NHS
Clinical Leaders Network

Enhancing Mental Health Resilience

Evaluation of The North West Offer

The University of Manchester

Commissioned by the NHS Clinical Leaders Network

Date:

November 2021

Contents

EXECUTIVE SUMMARY

The outbreak of COVID-19 has been the greatest crisis faced by the world this century. The initial wave of the pandemic surged across the United Kingdom in early 2020, resulting in novel concerns and sweeping changes in day to day life for all. Whilst still reeling from the first, second and third waves followed. Healthcare professionals are experiencing both professional and personal challenges posed by the pandemic. These stressors have a pejorative effect on the mental health of the workforce. Consequently, the NHS Clinical Leaders Network (CLN), took a proactive stance to address the mental health and resilience of the NHS workforce.

Through an expert Advisory Steering Group, the CLN reviewed available evidence and produced a report advising how to enhance mental health resilience of the workforce and then advocated thorough preparation for the on-going impact of COVID-19 pandemic. This Call for Action, authored by CLN Leader Dr Cecil Kullu, Consultant Liason Psychiatrist, was responded to positively by NHS and wider organisations.

Enhancing Mental Health Resilience (EMHR) "*The North West Offer*," adopted a three-pronged strategy to facilitate spread, adoption and evaluation:

a. Individual support for CLN members (IS for CLN) using digital action learning sets (DALS)
b. Organisational alignment (OA) of existing health and wellbeing approaches
c. Targeted interventions (TI) to reinforce and sustain the existing offer of health and wellbeing services available

In order to deliver these, the CLN planned to:

1. Use digital action learning sets (DALS) to encourage clinical leaders to focus and reflect on mental health resilience. The aim being to inform those involved about potential interventions and empower leaders to reach out within their organisations, to understand how they may align with best practices
2. Conduct qualitative interviews with HR/Workforce directors, and subsequently clinical psychologists hired for exclusive staff use, at various Trusts to explore and promote mental health initiatives
3. Disseminate the C-19 ASSET questionnaire to assess the needs of all staff and to identify and prioritise those most at risk

The CLN established the Evaluation & Metrics Committee to undertake an independent evaluation of the EMHR programme. The evaluation is to be reported in two parts. In this initial report, undertaken by the University of Manchester team (Dr Amy Leigh Rathbone & Dr Elise Kleyn), the internal validity returned data was compared and contrasted across each aspect of the EMHR programme. Secondly, the regional results were compared and contrasted with a national data set. Finally, Donabebian's (1980) Structure Process Outcome model was used to evaluate the programme. A further detailed analysis will be undertaken and a final report will be issued in May 2022.

In summary, the evaluation evidenced that the EMHR programme was well designed and executed in terms of structure. The process was pragmatic and ensured comprehensive expertise and wide stakeholder engagement to enable programme delivery and promote impartiality in evaluation. Outcomes of the EMHR programme included;

Individual Support for CLN Members

- Guided current and aspiring clinical leaders/managers to engage in reflective practice
- Promoted mental health resilience with open discourse between colleagues
- Aided the implementation of personal and professional practices to ensure improved mental health resilience (although tentative due to low feedback)

Organisational Alignment

- Identified the need for ongoing use of mental health first aiders and COVID-19 staff wellbeing executive leads
- Highlighted the benefits of staff dedicated clinical psychologist and the need for further funding
- Acknowledged the beneficial aspects of Support|Care|Assist|Recommend|Family initiative (S.C.A.R.F.) and encourages further organisational adoption of the programme

Targeted Interventions

- Evidenced that North West staff must be encouraged to address issues such as, lack of autonomy and enthusiasm in job roles
- Identified that all staff experience the negative physical and mental impact when working throughout a pandemic. However, administrative and clerical staff, longer serving staff, clinical staff providing face to face inpatient services and non-clinical support staff working, staff aged between 40-54, staff with a disability, non-managerial leadership staff, and estates and ancillary staff require further focus and increased use of risk assessments as early intervention to identify possible physical and psychological health problems due to scoring higher for poor mental health
- Highlighted the need for the promotion of a positive, empathetic culture amongst peers

There is minimal evidence-based guidance regarding the mitigation of the negative impact on mental health in the workforce during pandemics. This evaluation has highlighted the benefits of the CLNs North West Offer and provided eleven recommendations for encouraging mental health resilience in the workforce, to be considered in future pandemic planning.

EMHR Programme Recommendations

1. Individual support for CLN members will guide aspiring clinical leaders/managers to engage in reflective practise, promoting optimum personal and professional mental health resilience
2. Tailored Digital Action Learning Sets for clinical leaders/managers will promote the transference of departmentally relevant best practise to healthcare workers
3. Where comfortable, it would be beneficial for leaders/managers to be open with healthcare staff about their personal experience of mental health to encourage discourse and disclosure, working to eradicate stigma
4. Trusts should continue working in partnership with both internal and external agencies for access to a wider array of mental health services
5. All NHS organisations should actively sign the Ask Twice campaign to ensure that staff have multiple opportunities to disclose mental health issues if they wish to do so
6. Trusts should promote and utilise the S.C.A.R.F initiative (e.g. Wellbeing Passport, Reset Days, etc.)
7. The funding of staff exclusive clinical psychologists within Trusts would be beneficial for longitudinal use

8. Monitor administrative and clerical staff, longer serving staff, clinical staff providing face to face inpatient services and non-clinical support staff working, staff aged between 40-54, staff with a disability, non-managerial leadership staff, and estates and ancillary staff, as they are at higher risk for poorer mental health
9. To ensure inclusivity, NHS organisations must further explore perceived marginalisation amongst all staff and the report of under representation by BAME employees
10. Take into account that all staff are susceptible to poor mental health throughout pandemics and early identification and intervention are key to promoting optimum mental health resilience
11. The EMHR programme should ensure continuation and advancement to further promote mental health resilience in the NHS workforce

INTRODUCTION

This report presents the evaluation of the EMHR programme in eight parts. The executive summary provides a broad overview of the evaluation. This section provides an introduction and reports the layout and contents. The background provides information about the development of the EMHR programme. The methods section depicts the materials and evaluative methodology used. The results section reports the data returned from each aspect of the programme; individual support for CLN members, organisational alignment and targeted interventions. The discussion section is inclusive of programme limitations and evaluation, accompanied by implications for practice and future research. Following this, eleven subsequent recommendations are made. At the end, there is a reference section and appendix. The appendix also includes abbreviated words used throughout the document (Appendix 1).

BACKGROUND

To address enhancing mental health resilience in the workforce the CLN formed an expert Advisory Steering Group, made up of senior clinicians and managers from several organisations across provision, commissioning, public health, academic university and the CLN (Appendix 2).

