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# Evaluating Facilitators and Barriers to Accessing Staff and Volunteer Support Services in the West Yorkshire Health and Care Partnership



The West Yorkshire Health and Care partnership (WY HCP) offers staff and volunteers a range of services designed to support and enhance their mental and emotional wellbeing. This evaluation investigated the factors which facilitate and hinder staff using these services. It was commissioned by WY HCP and completed by the University of Leeds.



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# Preface

Core to our West Yorkshire People Plan; [People Plan: Workforce Transformation \(wypartnership.co.uk\)](http://wypartnership.co.uk), is our focus on looking after our people. By creating an environment of compassion and inclusion and enabling a sense of belonging, we want people to fulfil their potential. In a context of workforce shortages, pre-existing burn-out, high demand and the related unprecedented workload, ensuring our colleagues' wellbeing is of utmost priority. The issues related to COVID-19 have exacerbated this, sharpening our focus on employee health and wellbeing further. Our top priority is to ensure we look after, value and develop these teams and colleagues, whilst we continue to grow the workforce of the future.

Our 'looking after our people alliance' (LAOPA) is a group of cross-sector professionals (social care, voluntary sector, care homes and the full breadth of health including primary, acute and mental health) representing our five places, plus expertise from our mental health and wellbeing hub and system and leadership development team. Together, the group provides leadership for our cross-system work on promoting health and wellbeing. The group also oversees the use of the enhanced occupational health funds for 2020/21 and 2021/22 which is being invested in a number of place-based initiatives and also some system wide projects including focus on long-COVID, menopause, and compassionate leadership. These scaled up offers are available to all colleagues across our system.

We are undertaking a longer-term evaluation, as part of our 2020/21 enhanced occupational health funding to understand the impact of individual projects, as well as separately using the funding to explore the barriers in accessing health and wellbeing offers. Together, this will give us a full picture of how intelligence can be used to drive continual improvement and review recommendations for the future about what would make a real positive difference for our colleagues.



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# Background

Healthcare professionals suffer from disproportionately high levels of stress and burnout, the psychological syndrome characterised by emotional exhaustion and disengagement (1). Burnout and stress levels have further risen in response to the onset of the Covid-19 pandemic, particularly in more junior staff members (2). One in three trainee doctors and 34% of all NHS staff now report suffering from burnout (2, 3), and 43% of NHS staff describe feeling unwell due to work-related stress (3). Evidence from previous pandemics suggests this increase is likely to persist moving forwards (4).

The higher levels of burnout and stress faced by health and social care staff (2, 3) has led to an improved offer of interventions by NHS services to improve wellbeing within the workforce. Such interventions have generally focused on increasing the support available for staff or improving individual coping skills rather than reducing workplace stressors (5). Whilst evidence suggests that such interventions are effective in improving staff wellbeing (6), research has also pointed to the benefits of making changes at an organisational level (7).

By tackling cultural, social, practical and systemic issues, the health and social care sector can support the uptake of sustainable and effective health and wellbeing interventions (7). However, in order to help make these improvements, more evidence is needed to understand the barriers and facilitators which influence the likelihood that staff will access the support services provided.

The present evaluation explored these issues in staff and volunteers within the West Yorkshire Health and Care partnership (WY HCP). The WY HCP is made up of equal partners from across health and care sectors, including the NHS, local councils, social enterprises, hospices, Healthwatch, the voluntary and community social enterprise sector (VCSE) and the education sector. It includes a workforce of around 110,000 across NHS and local authority, and approximately 300,000 unpaid carers. The VCSE sector employs around 43,100 full time equivalent posts. On top of this there are an estimated 147,000 regular volunteers. The WY HCP offers a range of wellbeing support services to staff and volunteers, but uptake of these has been below expectations. As such, this evaluation investigated wellbeing culture within the WY HCP and identified the barriers and facilitators to accessing the health and wellbeing offers which are available.

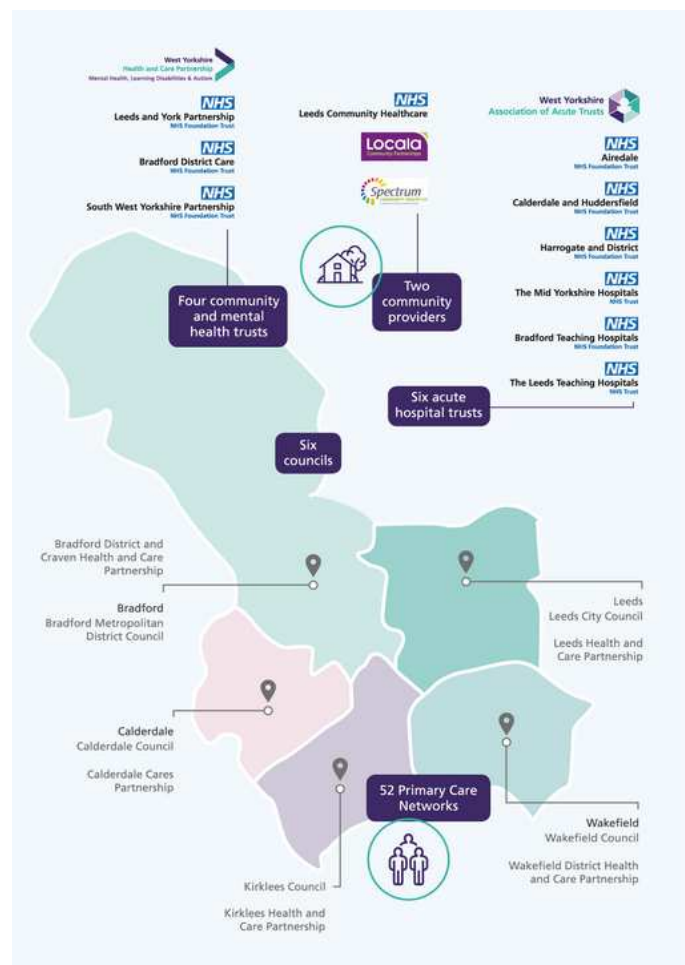


Figure 1. Health and Care Organisations in West Yorkshire, not inclusive of social care and VCSE voluntary sector

# Executive summary

The West Yorkshire (WY) Health and Care Partnership (HCP) serves healthcare organisations, social care, local authorities and organisations within the voluntary, community and social enterprise (VCSE) sector. Following the onset of the Covid-19 pandemic, pressures on staff and volunteers within the WY HCP and in similar organisations nationwide increased significantly. These increases have been reflected in large survey data indicating growing levels of work-related stress and burnout, the syndrome characterised by emotional exhaustion and disengagement.

