Research Article

Staff Wellbeing and Networks Support (SWANS) Study

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Background

Anecdotal evidence from Lincolnshire National Health Service (NHS) Provider Trusts alluded to widely publicised reports of increased levels of stress and anxiety among health and social care staff, especially those identified as having an elevated risk of COVID-19 (ERiC). The clear need for support did however not translate to an increased demand for staff wellbeing and staff networks across Lincolnshire. Several studies have since alluded to adverse emotional and psychological impact of the pandemic on NHS, social and private sector front-line workers (Choudhury et al (2020), Al-Ghunaim et al (2021), Nyashanu et al (2022).

The SWANS Study was sponsored by the Sir Captain Tom Moore COVID relief funds via the NHS Lincolnshire Charities and was approved and vetted by the University of Lincoln Research Ethics Committee.

The Study was proposed and carried out in response to the increased burden on the health and wellbeing of the identified NHS Staff groups to establish barriers and enablers. The study was therefore aimed at equipping local NHS provider trusts with qualitative data that aids their response to the support needs of the identified clinically vulnerable staff groups during the COVID-19 pandemic.

Methods

The Study explored the determinants of staff wellbeing and staff network access and uptake during the COVID-19 pandemic across the 3 Lincolnshire NHS Provider Trusts and recruited participants among healthcare staff, Nurses, Doctors, Therapists, Pharmacists, Leadership and Administration. A three-layer qualitative data collection method was adopted as follows.

1. Key informant interviews were held with Trust leadership and department leads including wellbeing services, equality, diversity and inclusion departments and staff network chairs.

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2. Focus groups were carried out to explore the issues discussed in the 1st stage in order to seek the views of colleagues identified as clinically most vulnerable to Covid 19.

3. Finally, one-to-one interviews were held to capture more in-depth experiences of clinically most vulnerable colleagues including capturing some of the recommendations colleagues felt would benefit them if implemented by local NHS Trusts.

The SWANS study is a Lincolnshire-wide NHS qualitative research study to establish determinants of poor uptake of staff networks and wellbeing support during the COVID-19 pandemic among staff identified as having elevated risks of COVID-19 (ERiC) serious illness from the infection. ERiC groups of interest in this study include those for whom staff support networks were set up, including Black, Asian and Minority Ethnic (B.A.M.E.) communities and those self-identifying as living with long-term morbidities and/or disability.

Staff wellbeing and Staff networks generally belong to different organisational positions. Staff networks often fall within the realms of equality Diversity and Inclusion, while wellbeing is generally aligned to occupational healthcare departments in NHS organisations. The SWANS Study however brought these 2 dimensions of staff support together owing to the responses each made in promoting staff support during the COVID-19 pandemic. Furthermore, both services were reporting similar access and uptake issues/challenges when COVID-19 hit.

To explore barriers and/or enablers of accessing the various staff support services, this study recruited participants as follows:

Five focus (5) groups comprising six to eight NHS worker participants were recruited to take part in the study. Furthermore, fifteen (15) key informants such as Executive, Health and Wellbeing as well as Equality Diversity and Inclusion Leads were recruited to take part in one-to-one semi-structured interviews.

Finally, twenty-five (25) individual interviews with COVID-19 ERiC members of staff were held. The interviews were carried out via an online platform called MS Teams. MS Teams online platform was used in facilitating all the interviews to observe national social distancing guidelines to curtail the spread of the COVID-19 virus.

Results

A number of key findings and recommendations are included in the report and can be summarized as follows:

i. A lack of opportunity among colleagues to be released from busy work schedules to attend staff networks and/or access staff wellbeing services. The recommendation of setting up wellbeing-protected time allocation for ERiC staff was potentially able to address this challenge by giving staff as well as managers the validation to/allow access to the needed wellbeing offers.

