that have occurred from the impact of the pandemic on the working environment and pressures faced by the workforce have influenced the way in which health and social care professionals think about wellbeing in a number of key ways. Firstly, several participants who would like to seek support cited the impacts of COVID-19 in creating excessive workloads as a key barrier to accessing help. Secondly the participants indicated that although COVID has had an overall negative effect on wellbeing, it has heightened awareness at both the individual and organisational level.

“It’s very difficult. I think one stressor to mention is that I can’t access the hub because of the time constraints of work.’

“I think we are getting more aware, particularly of mental health, as well as more aware of listening to people’s negativity than before [COVID-19].”

"I've had a few line managers since I started, and the CEO seemed to be much more concerned with staff well being than they were before [COVID-19]."

Theme 4: Awareness and Communication of Resources

Participants expressed that having clear and consistent messages regarding the range of resources available to them and the delivery of these messages were key to ensuring utilisation. Participants noted that although they were aware of the Hub through a number of communication methods, many weren't sure exactly what resources were offered. Additionally, for those that sought support the majority did so at the recommendation or referral of another. Awareness of the Hub was limited especially among third sector or social care employees.

"I know of it [WY Hub], but I don't know really anything it does to be honest."

It’s really hard to know what to click on, so just make it as simple as possible. Just the information... really straightforward, call this number.”

“People went, Oh yeah, I forgot about that [Hub resources] People go blind when it’s out there all the time and forget about it.”

“I have an organisational [third sector employee] email and an NHS email, and it goes to your NHS email, and some people don’t access that email.”

Evaluation of Level 1

Part 2: Evaluation of hub impact on system networks and relationships

Aim

To explore the relational, strategic and system impact of the Hub. With Partnership Working at the heart, the consultation data captured promotional and relational work with those across the partnership contributing toward cultural change.

Methodology

Hub assistants collected consultation data weekly via a template sent out through emails to core Hub team. Data was collated on a monthly basis and included within the NHS reporting data. A qualitative study was also being undertaken to review the nature of relationships, processes and system impact of the hub. This will be reported on later in the year.

Key findings

A total of 1911 people had been reached through relational, strategic and consultation meetings between July 2021 and February 2022 (Table 11). The majority of people reached had been through Hub promotion (n=688; 36%) and place based development (n=373; 20%). Chart 19 outlines the breakdown of consultation data by meeting purpose.

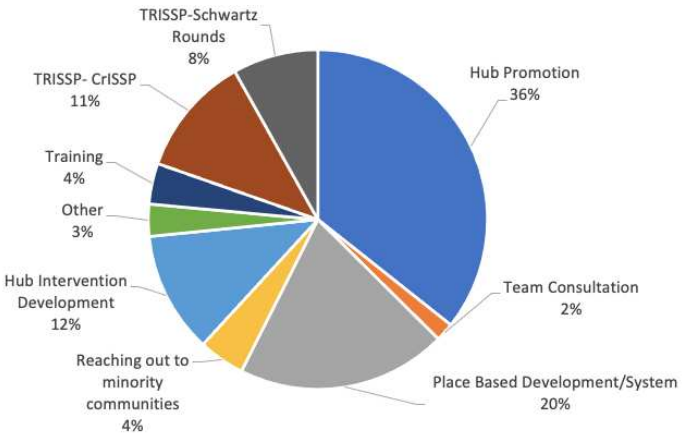


Figure 19

Month	Number of people reached through consultation data per month
July	293
August	79
September	381
October	239
November	255
December	337
January	167
February	176
Total	1929

Table 11

Evaluation of Level 1

Part 3: Evaluation of Schwartz rounds

Aim

To explore the perceived benefits of individual attendees attending Schwartz Rounds with a specific focus on the novel licence arrangement that allows Schwartz Rounds to be hosted across organisations rather than just within.

Methodology

As part of standard licensing agreement, the Point of Care Foundation (PoCF) ask that all Round participants are given the opportunity to complete their standard evaluation form that asks questions assessing the impact of the Round. Participants (audience members) of each Round were asked to complete and return the evaluation in electronic form. The evaluation forms included questions relating to the stories utilised within the Schwartz Round, how the Schwartz Round had impacted on their work, and gave participants an option to provide any feedback or comments on the round. Data was compiled using an Excel spreadsheet returned to the PoCF. Where necessary, the Assistant Psychologist liaised with place-based Schwartz networks to obtain this data. The Assistant Psychologist produced summary statistics following each Round and on a quarterly basis for all Rounds conducted during that time-frame.