To address these challenges, the WY HCP has increased the number of staff and volunteer support services it offers. These services vary widely, and include a one-to-one therapy service, Schwartz Rounds, neurodiversity coaching and menopause awareness webinars. However, uptake of these services has been below expectations and there are concerns that staff who would benefit from accessing them are not.

The present evaluation aimed to identify the reasons why some staff and volunteers are not accessing support services. We used a mixed-methods approach, first conducting interviews with staff and volunteers to elicit facilitators and barriers which influence service access, and then using this information to create a quantitative survey. The quantitative survey aimed to test whether the number of facilitators and barriers which were reported were linked with service awareness and service access.

The qualitative interviews identified 22 barriers and facilitators, which reflected 20 underlying factors influencing likelihood of service awareness and access. These were diverse, including location of services, managerial support, workplace wellbeing culture and effectiveness of organisational communications. A 46-item survey was then generated which included 23 barriers and 23 matched facilitators. This survey was distributed to WY HCP staff and volunteers, along with questions about the number of services which staff and volunteers were aware of, and the number they had accessed. Analyses were conducted on this data, which indicated that a greater number of facilitators was associated with greater awareness of services, and that a greater awareness of services was associated with greater uptake. The findings also indicated that a greater number of facilitators was associated with a higher likelihood that respondents would have accessed at least one service.

These findings indicate that there are steps organisations can take to improve staff and volunteer awareness of services, which could lead to concomitant increases in uptake. In particular, organisations should deliver consistent, clear and regular information to their staff about the services that are available. If confidentiality is offered by these services, that should be made clear on all advertising materials. Access routes should be simple, not relying on complex technology or involving complicated pathways. Personal recommendations are particularly valuable, so organisations should encourage managers and staff to provide recommendations to their colleagues where appropriate. Furthermore, advertising materials should aim to be representative of the staff groups they are serving, in terms of gender and ethnicity. Services should be available both online and in-person and managers should be encouraged to offer their staff flexibility to enable them to attend sessions.

# Phase 1: Eliciting Barriers and Facilitators



## Aim

To elicit the barriers and facilitators to staff and volunteers accessing wellbeing support services.

## Methodology

Phase 1 of the evaluation used a qualitative exploratory research design. A semi-structured interview schedule was developed, consisting of open-ended questions with additional probe questions. The interviews aimed to elicit information regarding participants' views of personal wellbeing in their workplace. The interview schedule covered 1) wellbeing culture in the workplace, 2) awareness and access of wellbeing support services, and 3) the barriers and facilitators to healthcare workers recognising the need for and seeking help.

Recruitment comprised of advertisements being disseminated via email, posters and social media announcements in the organisations served by WY HCP. Participants were directed to contact the research team directly if interested in participating. The research team screened interested participants by first checking 1) that they worked or volunteered in one of the following sectors or organisations: NHS, Local authority, Primary Care, Social Care and VCSE partners and 2) that this work or volunteering was based in West Yorkshire. We also asked if participants had ever used the wellbeing hub



or any other occupational wellbeing support services, and used responses to recruit a balanced number of participants who had and had not accessed these services. Additional purposive sampling was utilised to recruit participants from a range of professional roles, genders and ethnicities.

Interviews were conducted between February 2022 and May 2022. Participants were interviewed remotely and interviews were recorded and transcribed verbatim via Microsoft Teams. Participant demographics were collected during the interview which included gender, ethnicity, age group, occupational group, sector and job role. Participants received a £30 shopping voucher for participating as a gesture of thanks for their time.

A directed content analysis was used to code the transcribed data and group findings into categories which were based on the interview topics. These categories were collapsed into explanatory themes and mapped on to a matrix containing the Theoretical Domains Framework (TDF). The TDF is an integrative framework which identifies the different factors which influence health professionals' behaviours. The TDF enabled the research team to characterise and understand the barriers and facilitators that may influence behaviours in healthcare workers.

## Key findings

Twenty participants took part in the interviews, they included 12 who identified as women and 8 who identified as men. The mode age category was 31-40 years and the job roles identified included a range of clinical, administrative and professional roles. There were a total of 12 participants that had not accessed wellbeing support services through their workplace and 8 participants who had accessed these services.

Eight theoretical domains emerged that explained the barriers and facilitators to staff accessing wellbeing support services; 1) Knowledge, 2) Skills, 3) Social Professional role and Identity, 4) Beliefs about consequences, 5) Environmental context and resources, 6) Social influences, 7) Emotion, 8) Behaviour regulation (see Figure 2).

### 1: Knowledge

One barrier and one facilitator was described in relation to the domain 'knowledge'.

#### Knowledge and awareness (barrier)

Participants described a lack of knowledge or awareness of available support resources as being a barrier. They also described that if they did have an awareness of support being available it was superficial and limited, and they did not know how to initiate access.

"You know, they advertise it. I would say, if I didn't know about it, it would be hard for me to find it right?" (P4)