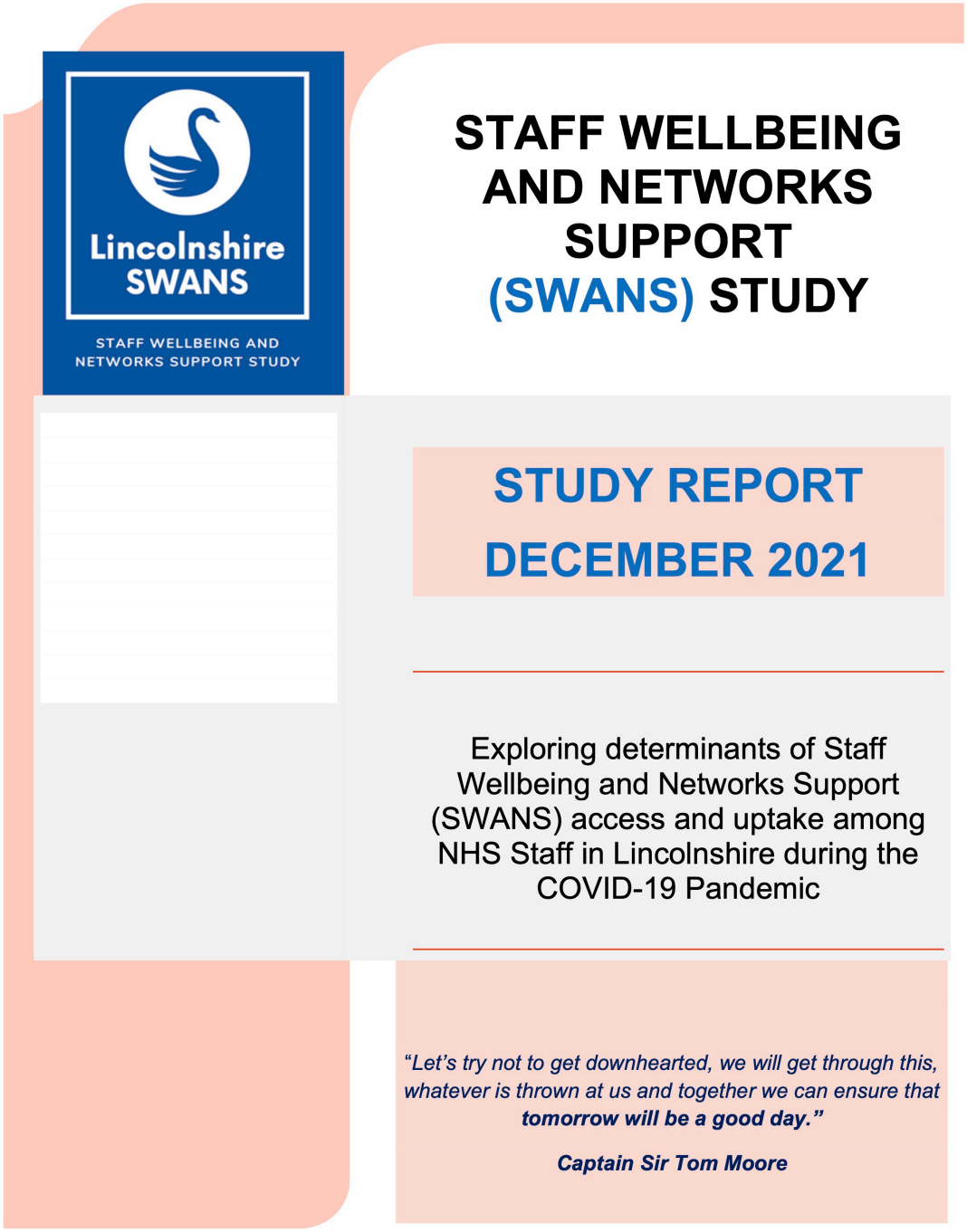
ii. The strengthening of staff networks through executive sponsorship at the Trust Leadership level and allyship at the team level was seen as essential for the seamless facilitation of the study recommendations.

iii. An Action Research phase of the SWANS Study was also proposed in order to document the planning, implementation, and evaluation of any actioned recommendations. This would result in a 2nd report detailing the efficacy of any implemented actions and capturing any new learning for further policy-making, action and research recommendations.

Conclusions

The study yielded several key findings as detailed in the attached study report.Time to attend to the provided Staff Wellbeing offers was identified as a real challenge, especially among patient-facing roles.Line Managers who participated in the study felt that there was potential for staff members to access staff wellbeing offers if these were arranged in advance so that patient care was not compromised because of staff taking time out to seek support.

Trust Leadership or Board Sponsors and colleague Allies were identified as being of great value in strengthening Staff Networks and promoting staff access to wellbeing services. Beyond defining the above roles, emphasis needed to be on the promotion and sponsorship of allyship.



Keywords: COVID-19, Elevated risk of COVID-19 (ERiC), staff networks, staff wellbeing.

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Authorship and Supervision

This report was prepared for the three NHS Provider Trusts in the Lincolnshire Integrated Care System by Musiiwa V Takavarasha, RN. Chief Investigator of The SWANS Study

Lincolnshire Community Healthcare Trust (LCHS) Celebrating Success Staff Awards 2021: Equality Diversity and Inclusion (EDI) Award Winner

I wish to thank Mrs Rachel Higgins, LCHS EDI Lead for having initiated me into the EDI world and for her continuous motivation in the field.