The CLN approached Dr Cecil Kullu (Consultant Psychiatrist, Deputy Medical Director for Research, Clinical Senate Chair), who, with the support of the Advisory Steering Group, authored a Call for Action. The paper was published in April 2020 and entitled, "*Enhancing mental health resilience and anticipating treatment provision of mental health conditions for frontline Healthcare workers involved in caring for patients during the COVID-19 Pandemic – A call for action"* (Kulu *et al*., 2020; Appendix 3). It explored how individuals and organisations must enhance mental health resilience of the workforce and advocate for thorough preparation for the impact that COVID-19 has had, and will continue to have on staff. The Call for Action paper reported background information, recommendations, and examples of good practice, alongside six key considerations for the NHS:

1. It is imperative that mental health and wellbeing of healthcare workers is given an equal priority in the health care organisations response plans to the pandemic.
2. Greater co-ordination is needed to identify mental health needs, wellbeing needs of healthcare staff and the required help and support for this is urgently provided.
3. Mechanisms are developed within organisations to identify long-term effects on healthcare staff such as depression, anxiety, Post Traumatic Stress Disorder, Addictions (alcohol/drug/gambling), increased risk of suicide and provision of care and treatment for these are planned and arranged.
4. Funding to provide dedicated capacity within the healthcare system to meet the mental health needs of the healthcare workers is established and ring fenced.
5. It is urged that collaborations between Mental Health services providers (public and private sector), Emergency and Hospital service providers, Primary Care organisations and charitable organisations be encouraged to develop a coordinated and unified approach for mental health triage, referral and treatment processes for frontline health, care and managerial staff.
6. The right type of clinical and managerial leadership, at all levels, to provide compassionate, empathetic and thoughtful leadership to healthcare workers.

The Call for Action was responded to positively by Trusts across the North West who actively began to implement recommendations from the document, as part of the Enhancing Mental Health

Resilience (EMHR) programme – The CLN Offer. The programme adopted a three pronged strategy to facilitate spread, adoption and evaluation.

1. Individual support for CLN members
2. Organisational alignment of existing health and wellbeing approaches
3. Targeted interventions to reinforce and sustain the existing offer of health and wellbeing services available

In order to deliver these, the CLN,

- Used digital action learning sets (DALS) to encourage clinical leaders to focus and reflect on mental health resilience. In doing so, emerging actions emerging actions they can take away from the Leading Mental Health Resilience approach and commitment to reach out within their organisations to understand how they may align with the approach were considered
- Conducted qualitative interviews with HR/Workforce directors, and subsequently clinical psychologists hired for exclusive staff use, at various Trusts to explore and promote mental health initiatives
- Disseminated the C-19 ASSET questionnaire to assess the needs of all staff and to identify and prioritise those most at risk

The aim of the programme was to develop an effective, coordinated model to understand and proactively respond to current and future mental health crises.

This report is an evaluation of the EMHR programme from conception to completion. To do so, results from all aspects of the programme are reported and considered, alongside the overall structures, processes and outcomes.

METHODS

The following initiatives were used:

1. Digital Action Learning Sets (DALS) are purpose made, targeted training sessions and monthly meetings for CLN members, inclusive of action learning sets which are grounded in known reflective frameworks. The action learning sets were aligned to the Call for Action paper, encouraging participants to translate the proposed principles into professional practice. Within the DALS, emergent actions were taken from the Leading Mental Health Resilience approach and clinical leaders were encouraged to connect with their organisations to better understand how the action learning sets would align with their current approach (Appendix 4).
2. Semi-structured interviews were initially carried out with HR/Workforce Directors and other executive team members in organisations across the North West of England (Appendix 5). The HR/Workforce Director interviews were based around the themes of organisational baselines, clinical leadership, engagement, culture and infrastructure. The interviews provided the opportunity to learn about the mental health and wellbeing offers of support that individual organisations were presenting and explore OA regarding mental health initiatives. In continuation of the HR/Workforce director's interviews, further interviews were conducted with clinical psychologists, using the same methodology as the HR/Workforce Directors interviews. The interview questions focused on topics such as, funding and contracts, role and responsibilities, most frequently reported mental health issues, experiences in fixed term posts and future recommendations for Trusts.
3. The COVID-19 specific: A Shortened Stress Evaluation Tool, (C-19 ASSET) questionnaire was disseminated to R & D departments of Trusts across the North West. When participation was consented to by R & D departments, all relevant information was provided to be disseminated to employees internally. The questionnaire consisted of three sections measuring employee job perception, organizational commitment and employee health. For the purpose of the programme, 14 purpose written questions specific to COVID-19 were included to capture COVID-19 specific data. These questions were devised collaboratively by Robertson Cooper and the CLN (Appendix 6).

The purpose of the report was to evaluate, to what extent the materials used within the EMHR programme were effective when used to provide IS for CLN, promote OA and provide TI. To do so, the Evaluation and Metrics Committee considered the internal consistency and validity of the results and considered whether results from each aspect of the programme correlated. Overall results were then compared to the NHS Staff Survey Results 2020 to explore whether the CLNs EMHR programme results were reflected on a national level. Following this, the programme was then evaluated using Donabedian's (1980) healthcare quality model. The evaluative tool is a triadic, conceptual model which offers a framework by which the quality of healthcare may be assessed and appraised. The model suggests causality in that, improved structure results in improved clinical processes, which subsequently results in improved patient outcome and quality of care (Moore *et al*., 2015). The Evaluation and Metrics Committee opted to use this model when evaluating the EMHR programme due to its validity and reliability and its continued relevance to the healthcare sector.

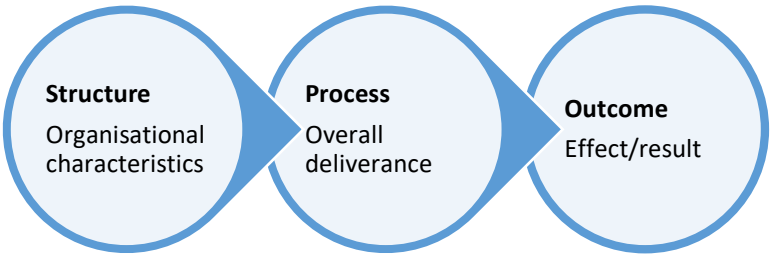

Figure 1. Structure Process Outcome Model

RESULTS

In the initial stage of the CLNs EMHR programme, the offer was limited to 14 Trusts across the North West of England. Of these Trusts, 12 elected to participate. DALS were made available to approximately 52 emerging CLN members & Trust staff, and 33 elected to participate. The HR/Workforce Director interviews were undertaken across 12 Trusts and 13 people were interviewed. The Clinical Psychologist interviews were carried out between two Trusts, with two participants. The C-19 ASSET questionnaire was disseminated to 13 Trusts, with 11 Trusts participating, resulting in 459 participants. Further details are reported in the following table.