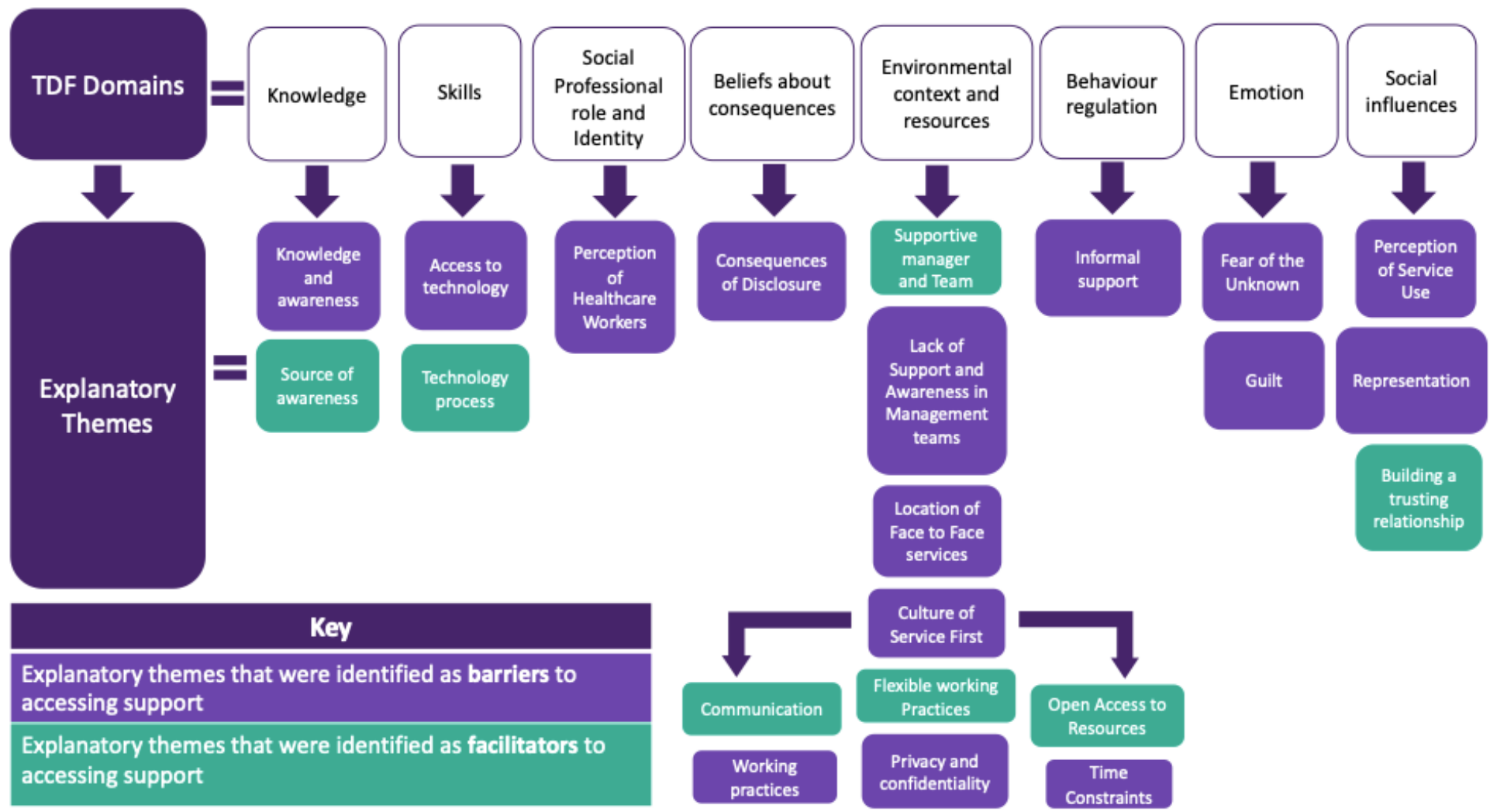


Figure 2. Barriers and facilitators to help seeking interpreted via the Theoretical Domains Framework (TDF)

“There might be like the odd thing. Uh, but I couldn't tell you what it was. I think it is normally the kind of thing like I'd gloss over unless I was feeling at that point like I needed to access it. Yeah, I would just kind of not really clock it.” (P12)

## Source of awareness (facilitator)

Healthcare workers described the source of knowledge as being an important driver in compelling them to seek support. If the recommendation or information about a wellbeing service came from a trusted source such as a colleague, especially if that colleague had accessed it previously, they felt more confident in seeking or accessing support themselves.

“If somebody who has accessed the service, if there was again some kind of in in team meeting so if somebody would share their experience. To make it, yeah, again, to understand the process of stuff and maybe bring in some teams that have view of various services.” (P20)

“So I think having people like colleagues from Chaplaincy. Uh, but also sort of peers as well? I had heard the term champions for this sort of health and wellbeing... and just people within your own team who are a safe pair of ears. And that, you know, its confidential, they're not going to talk to your line manager unless you know there's some real concerns. Uhm, but would you know go. Why did you wait? You try this. I've heard that there's this or something like that.” (P7)

## 2: Skills

One barrier and one facilitator was described in relation to the domain ‘skills’.

### Access to technology (barrier)

Not being able to use or access a computer or device to access support services was considered a practical barrier to accessing wellbeing support. Furthermore the complicated process of seeking support online was also discussed as a barrier; participants noted that they didn't always know how to navigate the online resources or know where to look for them.

“Then we have a bunch of staff, a section of staff that they don't have access to IT. That's a whole different world. The biggest barriers finding it. On the Internet and I suppose. For those who don't have access to IT within the hospital.” (P4)

“I think some people don't even have access or personal access to a computer.” (P11)

### Technology process (facilitator)

Participants described the need for ‘simplification’. A key facilitator in enabling workers to access wellbeing support was to ensure that the process of seeking support was

straightforward and involved simple online or telephone processes.

“Just making it really simple and easy for them to go to and the way to do that is just taking things [resources] to them.”(P2)

### 3: Social Professional Role and Identity

One barrier was identified in relation to the domain ‘social professional role and identity’.

#### Perception of healthcare workers (barrier)

There was a perception held by some participants that healthcare workers are ‘super human’ and that ‘they just get on with it’. This acted as a barrier to help-seeking, leading participants to keep working despite struggling with their mental health.

“And that's the message I think we need to get out and all the recognition that you know. So we're not supermen and super women. You know we're good, but we have needs as well and sometimes those needs are bigger than advertised because of the caring that we're doing.” (P10)

“And two is almost like accepting that you're not superhuman.” (P4)



## 4: Beliefs about consequences

One barrier was identified in relation to the domain 'beliefs about consequences'.

### Consequences of disclosure (barrier)

Participants described that they feared that if they disclosed a wellbeing concern this may have an impact on their career. Participants felt that they may not have the same opportunities to progress if senior management were aware of wellbeing issues.

"I mean, I'm not saying there would be any repercussions if you if you raised it with the manager, but I just feel like potentially like you say, there's kind of formal and informal conversations about mental health." (P14)

"I only recognize a lot of people and they're not in that position, though they don't feel assertive and they're worried about the impact it will have on their on their own careers, really." (P10)

"I wanted to be, I wanted to say what I wanted to say without the fear of any reprisal occurring." (P4)

## 5: Environmental context and resources

A total of six barriers and four facilitators were identified in relation to the domain 'environmental context and resources'.

### Culture of 'service comes first' (barrier)

Participants described an organisational culture of the 'service comes first', especially in clinical environments. This was reported as a key barrier to accessing support. Participants said that they felt they could not prioritise their own wellbeing needs and instead felt 'pressure' to continue working.