I would like to appreciate the remarkable mentorship and encouragement of Dr Rumbidzai Mukonoweshuro from the University of Plymouth who volunteered her time and told me at the onset that this research study is achievable and valuable, and to Dr Mathew Nyashanu of Nottingham Trent University who supported me along the journey.

I also appreciate the patience and rigour of Professor A. Powell and Professor B. Colston of The Eleanor Granville Centre, School of Equality, Diversity & Inclusion at the University of Lincoln without whose supervision this work would not have been completed.

My special thanks go to the NHS Trust Research teams involved and to those who provided critical feedback to the report, I would have never gotten to this final version without you. Ultimately, I wish to appreciate the Lincolnshire People Board for receiving and considering the SWANS study report

with its findings and recommendation in alignment with the Lincolnshire Health and Wellbeing Strategy.

I dedicate this work to my family, thank you for inspiring me each day.

Musiiwa Takavarasha, 1st December 2021

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1. Sponsorship

The Staff Wellbeing and Networks Support (SWANS) Study was sponsored by Sir Captain Tom Moore COVID relief Funds via Lincolnshire NHS Charities. Special appreciation goes to the Leadership of the 3 NHS Provider Trusts within the Lincolnshire ICS and to their respective Equality Diversity and Inclusion (EDI) and Wellbeing Leads, Staff Network Chairs and all who participated in this study.

2. Introduction

COVID-19 has claimed millions of lives since its outbreak in China in December 2019 (European Centre for Disease Prevention & Control, 2020). The World Health Organisation (WHO) declared the outbreak a Public Health Emergency on 30th January 2020 posing a high risk to countries with vulnerable health systems (Bchetnia et al., 2020). More than four million deaths due to the disease had been reported across the six continents of the world by August 2021 (Hillis et al, 2021). The report from WHO probably reflects only a fraction of the actual number of infections as most countries only conducted tests on people with serious symptoms. At the start of this study, both treatment and vaccinations for COVID-19 were still undergoing trial. (World Health Organisation, 2020). This situation was a great cause of anxiety and depression among healthcare workers. (Pfefferbaum & North, 2020).

Beyond the stress inherent in COVID-19, there is a myriad of challenges that may affect employees. Many employees in the NHS and other organisations were faced with shortages of personal protective equipment (PPE) and other medical supplies needed to carry out their duties which added to the anxiety that came with the possibility of facing an untreatable disease. It is therefore possible that COVID-19, inadequate testing, limited treatment options and other emerging concerns may have been

sources of stress and had the potential to overwhelm the health systems thereby affecting employees (Pfefferbaum & North, 2020). Nevertheless, evidence suggested that employees on duty during the COVID-19 pandemic may have experienced distress because of the changing nature of guidelines, increased pressure during care delivery, and other unforeseen obstacles.

The scale and impact of the COVID-19 global pandemic seemed downplayed when the first cases reached the United Kingdom, yet the devastation that the deadly virus caused was both unpredicted and catastrophic (Anderson et al 2020). As soon as the initial impact of the pandemic was felt among frontline staff in the National Health Service (NHS) and other care providers, it became evident that some groups were affected more than others (Chisnall& Vindrola-Padros, 2021). The inequalities and vulnerabilities of the worst affected groups became the subject of COVID research and broadcasts during the early days of the pandemic (Fagan A, 2020). Among those most identified as having an elevated risk of COVID-19 (ERiC) are Black Asian and Minority Ethnic (B.A.M.E) groups, all adults aged over 70 and those with underlying health conditions such as respiratory, cardiovascular disease, and cancer.

3. Background: Wellbeing services and staff networks

Adopting the Health and Safety at Work Act (HASAWA) 1974 and its various updates is an established employer requirement in seeking to ensure workplace safety (Bibby, 2017). Beyond this, there is growing data, recognition as well as appetite for employers to provide sustainable staff physical and mental wellbeing offers (Leiter and Cooper, 2017). Leiter and Cooper (2017) however state that defining wellbeing is more challenging than other aspects of health and safety at work because there is no consensus on what constitutes wellbeing.

Staff wellbeing has, however, attracted a lot of attention and publicity from the beginning of the pandemic and when the health services began to record deaths among healthcare staff especially given the distress that fellow frontline staff experienced as a result (Selman et al, 2020). Among their recommendations for what they termed moral injury and distress of healthcare staff, Selman et al (2020) reiterated that the mitigation of the effects of the emotionally challenging work on staff during the COVID pandemic required an organisational and systemic approach which includes access to informal and professional support.