Table 1. EMHR Programme, Offer, Aspect and Participation

EMHR Programme Offer	EMHR Programme Aspect	Participant Role	Dates conducted	Participants (N)	Trusts (N)	Frequency/ Span
IS for CLN	DALS	Clinical leaders	June 2020 to March 2021	33	12	4-6 Weekly meeting
OA	HR/ Workforce Director Interviews	HR/Workforce	October 2020-January 2021	13	12	60-90 minutes
	Psychologist Interviews	Clinical psychologists	June 2020-July 2020	2	2	30-60 minutes
TI	C-19 ASSET	Various Administrative and clerical (n=96) Allied health professionals (n=75) Clinical services (n=16) Estates and ancillary staff (n=8) Medical and dental staff (n=59) Nursing and midwifery (n=166) Professional scientific and technical (n=7) Others (n=32).	September 2020-April 2021	459	11	One off snapshot survey

IS for CLN-Individual support for CLN members
OA-Organisational alignment
TI-Targeted intervention

Individual Support for CLN Members

The CLN provided individual support to clinical leaders across the North West via DALS to promote mental health resilience. Evaluation completion of the DALS was relatively low. From a sample of 33 participants, five responded. The DALS End of Programme evaluation combined both quantitative and qualitative enquiry. The initial five questions asked participants to score the importance of several aspects of the DALS from one to ten, one being very unimportant and ten being extremely important. The following table displays the responses.

Table 2. DALS Feedback

	1	2	3	4	5
How important were the DALS in relation to your current practice?	4	8	10	8	7
How important was the opportunity to present your thoughts/problem within the DALS?	6	8	10	9	8
How important was the use of the challenge/support from your colleagues within the DALS?	6	9	8	9	9
How important was engaging in reflective inquiry within the DALS?	6	8	10	9	7
How important have the DALS been with respect to your ability to problem solve?	4	8	10	7	7

The subsequent five questions were qualitative, open ended and asked, "*What new knowledge will you take away from your participation in the DALS?*", "*What actions have you taken as a result of your participation in the DALS? Were these actions successful?*", "*Did your organisation engage with you on the mental health resilience for their organisation?*", "*Would you like to be involved as a Leader, as we move from the here and now into the* "new normal" *within your organisation and the NW?*" and "*Finally, do you have any recommendations for future programmes?*"

Participant 1 enjoyed participating in the DALS and answered affirmatively to further organisation engagement, stating that, "*We have engaged with the Point of Care Foundation and implemented Team Time amongst other developments*."

Participant 2 stated that the new knowledge they were taking away from their participation in the DALS was, "*the importance of multi-disciplinary support including management colleagues*." The DALS was a positive personal motivator for Participant 2 who reported that, due to DALS participation, they had, "*actually taken control of my mental and physical health and despite of work pressures have ensured I have 2 exercise sessions per week which for me personally is a huge achievement as I didn't exercise regularly before this*." Participant 2 disclosed that they would like to be further involved in the DALS as a Leader. It was mentioned that Participant 2's organisation had engaged with them on the mental health resilience for their organisation "*to a degree*." No further expansion was provided.

Participant 3 opted to skip the qualitative questions.

Participant 4 found the DALS reassuring in practise due to the realisation that "*colleagues from other specialities/departments were facing similar challenges."* Informed by participation with DALS, participant 4 had since initiated a wellbeing programme within their speciality and developed a

purpose made DALS which aligned with their clinical specialty, hence evidencing organisation engagement. Participant 4 also answered affirmatively to further DALS involvement as a Leader.

Participant 5 took actions as a result of their participation in the DALS and described them as "*partially*" successful. They also reported that their organisation engaged with them on mental health resilience. Further details are unknown as these answers were not expanded upon.

Participant 1, 2, 3 & 5 did not provide any recommendations for future programmes, however, Participant 4 stated, "*DALS is very effective - the challenge is to align diaries for attendees.*"

KEY POINTS

- Responses highlighted the effectiveness of DALS
- DALS content can be transferred into both professional and personal aspects of life
- It is a challenge to align diaries for DALS attendance
- Increased participation and feedback is required to further evaluate DALS

Organisational Alignment

The EMHR programme explored OA of existing health and wellbeing approaches by conducting qualitative interviews with HR/Workforce Directors.

HR/Workforce Director Interviews

Several common themes emerged from the HR/Workforce Director interviews. Unanimously, Trusts reported variations in stress between Waves 1 & 2. The stress in Wave 1 focused on the virus itself, possible professional and personal transmission and the subsequent detrimental effects of this. As Wave 1 diminished staff were left exhausted but sustained by a sense of community, shared experience and a wider sense of worth and gratitude by the general public. Prior to the onset of Wave 2, COVID-19 had become 'normalised and rationalised.' However, it was noted that some staff were displaying longitudinal signs of stress, such as PTSD and moral injury. As Wave 2 grew rapidly alongside the 'usual' winter pressures, staff stress and anxiety concentrated on personal, professional and organisational ability to cope.

Mental Health Initiatives

Most organisations interviewed had named executive leads for health and wellbeing. Additionally, most had named non-executive director leads for health and wellbeing, who acted as 'critical friends,' to challenge and support Trusts' initiatives. Several organisations had a specific COVID-19 staff wellbeing executive lead. Alongside internal mental health initiatives, organisations reported being much more open to external companies as means of counselling and other mental health and wellbeing offers. One such offer was the integration of clinical psychologists dedicated to assisting the NHS workforce. Some had partners assisting with mHealth app development for staff use. Others, had charities and volunteers offering respite resources specifically for NHS staff. An increased use of the Resilience Hub was reported across organisations. Overall, staff reported feeling appreciative of the holistic practical support being offered.

External and Internal Initiatives

Following the outbreak of COVID-19 and the Call for Action paper it was vital to communicate with Trusts to further explore the provisos in situ, and those that had subsequently been implemented to address the mental health resilience of the workforce.

- Using the HR / Workforce Director Interviews it was found that executive teams have been pre-emptive and persistent in their approach to identifying employee mental health issues by signing up to the Ask Twice campaign (https://www.time-to-change.org.uk/asktwice). This campaign advocates the continuous monitoring of staff mental health. Trusts are using their intranets and wellbeing pages to facilitate regular, open communication between those in the workforce.
- The Shiny Minds app was co-created to improve wellbeing, resilience and teamwork (https://shinymind.co.uk/public-sector/).
- The S.C.A.R.F. Health and Wellbeing campaign is an ongoing initiative that sets short, medium and long term goals for staff. Weekly health checks are carried out using World Health Organisation (WHO) index questions and efficacy is monitored using regular feedback. More recently the campaign have introduced the Wellbeing Passport (https://www.pat.nhs.uk/scarf-news/SCARF-Wellbeing-Passports.htm), which entitles an employee to four hours protected rest time away from work and Reset Days (https://www.pat.nhs.uk/scarf-news/Reset-Day-is-back.htm), which minimise time spent at a screen in work.
- Some Trusts are actively using the Perform @ Your Peak programme, part of the NHS North West Leadership Academy's continued support of the Health and Wellbeing (https://www.nwacademy.nhs.uk/discover/offers/perform-your-peak#:~:text=Using%20a%20combination%20of%20education,organisational%20health%20and%20wellbeing%20strategies).
- A number of organisations in the North West are actively using the Resilience Hubs. The outcome interventions for enhancing mental health resilience in this programme align with and inform the national development of Resilience Hubs across the country.

Communication

All organisations interviewed explained that they had increased their communications with staff, delivering frequent messages regarding the pandemic, and separate targeted messages relating to mental health wellbeing. Some organisations also described how they have encouraged the use of closed social media platforms as a means of communication and support between staff. To identify staff at risk, organisations have placed an increased emphasis on risk assessment to highlight the need for additional support and where redeployment may be necessary, post pandemic. Although there is evidence of various avenues of support in situ for the NHS workforce, overall, an increased use of mental health first aiders was recorded. This, alongside a growing rate of sickness absence with markedly higher referrals to Occupational Health evidences the ongoing need for further provisions.