"When I was clinical, it was not very compassionate. People were nice. Don't get me wrong. But then if I had like 3, I wanted to kind of change my hours to fit around their work life balance 'cause I was having a lot problems at home. It was a well known because service comes first, which I strongly disagreed with." (P6)

"And again, I'm not really speaking for myself, but for my colleagues, the clinical frontline. They're absolutely rammed and under this kind of like moral duty that they have and where they feel like they can't take time off because it's then affecting somebody else." (P12)

### Communication (facilitator)

Effective communication methods were described as a facilitator, in particular organisation-wide communication. Participants said that they felt supported and better

connected with their workplace if they were informed about organisational wide changes, event or news.

“I think it is having more open, open communication about it face to face communication. Letting people know a bit more about the services there.” (P19)

“They've since done as the pandemic has continued them, daily emails have dropped down to three times a week, and now it's a weekly update and in it it's again. It's not necessarily just wellbeing, but there's always a bit in there about look after yourself to make sure you can take care of yourself, et cetera, et cetera, and highlight resources as appropriate. It's nice to see. I think it's. I think it means a lot to me. Definitely when I'm reading it, I don't know what other people think.” (P6)

## Time constraints (barrier)

Participants described feeling under significant time constraints and pressures to deliver a service. Lacking time meant they were unable to seek or access support when necessary as this cut into their already busy schedule. Participants also indicated that they did not feel able to access support in work time and that they were not willing to sacrifice their already limited personal time.

“But some of them are really difficult to access. Some of them you have to access in your own time, and if and if you're working shifts and you only have nights off, you know. 7:00 PM, while 7:00 AM and your counselling session or the mental health support is only available, you know 9 till 5”. (P2)

“And again, I'm not really speaking for myself, but for my colleagues, the clinical frontline. They're absolutely rammed and under this kind of like moral duty that they have and where they feel like they can't take time off because it's then affecting somebody else.” (P12)

## Supportive manager and team (facilitator)

Having a supportive manager and team enabled participants to discuss their wellbeing concerns and seek support in an understanding environment.

“And also my manager has, you know provided Uh, an environment we're in. He is ready to listen. Come to with any problems you're going through, including mental health and wellbeing... in that he has reassured us that, you know there will be support provided. So it's a very easy conversation with him.” (P15)

“And like feeling like they want to connect on like a human level rather than just kind of doing the bare minimum and just being another person on their job list. I've personally felt really supported, and particularly by my current manager, after my return to work.” (P12)

## Lack of support and awareness in management teams (barrier)

Participants indicated that having an unsupportive manager and a manager that was unaware or uninformed about available resources was a significant barrier to accessing wellbeing support resources.

“I would say that you know, personally to speak, speaking proactively and approaching something like this with my line manager isn't something that would you know, I would feel that great about.” (P14)

“And the majority of time was without any support from a manager or, you know, a team leader. Uhm. So really that was the point where I thought about the wellbeing services where I first considered contacting the wellbeing services, but I haven't done.” (P13)

“So some feedback. I had that good relationship with my manager, whereas other people in the team, they were like, we don't feel like being supported enough, etc.” (P6)

## Open access to resources (facilitator)

Participants described that having access to both local and remote services was an important factor in accessing support. Having the choice to attend in-person services or to access remotely (via telephone or online) gave participants better flexibility and increased the likelihood that they would feel able to use the services.

“Having a number. That's readily accessible, like you know. So if they won't be interested, at least there's a number to say. Oh well, there'll be one to one conversations available if they if I don't want to attend the group. So I think a number is very important.” (P15)



## Location of face to face services (barrier)

Participants described wanting to attend in-person services but this was not always feasible or possible due to their location. In-person services were not always located close to their workplace and a long travel distance was a significant barrier. The location of services presented a particular barrier of not being able to access services in work time and presented the issue of having to negotiate access outside of working hours, which was not always feasible or desirable. Conversely, for some participants a face-to-face service that was hosted in their workplace was also undesirable as they wanted some mental distance from work.

“Some of the sessions taking place in like a hospital setting like 'cause. They have some community rooms; a lot of the feedback was that people didn't want that. They didn't want to receive that care in there like work setting because that was where they were the carer. So they wanted like a break from that location. They wanted it to be somewhere different. They didn't want to feel like they were at work.” (P1)

## Working practices (barrier)

Participants described some working practices as a barrier to seeking or accessing support resources. Having a lack of autonomy over their diary or working practices, especially if they were based in a clinical environment, seriously impacted their availability to access resources.

“I think my opportunity, my only opportunity would be to access those during my work time and if I was to do things face to face or things because of the schedule that I would have when I'm not working it, it means that I'm caring for my son and so I wouldn't be able to access such things.” (P8)

“Practical aspects is an interesting one. I think people who work clinically, so like you're a doctor or your physiotherapist or whatever, they are not going to have as much control over their diary. To book time to go and get mental health support.” (P6)

## Flexible working practices (facilitator)

Participants described that having autonomy over their diary and their working practices allowed for flexibility in their availability. In having control over their diaries, participants felt that they were able to use their time more effectively, which included scheduling in time to improve their wellbeing. Flexible and remote working practices were noted to have increased since the outbreak of COVID-19, which improved participants' ability to access services.

“You can access private support in work time like we can do flexible working to make that happen” (P12)

“Myself I had it quite easy, but then you know a lot of it becomes about availability to access these services, and myself I have quite lot of flexibility in my schedule to actually achieve that.” (P3)



## Privacy and confidentiality (barrier)

Participants described confidentiality as a significant concern when seeking and accessing support services. A key aspect their concern regarding confidentiality was a written record of their wellbeing issue existing and the potential for colleagues to discover this. Having total anonymity when using services was also desirable; a service based in their organisation may pose the risk of being supported by a colleague.

“We just, you know, professional. We want to make sure that your private life is kept private. And if somebody sees me go into those pop up booths and then, Oh my, oh, she might be going through something 'cause obviously that's like psychologists are there and also basically it's mental health.” (P15)

“Obviously you want that kind of level of privacy and the things that they want to be discussing. You'd probably want to know an outside organisation is doing that, you know? Because you want that level of power over privacy as well.” (P3)

## 6: Social Influences

A total of two barriers and one facilitators were identified in relation to the domain ‘social influences’.

### Negative perceptions of service use (barrier)

Many participants felt key wellbeing support services such as counselling were reserved for clinical staff, and similarly that local mental health services were reserved for patients. Conversely clinical staff expressed that they felt that if they were perceived as needing mental health support this would negatively impact others' perceptions of their competency as a clinician. Additionally participants discussed feeling as though there is a hierarchy of need, and they shouldn't access services unless they had significant mental health issues as the services were needed most for these individuals.