The SWANS study is a Lincolnshire-wide NHS qualitative research study to establish determinants of poor uptake of staff networks and wellbeing support during the COVID-19 pandemic among staff

identified as having ERiC. Elevated risk groups of interest in this study include those for whom staff support networks were set up, including Black, Asian and Minority Ethnic (B.A.M.E.) communities and those self-identifying as living with long-term morbidities and/or disability.Considering the above assertions, this study aims to explore support-seeking behavior, including barriers, and facilitators to accessing staff networks. These are viewed in light of the response to the COVID-19 pandemic and to explore the implications for future network planning and support programmes among individuals identified as ERiC members of Staff through COVID-19 risk assessments.

4. Methodology

To date, the research has utilised Appreciative Inquiry methods to carry out qualitative interviews aimed at exploring strengths in staff wellbeing and network support access and uptake among NHS staff in Lincolnshire during the COVID-19 pandemic (Hennink et al 2020). Additionally, an explorative qualitative approach was used, this is normally utilised where researchers' intent is to better understand the issue as opposed to offering a final and conclusive solution to the matter under investigation (Gorynia et al 2007). The method has the potential to identify possible areas for further investigations and can provide an overview of the issue under investigation from a new perspective leading to key information for future interventions (Lockett et al 2005).

4.1 Data collection and recruitment

The data was collected using individual semi-structured interviews and focus groups to explore staff wellbeing and network support access and uptake among NHS staff in Lincolnshire during the COVID-19 pandemic. Guides for semi-structured interviews for key informants, staff with lived experiences and focus groups were constructed and informed by literature from previous primary and secondary research studies of pandemics in workplaces and communities (Robinson 2014).

Prior to fully holding the interviews and focus groups, a pilot study involving two semi-structured interviews with research participants and one focus group comprising five research participants was carried out to test the feasibility of both interview protocols. All the interviews were carried out via an online platform called Microsoft (MS) Teams.

The use of the MS Teams online platform as a method of facilitating data collection was in line with social distancing enforced by the central government to curtail the spread of the COVID-19 virus. Following the pilot interviews, the participants involved were invited to comment on the suitability of

the interview schedules with regards to understanding and responding to the questions. None of the research participants suggested any changes to the original interview schedules as they felt that they were suitable for the purpose.Following the pilot, five focus groups comprising six to eight NHS worker participants were recruited to take part in the study. Furthermore, fifteen key informants such as Executive, Health and Wellbeing as well as Equality Diversity and Inclusion Leads were recruited to take part in one-to-one semi-structured interviews. Finally, twenty-five individual interviews with ERiC members of staff were held.

The researcher sent letters and information sheets to all potential research participants inviting them to take part in the research study. Only those who had agreed to take part in the research study forwarded their names and telephone contacts to the researcher to organise interview dates and times.

4.2. Inclusion and Exclusion criteria

The inclusion criteria included men and women who were working for the NHS in Lincolnshire· All recruited staff had worked in the NHS for more than two years. It was important to recruit a heterogeneous sample with respect to the length of time they had spent working in the NHS to elicit a shared understanding of life before and during the COVID-19 pandemic (Townend 2007).The study involved three NHS Trusts that form the NHS Provider arm of the Lincolnshire Integrated Care System (ICS).As the three Trusts that participated in the study were already part of the new joint working initiative, it meant that participant recruitment through the snowballing technique was easily facilitated across all three Trusts. Snowballing refers to the recruitment of research participants through referrals from other primary or potential research participants (Edmonds, 2019).

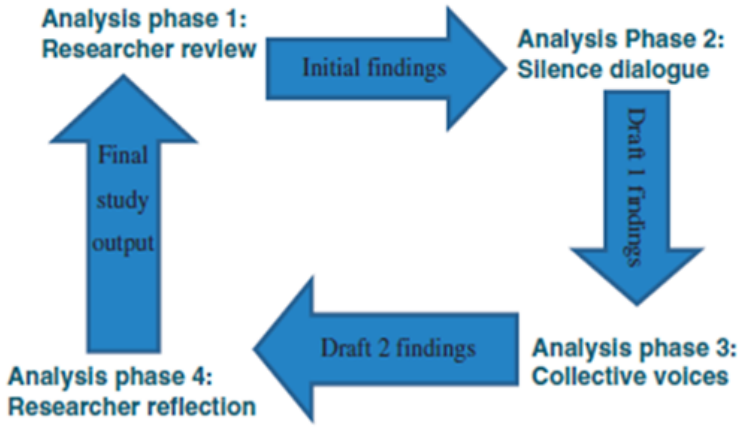
4.3. Ethical considerations

The research was vetted and approved by the University of Lincoln Research Ethics Committee (Ethics Reference UoL2020_4062) in addition to Health Research Approval (IRAS 289675). Research participants were given information sheets to read and understand the information concerning the study. They also signed consent forms which gave them the right to withdraw from the study without giving any reason. The author recruited all participants except staff who identify and or attend the Trust B.A.M.E and Allies Staff Network that he chairs. Participants from that network were recruited via the E.D.I. department of the Trust.