Key findings

To date, one ICS Schwartz Round has been run; 78 individuals attended and the topic that was covered was 'When we can't fix it- dealing with uncertainty'. One place-based Schwartz Round has also been run; 47 individuals attended and the topic covered was 'When there isn't enough time, how do we care within limits?' However, the feedback presented below only reflects data from the first ICS Schwartz Round because the data from the second Schwartz Round is not yet available.

Feedback from the ICS Schwartz Round:

Thirty-two (94%) participants 'somewhat agreed' or 'completely agreed' that the stories presented by the panel were relevant to them. Thirty-one (91%) participants 'somewhat agreed' or 'completely agreed' that the round had enabled greater insight into patients'/clients'/relatives' lives. Twenty-nine (85%) participants 'somewhat agreed' or 'completely agreed' to having a better understanding of how they felt about their work. All participants reported the Schwartz round was exceptional, excellent or good (Figure 20).

Participants came from four of the five places, with the majority from Wakefield (Figure 21) and from a wide range of occupations (Figure 22)

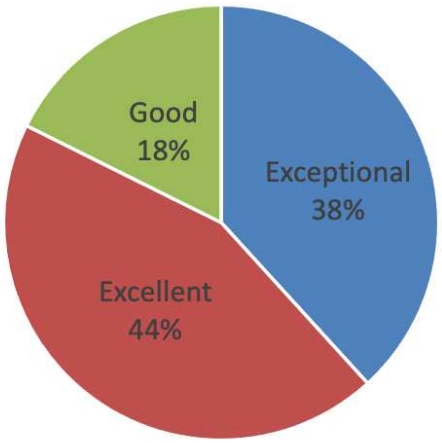


Figure 20

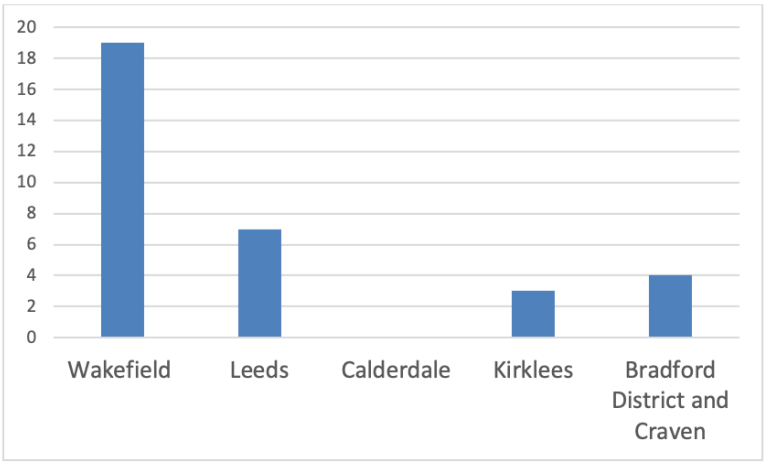


Figure 21

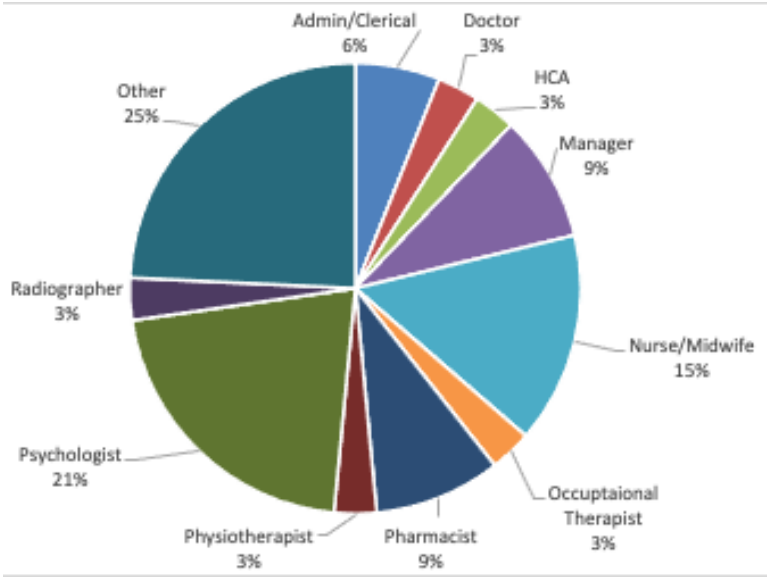


Figure 22

Qualitative Feedback from the first ICS Schwartz round included:

"Thank you, this was my first attendance and it really renewed my faith in people. It was a great reminder of how much care and compassion is held within our sector. "

"I feel like a weight has been taken off my shoulder, expressing how we feel and normalising this has been in itself somewhat healing I feel like a huge amount of connection with others both inside and outside of work has been lost for many- this was a great place to acknowledge and connect."

"The round was really powerful, the stories and reflections shared helped to reframe our narratives and understand our own thoughts and feelings when delivering health care."

Summary

Our data indicated that partnership working facilitated a wide range of conversations to promote the work of the hub, to co-develop interventions and to enable reciprocal knowledge exchange between Hub staff and leaders in different networks.

The data from the Schwartz Round initiative indicates it was well received; it created a safe space to have potentially challenging conversations across different organisations.

There were a number of key findings from the qualitative study which can be used to increase engagement with the hub. Having an environment conducive to accessing the hub services was seen as an important facilitator. The support of managers and other staff members may be crucial in facilitating access to the Hub, as well as the key role of positive discussions between staff, in relation to the benefits of the Hub itself. The recognition of the COVID-19-specific physical and mental health challenges (such as increased workload and the mental health burden of working during a pandemic) were recognised by participants. Reducing such pressures may be an important enabler to staff accessing the hub services, as well as reducing the stigma associated with help-seeking. User acceptance of the hub could be further strengthened with greater emphasis on communicating the benefits of the Hub, as a way of encouraging people to seek help for mental health challenges.

Culture change is challenging and complex, and the work presented here can be regarded as the start of a longer journey. The initial focus of the Hub was establishing the 'responsive' support represented in Level 4 and Level 3. However, moving forwards there will be continued investment in both Level 1 and Level 2 and further data will be available.

Contributors

Dr Kerry Hinsby

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Kerry Hinsby led the overall design of the evaluation from the Hub perspective and findings reported in the following sections: Level 4, part 1; Level 2, part 1 and 2; Level 1, part 2 and 3. She supervised and co-supervised data collection, analysis and reporting for these sections and contributed to the reporting of the findings for Level 3 part 1 and 2.

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Nigel Wainwright contributed to the overall design of the evaluation from the Hub and contributed to the data collection, analysis and reporting in Level 4 part 2 and Level 1 part 3.

Lucie Moores

Assistant Psychologist
WY Mental Health and Wellbeing Hub

Lucie Moores contributed to the overall design of the evaluation from the hub perspective and contributed to recruitment of participants for Level 4, part 1. She contributed to the data collection and analysis for Level 3, part 2; Level 2, part 1, 2 and 3; Level 1, part 2 and 3.

Jenny Bates

Assistant Psychologist
WY Mental Health and Wellbeing Hub

Jenny Bates contributed to the overall design of the evaluation from the hub perspective and contributed to recruitment of participants for Level 4, part 1. She contributed to the data collection and analysis for Level 4, part 2; Level 1, part 3.

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Judith Johnson led the design of the evaluation reported in the following sections: Level 4, part 1; Level 3, part 1; Level 1, part 1. She co-supervised data collection, analysis and reporting for these sections and contributed to the reporting of the findings for the Level 3, part 1 evaluation. She led the compilation of the overall report.

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Chris Keyworth contributed to the design of the evaluation reported in the following sections: Level 4, part 1; Level 3, part 1; Level 1, part 1. He co-supervised data collection, analysis and reporting for these sections and contributed to the reporting of the findings for the Level 1, part 1 evaluation. He provided feedback on the overall report.

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Lucy Pointon led the data collection for the following sections: Level 4, part 1; Level 3, part 1; Level 1, part 1. She led the analysis and reporting for the following sections: Level 4, part 1; Level 3, part 1. She contributed to the reporting of the findings for the Level 1, part 1 evaluation. She provided feedback on the overall report.

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Adnan Alzahrani led the analysis and reporting for the Level 1, part 1 evaluation. He provided feedback for the overall report.

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