“I think the majority of the things [resilience training resources] I could find were clinical based and again that brings back, well to what I said at the beginning that this role is very unique. Nobody really planned for these services.” (P13)

“Particularly again for clinical people, there's a lot of judgment attached to your clinical competencies and if you are, you know if you then disclose that y'all have things, some real mental health problems. What reflexion does that have? So I think we absolutely need to create a place where that safe conversation can be had and I think we do that with that peer to peer support and we don't necessarily have a hierarchical approach to wellbeing.” (P7)

“I think it's throughout the NHS social care, because services are so stretched, you have to prioritize those most in need and that then has like a trickle down effect on the people working there. And this idea that you're not unwell enough to access those services.” (P1)

## Representation (barrier)

Participants described a lack of representation as a key barrier to accessing support. They emphasised that having a lack of representation from your ethnicity, gender or cultural group within the support resources deterred them from accessing support. The need to be able to relate to someone from a similar background was described as crucial; this point was particularly important to participants from minority backgrounds

“An increase in representation so that more people, for example, if you're a man, you are in your in your preferred speak to another man or your woman and you look for speak to other woman or you, you know you've come from a certain background and you prefer to speak to someone from a certain background.” (P14)

## Building a trusting relationship (facilitator)

Participants described ‘trust’ as a crucial element in their decision to seek or access support. Having the trust in both their management team and the organisation was imperative when deciding to use workplace based services. A trusting relationship was also key to support service use, healthcare workers needed to have trust in their therapist or service/resource provider to enable its use.

“I would actually say it quite depends on the relationship you have with your manager. So I would actually say it [location named] is actually having that open and honest relationship with him, so I could actually just say it to him. Yeah, things aren't too good.” (P17)

“I do think it will involve time and little trust too because otherwise they wouldn't be going to services like this [counselling] really.” (P16)

“It you know, I felt you could kind of trust her [management colleague] in that way. And then and then she suggested somebody and If she knew who she thought might be useful and I accessed that.” (P14)



## 7: Emotion

Participants identified two barriers relating to the domain of 'emotion'.

### Fear of the unknown (barrier)

Participants discussed their fear of the unknown when considering accessing support resources. In particular they feared not knowing what was involved in their chosen support method or not knowing the process of accessing support such as 'what would happen to them during support?', 'how long would it take?' and 'what would happen after they had accessed support?'.

"People don't know what it entails, so they just kind of go by hearsay of what we think it might be, because nobody knows what it actually is. There's a fear of the unknown." (P6)

"I don't wanna keep saying fear again and again but a little fear of the unknown. You know, it's like more unknown and so I suppose it's kind of maybe that's a barrier as well." (P14)

### Guilt (barrier)

Participants described their feeling of guilt when discussing the access of support resources. A key concern was that they would be a burden on an already stretched service. Having knowledge of the impact that mental health has on the healthcare sector influenced participants' decisions to access resources.

"Because all like services are really scarce and you know that all kind of support services have a bit of a tier system in terms of who accesses them. So like. It should be prioritized for people who are like they're like really, really struggling to kind of go about their day-to-day, or they've got like a diagnosed mental health condition. Or they've you know, just gone through. Some are really difficult life situation and you would want it to be available to them, whereas if you're just like. You know it's a pandemic. I know a lot of people that use it and it's not because they're like I'm really struggling is because they use it as a way to manage their wellbeing and so then I felt a bit less kind of guilty for like taking up a space. And so I used it a couple more times after that." (P1)

"Yeah, yeah, I see a bit more guilt. I think for me to go out and go on and I can go to services, it takes time out of my day. So it's great that I can take time out of my day, but actually I'm not, I'm there to support everyone else." (P19)

## 8: Behavioural regulation

One barrier relating to the domain 'Behavioural regulation' was identified.

## Informal support (barrier)

Participants described the use of informal resources such as relying on family or friends for support. The use of informal support resources negated their need for formal or professional services. A variety of preferences for informal resources were discussed including the preference for these types of resources not having a 'written record' and having an existing trusting or familiar relationship which is easily accessible.

“So I think for me it's friends or family if Yeah, if I ever had to discuss anything I will discuss it with friends and family. Because it's more familiar.” (P19)

“Yeah. Yeah. So my friends were really always been really supportive. And my husband. Uhm yeah, my my mum. I've you know, I would bring her a lot. So yeah, I think I've always been. Like this is the thing I'm I'm not one for not accessing support. I guess I'm just not one for accessing workplace support. I think it's a trust thing. I don't trust it. I don't trust the reasons behind it.” (P12)

“That it was difficult to sort of go. Oh yeah, 10:30 on a Tuesday morning. We can sit and we can talk about these. You know, these really deep rooted emotional things that have been bothering me. Second, just regurgitate them at 10:30 on a Tuesday morning. That that's what I really struggles with. Whereas informal family support somebody just there, you feel in a particular way and it. Yeah. So I think what I'm trying to describe it's that it's that instantaneous thing.” (P7)

## Survey Creation Process

A total of eight domains were determined, which resulted in the identification of 22 key barriers and facilitators to accessing support. We scanned these barriers and facilitators to assess how many separate underlying 'factors' these captured. We determined that two factors were reflected as both a barrier and facilitator within the dataset (these were 'access to technology (barrier)' with 'technology process (facilitator)'; and 'working practices (barrier)' with 'flexible working practices (facilitator)'). As such, the 22 identified barriers and facilitators reflected a total of 20 factors.

For the remaining factors which were reflected as only a barrier or facilitator within the dataset, we created an inverse version of each (i.e., where the item was identified as a barrier, we created a facilitator version) to ensure balance in the valence of the survey items.

One factor ('representation (barrier)') was divided into two items in order to capture views of representation about both gender and ethnicity separately. These items were then phrased both positively (as a facilitator) and negatively (as a barrier). A second factor 'perceptions of service use' was also divided into two items in order to capture opinions on 'stigma' and 'priority of use'. Each of these items were phrased positively (as a facilitator) and negatively (as a barrier). A further two items were then added to capture experiences relating to the Covid-19 pandemic.

In total, this process produced 46 items for the survey (Table 1).