4.4. Data Analysis

All interviews were audio recorded through MS Teams and transcribed verbatim. NVivo was used to organise the data and streamline data analysis. For the verification of accuracy, all transcriptions were read back in comparison to the audio record for confirmation of the main points. A thematic approach underpinned by some aspects of Interpretive Phenomenological Analysis (IPA) and the Silences Framework was utilised (Callary et al 2015; Serrant-Green 2011). In the first instance, the researcher read the transcripts repeatedly to identify and ascertain the accounts of experiences that were important to the research participants. The themes identified were supported by captions from research participants. This formed the bases for the first draft of themes. In phase 2 the researcher compared the draft to the audio record of the interviews for verification of the themes and captions used to support them. This resulted in the production of draft 2.In phase 3 the draft from phase 2 was taken to the user voice group, this was a group of people who worked for the NHS but had not taken part in the research study. The idea was to subject the findings to a critical friend, thus strengthening the analysis through fresh eyes (Foulger, 2010).Following confirmation of the second draft in phase 3 it was taken to the stage where the researcher analysed the output for the 3rd time to form the final output of the research study which was presented as the main findings.Fig one below shows the four phases of data analysis undertaken in this research study.

4.4.1. The four phases of data analysis in The Silences Framework



TSF Phases of analysis (Serrant-Green, 2011)

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5. Results

Results of the data analysis for the SWANS Study revealed that there is a strong emphasis placed on the value and provision of wellbeing offers across Lincolnshire NHS organisations. There exists a broad suite of wellbeing offers and staff networks that are geared to provide welcoming, interactive environments where NHS colleagues said they feel valued and connected. The challenges that respondents highlighted were centered upon opportunities to access and to use the available services on offer. There were variations in perceptions of permission to access services, especially staff networks during work time. Colleagues reported that they had accessed sessions in their own time. Some colleagues also alluded to not having had the courage to ask their managers for time out to attend networks meetings and/or wellbeing services.

Colleagues largely felt that the issue of permission to attend staff networks during work hours, particularly for those in patient-facing roles, needed greater clarity. Asked how this major aspect of uptake could be resolved, colleagues felt that Wellbeing Protected Time could be allocated to allow staff to spread their allocated time across staff network attendance of their choice.The following are some of the themes that emerged from the analysed interviews. While there was an attempt to present these under distinct headings of key informants and lived experiences data, these interview categories became blurred as some key informants alluded to also being in the ERiC staff category. Equally some members of staff who were recruited as staff experiencing ERiC provided key information such as shielding and leadership that were used among key informant data.

5.1. Enablers: Leadership experiences

5.1.1. The network title and content of support

Title: The name given to a staff network was highlighted by research participants as influencing attendance and/or participation as it was deemed to be targeted towards a given protected characteristic rather than attempting to tackle diverse needs in one meeting.

In one organisation, the change of name from the disabilities group to include those with long-term medical conditions yielded a significantly higher attendance level because colleagues felt the group name was non-stigmatising:

"When this group started there was an attempt a few years ago to include all the protected characteristics in one group and allocate time to addressing the different aspects of the meeting e.g. LGBT or B.A.M.E, that did not work as most of us as B.A.M.E colleagues, certainly we couldn't relate with the challenges and issues that LGBT colleagues faced, and perhaps vice-versa" Staff 7

"Certainly, for me, attendance became easier when the staff networks had different meetings, don't get me wrong I sympathise but couldn't relate to some of the challenges my colleagues were facing.That change was a revelation, suddenly, our numbers increased, and colleagues commented that the name change had sent them a message that they felt included" Leader L

Inclusivity of names given to support groups for staff network is very important in bringing feelings of togetherness and inclusivity leading to increased engagement (Werner & Hochman, 2017). The research participants reported increased attendance emanating from the inclusivity of the staff network support groups' names which gave them a sense of belonging and purposeful engagement. It is therefore important that the Trusts continue to uphold this culture of using inclusive names for support groups to enable high engagement from staff.

5.1.2. The motivation to attend meetings

The research participants felt that the subject content of the group meetings encouraged them to attend forthcoming meetings because they found it useful and engaging.