KEY POINTS

- As Wave 1 diminished staff were exhausted but sustained by shared experience and sense of community
- During Wave 2, increased stress, anxiety and longitudinal mental health issues such as PTSD and moral injury were reported.
- Increased use of mental health first aiders, sickness absences and referrals to occupational health were reported
- Trusts increased the use of risk assessments to identify at risk staff requiring further support (e.g. redeployed)
- Trusts implemented non-executive directors as Wellbeing Guardians who acted as 'critical friends'
- Trusts collaborated with external partners to meet the mental health needs of staff (e.g. coaching, charitable provisions, mHealth resources, clinical psychologists for exclusive staff use)
- Trusts increased communications and the relay of information to staff
- Overall, staff reported feeling appreciative of the increased mental health support

Clinical Psychologist Interviews

Results of the HR/Workforce Director interviews evidenced that several Trusts had utilised charitable funds to hire clinical psychologists for exclusive staff use throughout the COVID-19 pandemic. In response to this information the CLN opted to explore the role of clinical psychologists throughout the pandemic, staff use and general recommendations from the professionals. The interviews were carried out remotely, by a fourth year medical student and a CLN associate from the University of Manchester, using the same methodology as the HR/Workforce interviews. Due to the natural cessation of the fixed term posts, two clinical psychologists were available to participate. Due to the small sample, the Trusts in which the clinical psychologists were based at, were not disclosed, so as to protect their anonymity. The clinical psychologist are here on referred to as CP1 and CP2.

The Role

CP1 reported that their contract was fixed term for two years. CP2 also stated that staff support psychologists were full time on a two year contract. However, CP2 was a permanent, high level psychologist overseeing the project at their Trust. CP2 was also aware that the posts were financed by COVID related occupational health and/or charitable funds. The role of staff support clinical psychologists were not confined to one to one patient sessions with staff. The roles were also inclusive of, but not exclusive to, delivering educational sessions, webinars and drop in sessions, data analysis and sharing resources with other services on a regional level.

Staff Counselled

All sessions were on a one to one basis and were conducted via telephone or video call. Each staff member had between 6 and 12 sessions. Staff were signposted/referred to further specialist services for all non-work related trauma. Both CPs highest reported mental health issues were anxiety, depression and PTSD. CP1 saw staff plagued with elements of guilt throughout the pandemic, suggesting a level of moral injury. CP2 reported that not only were BAME staff underrepresented, but they also felt as though they had been put under unnecessary risk. CP2 did not elaborate on the

context of underrepresentation. CP2 also raised the concern of how common self-medication for anxiety, using alcohol had become.

CP2 reported significant challenges faced by staff, such as, moving out of the family home to protect loved ones in times of uncertainty and other challenges triggered by the pandemic (e.g. domestic violence, financial difficulties etc.). They also stated that it was useful for the staff to be aware that, "*this data is not shared with GP. It's kept confidentially on an occupational health record*." This may have encouraged the staff to disclose information at ease and utilise the CP resource to talk through their experiences.

CP1's major challenges faced were at an emotional level. They state, "*I felt helplessness. People were telling me their anxieties and I was not able to change their situation. I cannot change the government guidelines. Therefore, I tried to only focus only on what I could control as a psychologist".* CP1 also experienced guilt from not being involved in patient facing care, but was able to rationalise it well; "[The NHS] *need people working in different environments to offer new perspectives in order to help staff on the frontline*".

CP2's major challenges faced related more to organisation issues, which may have been due to the fact that they had more responsibilities in the project. One concern was "*Influencing people at the top of the organisation to ensure that staff that were redeployed to critical care from the operating theatres and then back to the theatres again to deal with the backlog of elective surgeries are not pushed too hard as they've just finished on critical care.*" This suggests the promoting of an organisational mindfulness and empathy for staff experiences. CP2 preferred WhatsApp as means of communication to engage people in attendance. This again mirrored results from HR/Workforce interviews which reported positive engagement via the use of social media communications. CP2 also recommended that "*Trust wide engagement is needed to improve engagement.*"

General Recommendations

CP1 gave recommendations for the Trust which included support and training for those in leadership and managerial roles. The support suggested for leaders/managers was at a personal level as CP1 suggested that this cohort, "*feel that they need to keep going otherwise it reflects poorly on their competency*", and they feel they are, "*Keeping it together for everyone else*." CP1 suggested that further mental health support and training for those in leadership and managerial roles may promote a, "*cultural change*". CP1 also emphasised the importance of "*removing stigma*". This was interesting as, it echoed a recommendation which stemmed from the HR/Workforce interviews. This was for executive team members to be transparent about their personal mental health and wellbeing to further promote positive culture and eradicate residual stigma. So whilst staff who lead/manage were attempting to conceal their mental health experiences, due to being perceived poorly professionally, those being lead/managed believed that transparency and disclosure would actually further promote a positive culture.

CP2 explained that staff wellbeing should remain a first and foremost consideration in any and all decision making. CP2 reported that Trusts should, "*continue large current funding even after the pandemic as effects will be seen much after the pandemic. During the Pre-pandemic era there was an unmet need for wellbeing resources for NHS staff, this need is now being met but needs to stay for the future*". CP2 noted that, since the onset of COVID-19 wellbeing resources for NHS employees have improved. However, it is crucial that these resources stay in situ for staff wellbeing. CP2 suggested the continuation of staff exclusive clinical psychologists within Trusts due to the longitudinal psychological effects caused by the pandemic.

KEY POINTS

- Clinical psychologists exclusively for staff were on fixed term contracts
- Employees frequently reported anxiety, depression, PTSD and guilt (moral injury)
- All staff are susceptible to feelings of moral injury throughout a pandemic
- BAME individuals felt underrepresented and placed at risk throughout the pandemic
- Challenges faced by employees were in both their personal and professional lives
- Employees who had been redeployed to meet COVID-19 healthcare needs require time to process their experiences
- Employees in leadership/management roles felt that they needed to hide their mental health issues due to fear of judgment
- A cultural change is required to further eradicate the stigma shrouding mental health

Targeted Intervention

As a TI, the CLN disseminated the C-19 ASSET questionnaire which returned a tailored health and wellbeing report. The C-19 ASSET also served as a needs assessment tool and identified at risk staff.

General Exposure to COVID-19

Prior to exploring the data with regard to the effects of COVID-19 on the wellbeing of NHS employees, it was salient to first explore employees overall exposure. What was evident from the data is that at the time of survey distribution, employees' overall exposure to COVID-19 was relatively low, in both professional and personal aspects of life. This may be due to the fact that the C-19 ASSET questionnaire was disseminated during the second wave of COVID-19, meaning that employees were already aware of what measures to take to minimise exposure.