Table 1

Items generated from the qualitative analysis for the quantitative survey

Item number	Item	Domain/factor
1	I am knowledgeable about a range of support services and resources offered to healthcare staff and volunteers	Knowledge/ Knowledge and awareness
2	I believe I could make time in my working hours to access support services for healthcare staff and volunteers	Environmental context and resources/ Location of Face to Face services
3	I don't have the time to access staff and volunteer support services	Environmental context and resources/ Time constraints
4	I would feel uncomfortable discussing my wellbeing concern with my manager	Environmental context and resources/ Lack of Support and Awareness in Management teams
5	I am unfamiliar with the support services and resources available to healthcare staff and volunteers	Knowledge/ Knowledge and awareness
6	If I were to access support services I would feel pressured to do so outside of working hours	Environmental context and resources/ Location of Face to Face services
7	People of my ethnicity are not represented in the staff who work in the support services, or featured in the resources they provide	Social influences/ Representation
8	my colleagues have recommended support services to me	Knowledge/ Source of awareness
9	I have supportive colleagues with whom I can have open and honest conversations	Environmental context and resources/ Supportive manager and Team
10	I would be comfortable with my employer or organisation knowing about my wellbeing concern	Beliefs about consequences/ Consequences of Disclosure
11	People of my ethnicity will work within the staff support services, and be represented in the resources they provide	Social influences/ Representation
12	my colleagues have never suggested I could access a support service	Knowledge/ Source of awareness
13	The process of accessing support is too long or complicated	Skills/ Access to technology
14	I am concerned about my employer or organisation knowing about my wellbeing concern	Beliefs about consequences/ Consequences of Disclosure
15	My working practices are flexible and allow me to decide exactly how I use my time	Environmental context and resources/ Flexible working Practices
16	People of my gender will work within the staff support services, and be represented in the resources they provide	Social influences/ Representation
17	I feel guilty about the idea of accessing support services	Emotion/ Guilt
18	The process of accessing support is simple and easy	Skills/Technology process
19	I don't have supportive colleagues with whom I can have open and honest conversations	Environmental context and resources/ Supportive manager and Team
20	I have enough time to access support services	Environmental context and resources/ Time constraints
21	People of my gender are not represented in the staff who work in the support services, or featured in the resources they provide	Social influences/ Representation
22	I would prefer to use informal support such as family or friends over accessing professional services/resources	Behaviour regulation/ Informal support
23	My manager is approachable and I feel comfortable discussing any wellbeing concerns with them	Environmental context and resources/ Lack of Support and Awareness in Management teams

Table 1 (continued)

Items generated from the qualitative analysis for the quantitative survey

24	I would feel stigmatised if I were to access support services or resources	Social Influences/ Perception of Service Use
25	I think that there is a hierarchy or priority to accessing support services (e.g. priority for clinical staff or those with significant wellbeing concerns)	Social Influences/ Perception of Service Use
26	I do not have flexibility in my working practices which restricts my ability to decide how to use my time	Environmental context and resources/ Working Practices
27	There is a lack of trust between staff/volunteers and the management in my organisation	Social influences/ Building a trusting relationship
28	I do not feel like there is any stigma attached to accessing support services or resources	Social Influences/ Perception of Service Use
29	I prefer the idea of using formal support services instead of speaking with family or friends about my problems	Behaviour regulation/ Informal support
30	I feel comfortable about the idea of accessing support services	Emotion/ Guilt
31	My organisation regularly communicates to its staff and volunteers about support services and resources	Environmental context and resources/ Communication
32	There are good relationships between workers and managers in my organisation, including a high level of trust	Social influences/ Building a trusting relationship
33	I believe support services would treat all staff and volunteers who try to access them equally	Social Influences/ Perception of Service Use
34	I am not concerned about privacy and confidentiality when discussing my wellbeing at work	Environmental context and resources/ Privacy and confidentiality
35	I am confident about the process of accessing support	Emotion/ Fear of the Unknown
36	My organisation rarely shares information with employees about the support services which are available	Environmental context and resources/ Communication
37	I am fearful of what will happen to my confidential information (e.g. if I disclose a mental health concern)	Environmental context and resources/ Privacy and confidentiality
38	I am reluctant to access support as I am unfamiliar with the process	Emotion/ Fear of the Unknown
39	My organisation puts priority on service delivery over my wellbeing	Environmental context and resources/ Culture of Service First
40	In my organisation, healthcare workers are viewed as 'superhuman' people who 'just get on with it'.	Social Professional role and Identity/ Perception of Healthcare Workers
41	My organisation has a greater understanding of the importance of wellbeing since the outbreak of Covid-19	Covid-19 Statement
42	My organisation prioritises the wellbeing of its staff	Environmental context and resources/ Culture of Service First
43	I have had positive experiences of accessing different types of staff and volunteer support services in the past	Environmental context and resources/ Open Access to Resources
44	My organisation recognises that employees are human and need emotional support	Social Professional role and Identity/ Perception of Healthcare Workers
45	I have had negative experiences of accessing different types of staff and volunteer support services in the past	Environmental context and resources/ Open Access to Resources
46	My organisation seems to have learned nothing about staff wellbeing during the Covid-19 pandemic	Covid-19 Statement

# Phase 2: Evaluating Barriers, Facilitators and Service Awareness and Access



## Aim

To report trends and patterns in awareness and use of support services and investigate how these are associated with demographic variables, facilitators, and barriers.

## Methodology

We used a cross-sectional quantitative questionnaire which was hosted online on the survey platform Qualtrics.

A similar participant recruitment strategy was used as that described in Phase 1, with advertisements disseminated via email and social media in the organisations served by WY HCP. However, in Phase 2, rather than contacting the research team, participants were directed to the online survey where they read the Participant Information Sheet, provided Informed Consent and continued to the survey items. The survey interface was optimised for both desktop and mobile platforms to enable participants to easily respond either in their workplace, at home, or wherever was convenient for them. Participants received a £5 shopping voucher for participating as a gesture of thanks for their time.

The survey gathered information regarding participant demographics, service use, service awareness and facilitators and barriers. Demographics recorded included:

- Age (recorded in categories)
- Gender
- Ethnicity
- Disability
- Caring responsibilities
- Sector (NHS; VCSE; Social care; other)
- Organisation
- Role

Participants were asked if they had used any occupational wellbeing services, and if so, to tick which services they had accessed from a list of available services. They were also asked to tick which services they were aware of from a list. Finally, they were asked to mark whether they agreed with the 46 statements reflecting barriers and facilitators to accessing services, using a 3-point scale ('agree', 'disagree', 'neither agree nor disagree').

Quantitative responses were analysed using descriptive statistics and presented using figures and graphs to allow for visual analysis and the identification of trends and patterns. For the purposes of inferential analyses, demographic variables were collapsed to form binary variables. Service access and service awareness were investigated both as continuous variables (indicating the number of services participants were aware of/had used) and as binary variables (indicating any versus no awareness/access). First, correlations were conducted to assess for the presence of relationships between demographic variables, facilitators, barriers and service awareness/use. Due to the nature of this work being exploratory, p-values were not adjusted for the number of comparisons made for the analysis. The following variables were included in the correlations: Demographic variables [which were gender (male-female), caring responsibility (yes-no), ethnicity (white-non-white), disability (yes-no)], facilitators (total number), barriers (total number), services accessed (total number) and awareness of services (total number).