"I felt so encouraged that the content of the meeting was engaging as they discussed pertinent matters that impacted on our health and wellbeing; honestly I am looking forward to attending the next meeting...It was also great to be signposted to different services that I had not previously heard about" Staff 7

I found this meeting to be a good meeting where we found people from different bandings across the organisation...This other day I was surprised and intrigued to see the Trust's Chief Executive attend the meeting and I appreciated that this was a relevant meeting where colleagues can meet and share their experiences"...Staff 9

Attendance of wellbeing staff meetings is vital in mitigating stress isolation and despondence among the workforce (Boccio & Macari, 2014). Such attendance can only be enabled and supported through the motivation given to the workforce by the Organisations. The research participants reported that the subject content of the group meetings encouraged them to attend forthcoming meetings because they found them useful and engaging. It is therefore important that the Trusts continue to monitor the content of meetings and ensure that they are addressing the notions and aspirations of the workers to capture their motivation and engagement.

5.1.3. Dedicated staff wellbeing service

The research participants reported that the Trusts have dedicated staff wellbeing services which have been in existence for more than 10 years. The availability of wellbeing services has helped to mitigate some of the workplace and personal challenges that staff felt during the COVID pandemic.

> *"My organisation and my service are quite unique, so we are among the few NHS Trusts to have a dedicated staff wellbeing service…the service has been in existence for more than 10 years" Leader C*

> *We have continued with yoga, meditation…But more importantly, we've also asked line managers to be in tune with the health and wellbeing of their workforce, we've encouraged and made bite-sized blogs and we've encouraged people to take their annual leave even when we have nowhere to go for now… Leader A*

A dedicated wellbeing service for workers in an organisation is important in preventing stress and mental health among the workforce (Mellor & Webster, 2013). Such a service can also enhance attendance and job satisfaction on the part of the workforce and management at large (Kirillova, Fu, & Kucukusta, 2020).

The research participants reported that the Trusts provided dedicated health promotion activities to mitigate the psychological impact of working during the COVID-19 pandemic for example yoga, counselling, and art classes. All these activities were possible courtesy of dedicated wellbeing services in the Trusts. It is therefore important that Trusts continue to maintain and monitor dedicated wellbeing services to make sure that they are functional and serving their purposes. This will continue to improve the wellbeing of the workforce while preventing isolation and despondence.

5.1.4. Availability of health promotion activities

The research participants stated that the Integrated Care System (ICS) provided health promotion activities to alleviate the psychological impact of working during the COVID-19 pandemic. The health promotion activities are meant to raise mental health awareness among staff working in the system.

> *'We provide psychological support to our staff including physical health and long-term conditions...we also run workshops, health promotion activities and other awareness initiatives to enlighten our staff on their wellbeing' Leader B*

The research participants reported that the ICS has a dedicated telephone helpline service to manage the emotional wellbeing of staff and additional outsourced counselling services.

> *"We have a dedicated 12-hour, 7 days-a-week helpline that can be accessed by staff when experiencing any health and wellbeing problem...staff can also have that half-hour opportunity to just talk to someone as a way of enhancing their emotional wellbeing as well as contacting our contracted providers" Leader D*

5.1.5. Integration of Trusts

The research participants acknowledged the integration of Trusts as an enabler of health and wellbeing among staff as the Trusts were able to work together in mitigating factors affecting staff wellbeing.

> *"One other aspect that was different was that again we started to work as a system including the 3 provider Trusts from a health and wellbeing perspective. This allowed a collaborative health and wellbeing approach" Leader D*

5.1.6. The ICS autonomy

The research participants reported that the autonomy vested in the ICS gave them the opportunity to make decisions on issues under discussion without the need to consult with their individual Trust executives. This enabled fast-track attendance on pressing issues impacting staff wellbeing.

> *"All of us sitting in that system health and wellbeing group had authority to act on behalf of our organisations so I did not have to go back to the executives or somebody else to confirm before we can take a decision...to be honest this was amazing" Leader C*

5.1.7. Autonomy and empowerment

Providing autonomy and empowering staff wellbeing services as well as staff networks was highlighted as essential in strengthening their work and impact among staff as well as encouraging uptake.

> *"I think for me would be around how can the Trust strengthen the Wellbeing and EDI team to support people being able to access the staff networks or staff wellbeing. Is there anything we could be doing on top of what we're already doing? Have we missed something that could really open up the doors for people to join the staff networks?" Leader E*

5.1.8. Microsoft Teams virtual conferences

Although virtual meetings had been introduced as an alternative way of accessing a meeting, this option seemed rarely used prior to the COVID pandemic. When Microsoft Teams became the only option available to meet during the COVID pandemic, it soon became evident according to network leads that this method allowed 2 specific advantages: frequency and flexibility. This was particularly relevant to the rurality and expanse of Lincolnshire and the travel time between NHS services across the county.

i. Frequency capacity was greatly increased as a result of the creation and promotion of the virtual platform.