Table 3. Personal and Professional Exposure to COVID-19

		Frequency	Percent
I have been diagnosed with COVID-19	Yes	10	6.1
	No	154	93.9
I am living with someone who has suspected symptoms	Yes	0	0
	No	164	100%
I manage patients diagnosed with COVID-19	Yes	15	9.1
	No	149	90.9
A person(s) in my immediate family have been diagnosed with COVID-19	Yes	16	9.8
	No	148	90.2
A close friend has been diagnosed with COVID-19	Yes	20	12.2
	No	144	87.8
A neighbour or someone living in the same community has been diagnosed with COVID-19	Yes	10	6.1
	No	154	93.9

Workplace Approaches to COVID-19

Regardless of current general levels of exposure, COVID-19 remains a prevalent concern in all aspects of life, especially for those working within healthcare services. This section of the report explored employees workplace attitudes towards COVID-19 and subsequent issues.

The statement, '*The change in working arrangements was positively supported by colleagues*', was excluded from data analysis as 102 employees opted not to answer this question.

Most employees agreed that they actively socially distanced according to rules within their place of work (n=136/82.9%). However, over half agreed that colleagues who were unwilling to socially distance in the work environment were a causal factor of stress (n=112/68.3%).

Over three quarters of employees (n=125/76.3%) agreed that they were able to give feedback to their line manager about the impact of COVID-19 on them personally. Over two thirds of employees (n=111/67.7%) believed that their managers were concerned about their wellbeing.

Just over 80% of employees (n=132) disagreed that their job does not place their health at risk in regards to COVID-19. Almost three quarters (n=177/71.3%) believed that their job placed their family at risk of COVID-19. Almost all employees (n=138/84.5%) believed that they were experiencing burnout due to COVID-19; only 26 (15.5%) disagreed with this.

Exactly 100 employees (61%) disagreed with the statement, '*I do not feel valued by my colleagues/team for my COVID-19 contribution*', reflecting that 39% did not feel valued by their colleagues for their role throughout the pandemic. Over a third of employees (n=63/38.4%) did not agree to feeling overwhelmed by what their job expected of them, however, 101 (61.6%) agreed.

In regard to care, over half of employees (n=96/58.5%) believed that they could provide the care that their patients required, 20 (12.2%) believed they could not and this statement was not applicable to the role of 48 (29.3%). The majority of employees (n=148/90.2%) agreed that they were equipped with the appropriate PPE for their role.

Over 60% (n=101) disagreed and 63 (38.4%) agreed to the statement, '*The health risk assessment has made me feel marginalised*'. Over a third of employees (n=127/77.4%) believed that they had been marginalised for the decisions they had made to protect their or their family's health.

Physical Health

The lowest reported physical health issues were feeling nauseous or being sick (n=45/27.4%) and indigestion or heartburn (n=82/50%). Fifty percent or less of employees disclosed experience of these issues. The most reported physical health issues, experienced "sometimes to often", in order of frequency reported, were headaches (n=115/70.1%), muscular tension/aches and pains (n=122/74.4%), insomnia/sleep loss (n=133/81.1%) and lack of appetite or overeating (n=128/78.1%).

Mental Health

There was an almost equal split amongst employees who reported panics or anxiety attacks, when asked to answer "never", "rarely", "sometimes" or "often". Almost 60% (n=96) of employees "sometimes" to "often" felt constant irritability. Again, there was an almost equal split in the sample between those who "never" to "rarely" had difficulty making decisions (46.3%) and those who "sometimes" to "often" did (53.6%). Most employees "never" to "sometimes" lost their sense of humour (n=153/93.3%). Only 6.7% (n=11) reported that they "often" lost their sense of humour. Almost 60% (n=97) of employees reported that they "sometimes" to "often" became angry with others too easily. A large proportion of the sample (n=147/89.6%) found themselves frequently

experiencing constant tiredness. Around 61% (n=100) of employees felt the inability to cope, “sometimes” to “often”. A similar number of employees (n=99/60.4%) found themselves more frequently avoiding contact with other people. Over half (n=95/57.9%) experienced mood swings “sometimes” to “often”. Most employees 158 (94.4%) reported being unable to listen to other people “never” to “sometimes”. Only 6 (3.7%) employees found this to be an extremely frequent occurrence. Having difficulty concentrating “sometimes” to “often” affected 65.8% (108) of employees.

Resilience

Participants were asked to rate their feelings of resilience from “not at all”, “very slightly”, “moderately” and “very much”. Around 64.6% (n=110) of employees did not feel inspired or excited at work. However, over half of employees (n=88/53.6%) felt “moderate” to “very much” enthusiasm at work and 125 (76.1%) felt “moderately” to “very much” alert. Just under three quarters of employees (n=112, 68.3%) were determined in their job role but 131 (79.9%) were only “very slightly” or “not at all” to “moderately” happy. There was a strong theme of discontent, with 136 (81.6%) employees reporting that they felt content in their job role only “very slightly” or “not at all”, to “moderately”. No employees reported being “very much contented”.

Identifying at Risk Staff

The data set consisted of seven staff roles (administrative and clerical, allied health professionals, clinical services, estates and ancillary staff, medical and dental staff, nursing and midwifery, professional scientific and technical) and the group ‘other’. From said roles, results evidence that all staff were susceptible to negative physical and mental health impacts caused by working during the pandemic. However, administrative and clerical staff, longer serving staff, clinical staff providing face to face inpatient services and non-clinical support staff working, staff aged between 40-54, staff with a disability, non-managerial leadership staff, and estates and ancillary staff scored higher for poor mental health. Whilst all staff evidenced resilience throughout, those in clinical (providing face-to-face community services) and clinical (providing face-to-face inpatient services) roles were more likely to experience good days at work and feel as though they had made valuable contributions within their working day.

KEY POINTS

- A strong sense of job security was evident throughout the pandemic
- Staff reported being well equipped with PPE, information and support
- Working relationships with bosses remained strong throughout the pandemic, but not amongst peers
- Employees experienced physical and mental health changes and rates of burnout were high (84.5%)
- Below average/decline in positive emotions (e.g. enthusiasm, determination and happiness)
- Staff remain engaged, committed and motivated displaying resilience
- All staff evidenced susceptibility to negative physical and mental health impacts
- Administrative and clerical staff, longer serving staff, clinical staff providing face to face inpatient services and non-clinical support staff working, staff aged between 40-54, staff with a disability, non-managerial leadership staff, and estates and ancillary staff were at higher risk of poor mental health scores
- All staff evidenced resilience but clinical face to face staff were more likely to have good days at work with a sense of making valuable contribution

DISCUSSION

Limitations

As with any such large project, spanning such a diverse range of settings and employees, the EMHR programme was met with limitations. However, it is salient to note that most were directly related to COVID-19, as opposed to the programme methodology itself.

In regard to the DALS intervention, there was a low response rate upon evaluation. This was due to situations surrounding COVID-19. Whilst 33 clinical leaders were originally enrolled in the DALS, their focal role was providing optimum healthcare to patients. Therefore, attentional deficits were identified, alongside low evaluative responses to the programme, due to the patient need being greater and survey fatigue being higher, especially so in during Wave 2. Previous research has evidenced the efficacy of action learning (Leonard & Marquardt, 2010). Previous iterations of DALS have evidenced higher levels of engagement and feedback. The CLN have taken a proactive approach in refining their action learning sets to alter the provision for optimum outcomes (Appendix 7).