To further understand the associations between barriers and facilitators with both awareness of, and access to, services, multiple linear regression analyses (where the outcome was total number of services) and logistic regression analyses (where the outcome was any service awareness/access versus none) were performed. The regression analyses were bootstrapped (to 5000 samples), to compensate for non-normal distribution of some of the variables and to enhance the robustness of the conclusions. Barriers (total number) and facilitators (total number) were entered into these regressions as the independent variables.



# Results

## Participant characteristics

A total of 162 valid responses were received, with two mode age categories of 41-50 and 51-60 (Figure 3). Thirty-six (22%) participants identified as men, 124 (77%) identified as women, 1 (0.6%) identified as non-binary and 1 (0.6%) preferred not to say

The majority of participants (137; 85%) were White British. Other participants were Indian (Asian or British Asian) (5; 3%); African (Black or Black British) (3; 1.9%); White and Black Caribbean (Mixed Heritage) (3; 1.9%); Caribbean (Black or Black British) (1; 0.6%); Pakistani (Asian or British Asian) (2; 1.2%); from another Asian or British Asian background (1; 0.6%); White and Asian (Mixed Heritage) (1; 0.6%); or from another ethnic group not listed (2; 1.2%). Thirty-eight (24%) participants reported having a long-term illness or disability, 123 (76%) reported no disability and 1 (0.6%) preferred not to say. Most participants (87; 54%) reported having no caring responsibilities. The remainder reported caring for children/young people (46; 28%), other relatives or friends (18; 11%) or both (10; 6%).

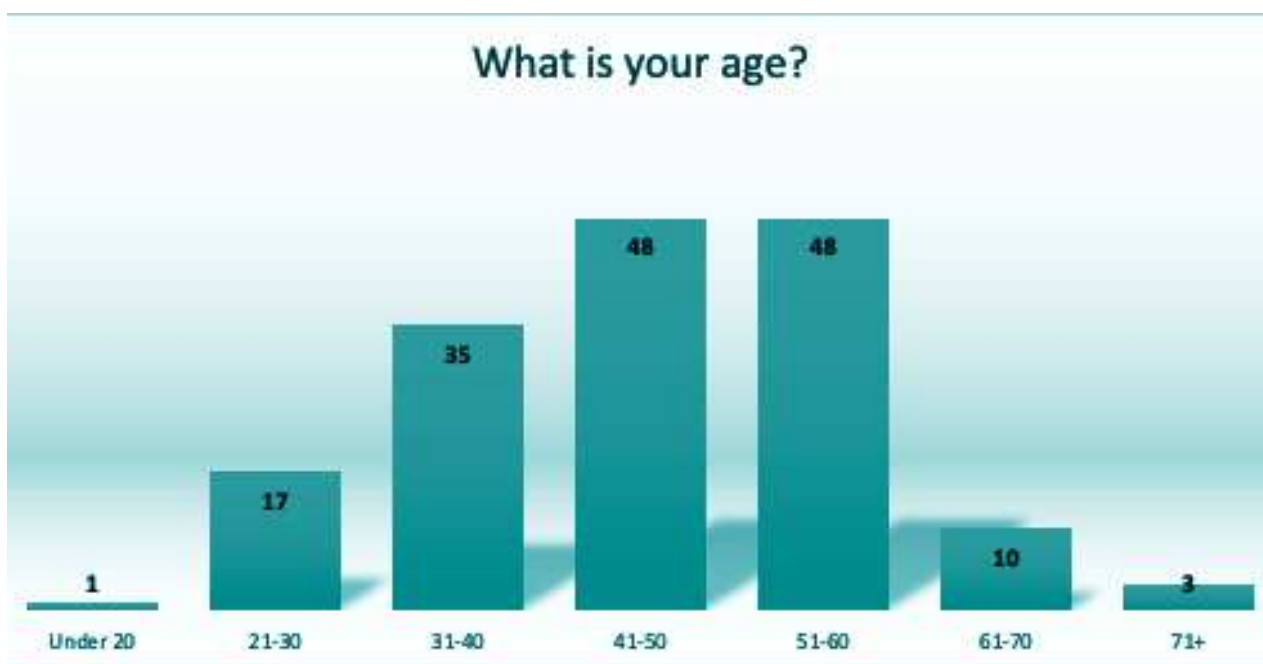


Figure 3. *Participant age categories*

Most participants worked in the NHS (127; 78%), followed by social care (13; 8%) and the VCSE sector (11; 7%). Ten participants (6%) reported they worked in 'another' sector and data was missing for 1 (0.6%) participant. Other specified sectors included hospices, public health and the council.

The largest proportion of participants worked in primary care (Clinical Commissioning Group; CCG) (60; 37%), with remaining participants working across a range of organisations (Figure 5).