> *"And we are able to increase the frequency of meetings. So pre-COVID, we would meet quarterly, all the networks would be quarterly. And obviously, given the impact that COVID has particularly on people with disabilities and long-term conditions, people from a B.A.M.E background, we've actually increased that. They've been meeting fortnightly". Leader G*

ii. Furthermore, the research participants said that they felt they could dip in and out of a virtual meeting as other commitments allowed and therefore there seemed to be greater flexibility:

> *"When there's a meeting on, I might not be able to attend the whole meeting. But because it's online, because I don't have to travel, I feel able to just drop in or leave the meeting... I found it's been much more flexible". Leader F*

iii. Microsoft Teams was also seen as allowing for continuous interaction of staff networks as opposed to waiting for the next meeting to highlight or discuss matters:

"I think keeping Teams will really help with access if we keep the online approach, and not keeping everything to meetings. We do a lot of chat on our network team's channel. So, people are posting stuff and communicating all the time". Leader E

5.2. Challenges: Leadership perspectives

5.2.1. Taking ownership and accountability

While there were discussions about barriers and enablers to staff wellbeing and networks across Lincolnshire Trusts, the issue of whose responsibility it is for access and uptake of the offers available also featured in the research interviews, one leader had this to say:

"*The one thing that I've noticed phenomenally in the healthcare sector is how people will put their patients above everything else. That's phenomenal on one level. But, if you were on a plane, that's coming down in a spiral, the first thing they tell you to do is put on your own mask, in order to help others. So we've got to get our workforce in a space. That's for everybody to take accountability and ownership for wellbeing. And to recognise my world is my responsibility. It's great that my line manager will have a conversation with me, but they're not going to be the one that's going to make me access, I've got to take some ownership for it. Leader H.*

Trust Leaders seemed to agree that there are real opportunities and benefits for promoting their wellbeing offers. About why facilitating wellbeing offers to pay, one leader had this to say:

"We are a people business. If we take care of our people, our people will deliver the best outcomes for patients, our people deliver the best performance. So, we've got to put our people first. We have to recruit for that, behave fully. We have to ask people to take responsibility for themselves as well.

Leader M

5.2.2. Creating Links between staff and Trust Leadership

Staff networks are vital elements in NHS Trusts and the research participants expressed the indispensable value they put in networks. One leader stated the value of staff linking in together, which consequently links back to the Trust leadership.

"I think our staff networks have played a critical role in reaching out and supporting colleagues. I see the role of staff networks as being a voice and having access to the highest level, myself and the board. I think our staff networks have brought together different people from different backgrounds, communities, to link in, supporting each other, and talk about issues... having a safe space to say I'm feeling like this. Usually, when you do that you might not just be the only person who's thinking like that, and then we can navigate and work through so I think that's been a really quick critical part to keep people supported, linked in, but more importantly as well on that is to link back into the Organisation. To tell us what we might not know" Leader H

5.2.3. Self-perceived position of strength

Some leaders who were interviewed saw their position of leadership as a barrier to personally accessing wellbeing support

"*I have struggled with seeking help, I think is because people look to me to be okay. They look to me to lead the way, and I'm there supporting people. And I suppose that's on me as well, I can't ring and tell someone I'm not coping...I did once phone the health and wellbeing line when I just couldn't stop crying and when the phone rang I put it down and said I just can't do this. I picked up the phone again and said to myself, come on look at the state of you, you've got to talk to somebody" Leader J*

5.2.4. Meeting attendance permission:

Research participants felt that the major obstacle to attending wellbeing and staff network offers was the lack of permission from managers. Key informants however appeared split as to whether staff were being denied access during working hours or whether the staff members felt they couldn't ask for permission to attend for one reason or the other. On that note, another leader expressed the futility of having a range of wellbeing propositions that staff felt unable to access:

"I think the challenges are people being able to be released from work to access staff networks is probably the biggest challenge. And though I'm not sure whether they feel they are able to ask their manager to be able to attend any staff networks. Leader E

"Sometimes people aren't giving their managers the opportunity to even say no because there's a perceived concept that the manager is going to say no. So, they don't ask because of that expected no. Some are never even given the chance to say yes or no. But that to me is also about, as managers, they need to be creating an environment where people feel able to ask. Leader C