Only two participants were recruited for the clinical psychologist interviews. Recruitment was difficult due to the fixed term posts coming to a natural end and clinical psychologists having gained further employment, resulting in less time to engage.

Several Trusts reported that uptake for the C-19 ASSET questionnaires may not have been optimum due to survey fatigue. NHS staff have been the focus of an abundance of research since the initial outbreak of COVID-19, with a heavy focus on mental health. Whether patient facing or administrative, it is feasible, and understandable, that staff would not be inclined to spend their time engaging in research after exerting their selves during their normal working hours. A minority of clinicians and managers who completed the C-19 ASSET questionnaire did not sufficiently identify it to be a unique valuable tool when used alone.

The limitations of the EMHR programme were more of a reflection of the NHS workforce's professional priorities being aligned accordingly during the pandemic, as opposed to the strengths of the EMHR programme.

KEY POINTS

- DALS returned low response rate upon evaluation due to increased healthcare need and clinical leader redeployment
- Due to fixed term posts, only two clinical psychologists were available for interview
- The C-19 ASSET was not identified as a valuable measure when used alone

Internal Consistency

Throughout the EMHR programme, results were echoed. Across all aspects of the programme, mental health issues such as anxiety, stress, depression, burnout and PTSD were reported. Across both sets of qualitative interviews, staff reported that the mental health initiatives in place were beneficial. The HR/Workforce director interviews evidenced that Trusts had increased their use of risk assessments, however, the C-19 ASSET results suggested that some felt marginalised by said risk assessments.

At points, the results traversed from the identification of, to recommendations for, then addressing an issue. For example, the results from the C-19 ASSET questionnaire reported that staff had conducive relationship with their managers, but not with their peers. The data returned from the qualitative HR/Workforce Director interviews suggested that leaders/managers open disclosure about their personal mental health experiences, would promote further discourse and understanding between teams. Subsequently, although separate aspects of the programme, the DALS then addressed this issue by resulting in the implementation of 'Team Time' within a Trust. This suggests that whilst the EMHR programmes consisted of differing aspects, they correlated well. The clinical psychologist interviews however, provided information which suggested that leaders/managers actively hid their struggles with mental health as they did not want to be perceived as being incapable of carrying out there role. This highlighted the need for further communication which the DALS aimed to promote.

Evaluative Comparator

To verify the validity of the data returned from the EMHR programme, results were compared and contrasted with the NHS Staff Survey Results 2020, partly to explore whether the EMHR programmes regional results were reflected nationally.

The NHS Staff Survey reflected results of the EMHR programme in that the theme of Health and Wellbeing saw a decrease in positive emotions and increase in stress and burnout. In the NHS Staff Survey, almost three quarters of staff agreed that their immediate managers were encouraging of them and over half reported strained peer to peer relationships. Employees in the North West region were less likely to experience autonomy in the decision making process and how to do their work, than others nationally. Having improved year on year since 2017, almost half of employees (47.7%) felt able to meet the demands of their work. Considering the unprecedented strain placed on the NHS in 2020, this evidences a strong theme of national resilience, as threaded throughout the EMHR programme results. Over 60% of employees felt adequately equipped in their role. These results are especially reflective of the C-19 ASSET. Job enthusiasm had declined but remained nationally high (73%). According to the EMHR programme results, levels of enthusiasm were markedly lower in the North West. In regards to equality and diversity, there was an increase in discrimination stemming from colleagues or management (8.4%). Reflecting back on the EMHR programme results, employees reported feeling marginalised by the health risk assessment and decisions they had made to ensure their families safety.

Overall, the results from the EMHR programme reflected the results of the national NHS Staff Survey 2020. It evidenced throughout that work related stress and burnout were high whilst positive emotions were low. Immediate/line managers throughout the NHS actively supported employees and encouraged online lines of communication within Trusts. The breakdown of, and strain between, employee peer relationships was identified at both regional and national levels. Whilst not a national issue, employees in the North West experienced less autonomy within their own role. Employees felt equipped and able within their roles and evidenced dedication and resilience on both regional and national levels. The care of patients/service users is the employing Trusts focal priority across the board. However, levels of enthusiasm in employee job roles was markedly lower in the North West. Nationally, most employees reported satisfactory approaches to equality, diversity and inclusion, yet in the North West, there were incidents of employee marginalisation due to the decisions they had made in their role in regards to personal and familial protection from COVID-19.

KEY POINTS

- The results from the regional EMHR were comparable to and reflective of, the national data of the NHS staff survey
- Staff in the North West experienced markedly lower levels of enthusiasm and were less likely to experience autonomy in decision making processes concerning their role
- High levels of resilience were evidenced across both regional and national data sets

Structure, Process, Outcome Evaluation

Structure

Within the North West there are 20 acute Trusts, one ambulance Trust, nine community and mental health Trusts, four specialist Trusts, 30 Clinical Commissioning Groups (CCG) and extensive Primary Care.

The CLN worked within these existing structures to implement the EMHR programme, first engaging stakeholders and then recruiting participants. This structure was used so that the programme may be beneficial across all levels, such as, individuals NHS organisations, sustainability and transformation plan (STP) footprints, ICS and regional partnership teams, employing NHS organisations, clinicians and subsequently, patients.

The NHS CLN stated that "*staff involvement was an essential aspect at all stages of the NHS CLN Enhancing Mental Health Resilience Programme."* Increased participation would, not only provide a broader data set, but also encourage participating staff to become reflective of their mental health and provide reassurance that the organisations for whom they worked, empathised and wanted to proactively help.

The panel who developed the programme consisted of clinicians from a number of different disciplines, including GPs, physiotherapists, psychiatrists, psychologists, psychotherapists, paramedics and organisation leaders. Fostering the input of a variety of professionals ensured that the NHS CLN EMHR programme was diverse and relevant to as many staff as possible. This evidence that the programme was pragmatic and lead by the needs of NHS employees.

The CLN engaged in direct outreach and sent correspondence to NHS staff and organisations across the North West outlining the issues caused by the pandemic, programme goals and detailing how they could take part. Engaging with staff was deemed a key aspect of the project.

As iterated in the background section of this report, the six recommendations of the Call for Action paper were;

1. It is imperative that mental health and wellbeing of healthcare workers is given an equal priority in the health care organisations response plans to the pandemic.
2. Greater co-ordination is needed to identify mental health needs, wellbeing needs of healthcare staff and the required help and support for this is urgently provided.
3. Mechanisms are developed within organisations to identify long-term effects on healthcare staff such as depression, anxiety, Post Traumatic Stress Disorder, Addictions (alcohol/drug/gambling), increased risk of suicide and provision of care and treatment for these are planned and arranged.

4. Funding to provide dedicated capacity within the healthcare system to meet the mental health needs of the healthcare workers is established and ring fenced.
5. It is urged that collaborations between Mental Health services providers (public and private sector), Emergency and Hospital service providers, Primary Care organisations and charitable organisations be encouraged to develop a coordinated and unified approach for mental health triage, referral and treatment processes for frontline health, care and managerial staff.
6. The right type of clinical and managerial leadership, at all levels, to provide compassionate, empathetic and thoughtful leadership to healthcare workers.