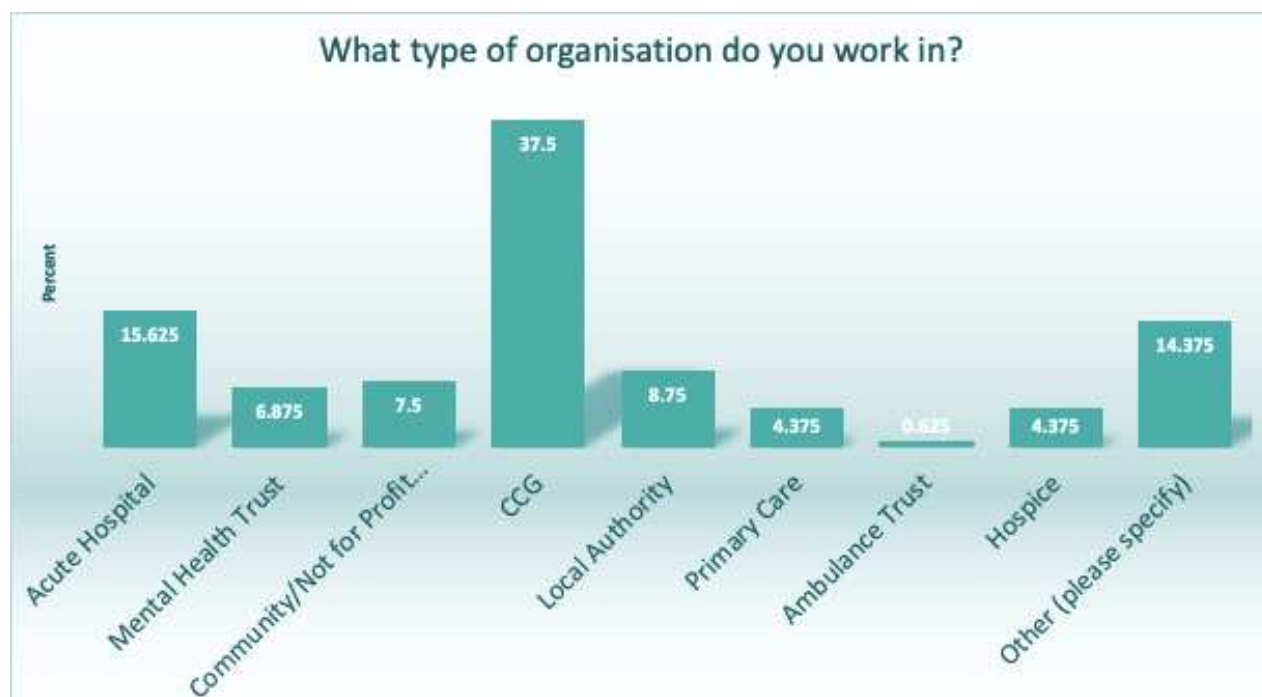


Figure 5. Organisations participants reported working in

## Facilitators, Barriers and Service Awareness and Use

Participants reported experiencing between 0 and 22 facilitators, with a mean of 13.0, and between 0 and 18 barriers, with a mean of 4.9.

Participants reported being aware of between 0 and 9 support services, with a mean of 2.07, and reported having accessed between 0 and 4 support services, with a mean of 0.68. Twenty-five (15.4%) of participants reported not being aware of any of the support services, and 137 (84.6%) reported being aware of one or more. Eighty-eight participants (54.3%) said they had not accessed any of the available support services, and 74 (45.7%) said they had accessed one or more.

## Correlations

A significant correlation was found between facilitators (total) and barriers (total) ( $r(156) = -.562, p < .001$ ), showing that as facilitators increased, barriers decreased. A significant correlation was also found between the number of services participants were aware of and the number of services participants had accessed ( $r(156) = .346, p < .001$ ).

The total number of facilitators was positively correlated with awareness of number of services ( $r(156) = .263, p < .001$ ) but not with number of services accessed ( $p = .068$ ).

The total number of barriers was negatively correlated with total number of services participants were aware of ( $r(156) = -.251, p = .002$ ) but was not significantly correlated with number of services accessed ( $p = .919$ ).

Disability, ethnicity, caring responsibilities, and gender were not significantly related to access or awareness.

# Regressions

## Awareness of services

The first pair of regressions investigated whether barriers (total) and facilitators (total), were associated with 1) awareness of at least one service and 2) awareness of total number of services.

The first regression assessed whether the number of facilitators and barriers reported was associated with awareness of at least one service. The overall regression model was marginally significant ( $F(2, 154) = 2.983, p = .054$ ) but neither facilitators ( $p = 0.525$ ) or barriers ( $p = 0.235$ ) were significant.

The second regression assessed whether the number of facilitators and barriers reported was associated with awareness of total number of services. The overall regression model was significant ( $F(2, 154) = 7.120, p = .001, \text{adjusted } R^2 = .073$ ) and facilitators was also significant ( $p = 0.035$ ). Barriers was not significant, although the significance level did indicate the presence of a trend ( $p = 0.063$ ).

## Service access

The second pair of regressions investigated whether barriers (total) and facilitators (total), was associated with 1) access to at least one service and 2) access to total number of services.

The first regression assessed whether the number of facilitators and barriers reported was associated with access to at least one service. The overall regression model was significant ( $F(2, 154) = 3.136, p = .046, \text{adjusted } R^2 = .027$ ), and facilitators was also significant ( $p = .019$ ) while barriers was not ( $p = .459$ ).

The second regression assessed whether the number of facilitators and barriers reported was associated with total number of services accessed. The overall regression model was not significant [ $F(2, 154) = 2.313, p = .102$ ]. Facilitators was significantly independently associated with number of services accessed ( $p = 0.031$ ) but barriers was not ( $p = 0.031$ ).

# Summary of findings

Our qualitative analysis revealed the presence of a range of factors which facilitate or act as barriers towards staff accessing organisational support services. These were wide ranging, but supportive managers, easy access routes and regular organisational communications about services were all suggested to facilitate access. Conversely, unsupportive managers, complicated or opaque access routes and irregular or poor organisational communications about services acted as barriers towards access.

In our quantitative analysis, demographic variables did not appear to be associated with facilitators, barriers or service access or use. However, greater awareness of services was associated with greater uptake of services. There was also some evidence to suggest that a greater presence of facilitators was 1) associated with greater awareness of services, and 2) a higher likelihood that respondents had accessed at least one support service.



# Recommendations

We found that a higher number of facilitators was associated with 1) greater awareness of services and 2) a greater likelihood that respondents had accessed at least one service. Greater awareness of services was also associated with increased rates of service access. Future interventions aimed at increasing access to mental health support services could therefore focus on increasing the *number* of facilitators that are in place, which has the potential to improve greater awareness of services and subsequently, to improve overall uptake of services. Specific facilitators organisations can put in place include:

- Creating a supportive work environment, where managers and colleagues are encouraged to recommend services to each other. Personal recommendations are particularly valuable for enhancing uptake.
- Encouraging managers to offer their staff flexibility to take up services, either by allowing them to access services during working hours, or by allowing them to work flexible hours around their service access.
- Improving access routes to support services by making these simple and efficient, for example by offering a phone number rather than an online form.
- By circulating regular and clear information to all staff about the services which are on offer and how these can be accessed. All advertising materials should be representative of their staff groups, in terms of gender and ethnicity.
- Services should be available both online and in-person, as preferences for modality vary. In-person services may best be situated near to the healthcare organisations they serve, but not within them.



# Contributors



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Judith Johnson led the design of the overall evaluation . She co-supervised data collection, analysis and reporting of both phases of the evaluation. She led the compilation of the overall report.



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Lucy Pointon contributed to the design of the overall evaluation and led the data collection for both phases. She led the analysis and reporting of the findings for Phase 1: Eliciting Barriers and Facilitators. She provided feedback on the overall report.



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