These recommendations were considered and addressed by the EMHR programme in which the focal outcome was to improve mental health resilience in the NHS workforce and inform future pandemic planning. The programme was novel to the North West and it would be beneficial for the CLN to offer the EMHR programme on a larger scale, nationally as opposed to regionally, ensuring a more extensive implementation of the CLN model.

Process

The CLN elected to involve several independent agencies from private health and wellbeing professionals to Trust research departments, ensuring that their board did not unintentionally steer the process. Overall, throughout the process, the CLN remained aware of their position in the research and made concerted efforts to remove any biases.

In the process of the EMHR programme the CLN addressed the six recommendations. The overall results of this report draw attention to the importance of mental health resilience in the NHS workforce and inform health care organisations response plans to the current and future pandemics (1). To identify staff mental health needs, the EMHR programme utilised the C-19 ASSET questionnaire (2). Whilst this tool provided a snapshot of employee mental health, it was not deemed a sufficient tool alone to provide a complete understanding of the mental health status and needs of staff. HR/Workforce Director interviews results suggested that Trusts were considering the long term effects on staff by pledging their support to campaigns which remain vigilant in the monitoring of staff mental health and work to intervene to allow staff a break from the work environment (3). The Call for Action paper highlighted how funding is required to provide dedicated capacity within the healthcare system to meet the mental health needs of the healthcare workers. This was further emphasised by the clinical psychologist's interviews. This proviso was deemed effective by both the psychologists and the staff, however, the funding was not ongoing, and therefore the counselling sessions became unavailable after a fixed time (4). Interviews with HR/Workforce Directors have shown how Trusts are engaging in further collaboration with both internal and external mental health service providers in both the public and private sector (5). The DALS is an effective resources to promote compassionate, empathetic and thoughtful clinical and managerial leadership (6).

The NHS CLN board, from the inception of the EMHR programme decided that it should be independently evaluated. To do so, the CLN worked in collaboration with the University of Manchester. The evaluation served to determine whether the suggested actions reduced mental illness morbidity and second, to inform future pandemic preparedness plans. In doing so, the CLN held themselves accountable for the quality of the programme.

Outcome

The outcomes section of this report considered the effects that the EMHR programme achieved. Ultimately the outcomes of interest were the improvement of mental health and mental health resilience, which was evidenced throughout.

The EMHR programme allowed NHS organisations to participate in a process that was separate from their own internal support processes, enabling them to learn new support measures and coping strategies from peers across the region via the DALS. Results evidenced that the continuation of this intervention should be promoted to further encourage regional multi-partner, collegial support across Acute, Community and Primary services.

The programme gave a qualitative platform to HR/Workforce employees and clinical psychologists. Whilst these staff groups aren't typically deemed '*frontline*', they are no less vital to the functionality of organisations and Trusts. These staff have been integral in providing information about external support processes, the importance of coping strategies and informing recommendations for future practise. The EMHR programme was pragmatic in its approach and implemented further qualitative research with external clinical psychologists, hired exclusively for staff use. This provided a deeper understanding of anxieties triggered by the pandemic and highlighted the importance of continuation of care for staff. This pathway of support also facilitated a space for full disclosure which would not stray outside of the employee's professional boundaries. Where funding allows, it would be beneficial to reinstate Trust based clinical psychologists for exclusive staff use.

Through the use of the C-19 ASSET, at risk staff were identified and implications for future practise have been recommended. However, it is salient to note that the C-19 ASSET was not perceived to be adequate as a standalone tool for evaluation by some clinicians and managers. These concerns were reflective of previous research which suggests that snapshot surveys do not appropriately indicate the morbidity of mental health in the workforce due to disproportionate participation, temporary distress and/or the presence of non-pathological distress (Lamb *et al*., 2020).

Overall, various methods were employed to explore and evaluate paths of research. It was evident that this approach was constructive, as findings were consistently replicated in differing aspects of the programme. When used as a comparator to further support the findings from the EMHR evaluation and the reliability of results, the NHS Staff Survey 2020 results were akin.

KEY POINTS

- The EMHR programme was pragmatic and used various methods (e.g. intervention, quantitative measure, qualitative interviews, comparable national data set)
- Several aspects of the programme reflected the results of others throughout
- The NHS Staff Survey results 2020 supported the validity of the EMHR programme evaluations results
- Implications for future practise and research are informed and may be beneficial to enhance mental health resilience in the NHS workforce in the near or post pandemic future

Implications for Practise

The EMHR programme effectively addressed the issue of mental health resilience. The implications from the EMHR programme were,

Individual Support for CLN Members

CLN members who were clinical leaders/managers were able to reflect on their personal and professional practise with colleagues, gain reassurance and promote mental health resilience. DALS meetings evidenced efficacy in making personal decisions to better ones physical and mental health.

- Professional benefits included wider dispersal of wellbeing initiatives to Trust employees, which are departmentally tailored
- Using the DALS as an initial information point, the process has the ability to encourage CLN members to relay data and materials to their employing Trusts to promote the integration of further mental health programmes
- It is evident that leadership programmes aid organisations in times of increased pressure, especially so during the pandemic. Due to this, it is vital that managers increase their knowledge base via online learning modules to support the referral of staff to health and wellbeing initiatives
- Where comfortable in doing so, it would be beneficial for executive team members to be transparent about their personal mental health and wellbeing to further promote positive culture and eradicate residual stigma

Organisational Alignment

The programme evidenced that Trusts were informed and proactively accessing mental health initiatives within organisations. This was evidenced through regular communication with staff and the increased use of mental health first aiders.

- The use of non-executive directors as wellbeing guardians encourages Trusts to reflect upon and remain accountability for the health and wellbeing initiatives they provide
- Alongside internal initiatives, Trusts are expanding the avenues of support available to the NHS workforce when collaborating with external partners to strengthen their health and wellbeing initiatives
- Further promotion of safe spaces for staff and closed social media groups/platforms would be constructive to promote a culture of collegial support and understanding within organisations
- The embedding of wellbeing conversations in organisational culture is a beneficial practise

Targeted Intervention

There has been an increase in burnout and stress and decrease in positive emotions, yet consistently high levels of commitment and motivation suggest high levels of resilience. The NHS workforce is renowned for its resilience in the face of struggle and adversity. However, results of the EMHR programme suggest that trait prevalence does not mean it should be relied upon for continuation of care. This may further increase burnout.

- To promote the maintenance of resilience it would be beneficial for staff to be offered initiatives to promote confidence and decision making and to enhance job autonomy
- Those identified as at risk for poorer physical and psychological health symptoms were administrative and clerical staff, longer serving staff, clinical staff providing face to face inpatient services and non-clinical support staff working, staff aged between 40-54, staff with a disability, non-managerial leadership staff, and estates and ancillary staff. These staff

groups should be focused on with increased use of risk assessments as early intervention to identify possible physical and psychological health problems
- There is further need to promote a positive culture of collegial empathy and support within organisations. This could be achieved through team building exercises and interventions

Implications for Future Research

The CLN's lead and involvement in evidenced based research promoted engagement and participation on both regional and national levels. Implications for future research arising from the EMHR programme were,

- To proceed with caution when attempting to use snapshot surveys to provide an overall representation of the mental health of the workforce. Due to confounding variables, returned statistics may be skewed leading to incorrectly reported prevalence. It is also true that participating in this study, and other amongst NHS systems (Lamb *et al*., 2020) were experiencing survey fatigue. This report supports the suggestion from Lamb *et al*. (2020), that quantity of responses should not be an indicator of quality of research. Standardised interviews and longitudinal designs, as included in the EMHR programme should be utilised in future to provide high quality research
- It is important to note that the researching and evaluation of the EMHR programme is an ongoing process. Continuation and investigation are vital when considering longitudinal efficacy

Concerns Identified

As reported throughout the EMHR programme, concerns identified were, survey fatigue leading to low response rates and the use of a snapshot survey to gauge the status of the mental health workforce. Although the participation rates were explained by role redeployment and survey fatigue due to the global pandemic, it would be beneficial for the CLN to devise novel methods of recruitment and ways to ensure low attrition rates. Many aspects of day to day life have been affected by the global pandemic and the research process is not exempt.

The C-19 ASSET questionnaire was a novel tool which returned constructive results. However, this method of data collection does not account for the subjectivity of the continuum of mental health. It would be beneficial for the CLN to explore staff use of the returned tailored health and wellbeing report. This would allow the CLN to further consider the efficacy of the C-19 ASSET questionnaire as a viable interventions, asking questions such as;

- Do employees feel the report is reflective of their current mental health?
- Are employee's proactively utilising signposting and suggestions from the report?
- Are the health and wellbeing reports advantageous in supervisory meetings?

The answers to these questions would support the use of the C-19 ASSET questionnaire, encourage employees to be reflective of and proactive in their personal mental health care, further highlight at risk staff, promote an in-depth understanding of staff who may feel marginalised and/or underrepresented, complementing the Ask Twice campaign and direct leaders/managers when tailoring staff support.

Summary of Findings

Prior to the evaluation of the CLN's EMHR programme, there was a lack of evidence-based guidance regarding the mitigation of the negative impact on mental health in the workforce during pandemics (Stuijfzand *et al*., 2020). The evaluation provides preliminary pilot evidence supporting the need for the CLNs North West Offer, consisting of IS for CLN, OA and TI.

Lessons learned from previous pandemics suggest that psychological protective factors are being '*mentally healthy*' and having strong support systems, pre and post pandemic work (Douglas *et al*., 2009). The CLN were able to offer this through the EMHR programme by offering reflective practise to promote personal and professional mental health resilience amongst clinical leader and managers, promoting OA in the advancement of both internal and external mental health initiatives, and the identification of at risk staff. From these results the following eleven recommendations have been made to promote the emergence of mental health resilience in the NHS workforce during COVID-19 and to inform future pandemic planning.

EMHR PROGRAMME RECOMMENDATIONS

1. Individual support for CLN members will guide aspiring clinical/managerial leaders to engage in reflective practice and develop a belief in promoting optimum personal and professional mental health resilience
2. Tailored Digital Action Learning Sets for clinical leaders/managers will promote the transference of departmentally relevant best practise to healthcare workers
3. Where comfortable, it would be beneficial for leaders/managers to be open with healthcare staff about their personal experience of mental health to encourage discourse and disclosure, working to eradicate stigma
4. Trusts should continue working in partnership with both internal and external agencies for access to a wider array of mental health services
5. All NHS organisations should actively sign the Ask Twice campaign to ensure that staff have multiple opportunities to disclose mental health issues if they wish to do so
6. Trusts should promote and utilise the S.C.A.R.F initiative (e.g. Wellbeing Passport, Reset Days, etc.)
7. The funding of staff exclusive clinical psychologists within Trusts would be beneficial for longitudinal use
8. Monitor administrative and clerical staff, longer serving staff, clinical staff providing face to face inpatient services and non-clinical support staff working, staff aged between 40-54, staff with a disability, non-managerial leadership staff, and estates and ancillary staff, as they are at higher risk for poorer mental health
9. To ensure inclusivity, NHS organisations must further explore perceived marginalisation amongst all staff and the reported under representation of BAME employees
10. Take into account that all staff are susceptible to poor mental health throughout pandemics and early identification and intervention are key to promoting optimum mental health resilience
11. The EMHR programme should ensure continuation and advancement to further promote the ongoing benefits of ensuring mental health resilience in the NHS workforce

REFERENCES

Donabedian, A. (1980). The definition of quality and approaches to its assessment and monitoring. Vol. I. *Ann Arbor*.

Kullu, C., Coley, A., Cooper, C., Aitken, J., Cummings, J., Gerada, C., Grant, C., Rafferty, J., Kumar, R., Gizzi, D., Kilcoyne, J., Madhok, R., Davis, D., Richards, Z., Chadwick, Y., Cheney, A., Hately, E., & Keily, H. (2020). Enhancing mental health resilience and anticipating treatment provisions of mental health conditions for frontline Healthcare workers involved in caring for patients during the COVID-19 Pandemic-A call for action.

Lamb, D., Greenberg, N., Stevelink, S. A., & Wessely, S. (2020). Mixed signals about the mental health of the NHS workforce. *The Lancet Psychiatry*, *7*(12), 1009-1011.

Leonard, H. S., & Marquardt, M. J. (2010). The evidence for the effectiveness of action learning. *Action learning: Research and practice*, *7*(2), 121-136.

Moore, L., Lavoie, A., Bourgeois, G., & Lapointe, J. (2015). Donabedian's structure-process-outcome quality of care model: validation in an integrated trauma system. *Journal of Trauma and Acute Care Surgery*, *78*(6), 1168-1175.

Stuijfzand, S., Deforges, C., Sandoz, V., Sajin, C. T., Jaques, C., Elmers, J., & Horsch, A. (2020). Psychological impact of an epidemic/pandemic on the mental health of healthcare professionals: a rapid review. *BMC Public Health*, *20*(1), 1-18

APPENDIX

Appendix 1: Abbreviated Words

CLN- Clinical Leaders Network

EMHR-Enhancing Mental Health Resilience

IS for CLN-Individual support for CLN members

OA-Organisational alignment

TI- Targeted interventions

DALS- Digital Action Learning Sets

C-19 ASSET-COVID-19 specific: A Shortened Stress Evaluation Tool

S.C.A.R.F.-Support|Care|Assist|Recommend|Family

CP-Clinical psychologist

Appendix 2: Individuals Involved

COVID-19-Mental-Health-Advisory-Group-Introductions

C19-CLN-Facilitators

Appendix 3: Call for Action

CLN Paper

Appendix 4: CLN - The Offer

C19 CLN EMHR Overview

Appendix 5: HR/Workforce Directors Interviews

EMHR HR and Workforce Director Interviews

Appendix 6: Robertson Cooper Results

NHS CLN Analysis Results Final Robertson Cooper

Appendix 7: CLN Evaluative Report

Evaluation of the Work of the CLN in the NW

List of Figures and Tables