"So, we've got a plethora of offers that staff members can use and access. But if we don't have line managers having the right conversations with maybe some more of those staff who are more hesitant to access it, that's the bit that we've got to be working on, having line managers engage in those right conversations" Leader H

5.2.5. Pressure of identifying and declaring interest

Some key informants reported pressure in having to identify and/or declare their reason for attendance particularly if they do not identify with the group or identify as an ally. Furthermore, some colleagues worried that they may not be welcome by the group based on their role within the organisation:

"I have been meaning to dial in and frankly at times I feel I do not have permission of the group to attend, I have felt like I'm intruding" Staff 7

"Because of my looks, I feel awkward when introducing myself in the group. Should I say I am a member or an ally so I often just say my name and not qualify why I'm attending the meeting" Leader N

"Working in my role and having worked on cases involving some of the network members, I don't know, somehow I felt they would feel uncomfortable that I am there". Leader H

5.2.6. Volume of work

Research participants who reported not having attended wellbeing services networks gave workload as their primary deterrent for access and that once they finished work, accessing work-based

wellbeing services was not a priority for them as a result.

> *"Even if I felt I needed wellbeing support, I was so exhausted at the end of the shift that all I had on my mind was to crush on my bed and sleep and when it's time to go to work just pressed repeat". Staff 11*

> *"I have never been so busy at work in all my time in the Trust, it felt like we did half a year's work in a couple of months and I accept I should have sought emotional help at the time but I preferred to just switch off" Leader H*

5.2.7. Travel time

Research participants remarked about the challenges they faced when meetings were face to face as Lincolnshire Trust operations are generally geographically spread out:

> *"I recall the challenges of travelling for 60 to 90 minutes to attend a 1-hour meeting and then back again… this made attendance incredibly challenging as that was your whole afternoon gone" Leader H*

Research participants said that Clinical staff were generally less likely to attend staff networks due to their care roles and schedules clashing with staff network times:

> *"But actually, what I would say is since switching to teams, not big numbers, but we have seen a couple of our clinical staff start to be able to attend, which is really positive because we've never seen that before. But obviously, if the ward is reasonably staffed and they're not struggling, actually allowing somebody an hour to sit in the office to come on to a staff network is much easier than an hour travel time." Leader F*

5.2.8. The impersonal nature of virtual meetings

Research participants felt that meeting virtually was basically impersonal in nature and lacked the human touch element such as being able to offer a shoulder to cry on:

> *"….I think there is definitely a feeling that people are missing that face-to-face contact. Some of the issues that we discuss in the networks are very emotive and are very personal, very*

sensitive and require at times to offer a shoulder to cry on..... If you're face to face, you can offer much better support to those kinds of topics" Leader I

The use of virtual space as the new way of holding meetings was seen by some of the research participants as a challenge as this came with snags such as internet breakdown, power cuts and operational demands e.g. technological know-how. Furthermore, as there was little opportunity for colleagues to meet face to face, resorting to virtual meetings saw difficulties in accessing online platforms due to poor technological know-how and internet breakdowns.

5.2.9. System working of Trusts

While collaborative working had been stated as an advantageous working environment, some key informants also reported that the amalgamation of Trusts came as a challenge as different Trusts had seemingly different ethos and values, which made it difficult to quickly reach a consensus when making decisions.

"When the different Trusts came together to overcome the impact of COVID-19.... this seemed to pose a challenge when making decisions as Trusts seemed to have different priorities and preferences" Leader J.

5.2.10. Organisational vs departmental priorities

There appeared to be a disconnect between organisational and departmental commitment to wellbeing. Departmental leads who participated in the research said that there seemed to be no strategic communication to them of the items that staff networks discuss and/or communicate to Trust leaders.

"....it might seem that I am reluctant to allow staff to access networks but often I had not been made aware and in fact have had to stumble across some information that I was meant to have received and acted upon...." Departmental Leader B

"*From a managerial point of view I think you are aware we have patient care as a main priority, I do not doubt that staff wellbeing is important but we have to get the balance right and often there just isn't the luxury of releasing all my staff..." Department Leader C*

5.3. Staff perspectives: Enablers of accessing wellbeing

5.3.1. Supportive environment:

The research participants felt that the existence of a support group enabled them to deal with stress and other disability-related issues. They expressed how the group imparted positive and supportive experiences following difficulties.

> *"The MAPLE (Mental and Physical Lived Experiences) group was so supportive that it enabled me to face my disability stress and other personal issues.....it was a place where I could talk to other people about my lived experiences while hearing from others" Staff 2.*

5.3.2. Opportunity to meet others

The research participants felt that the networks and their leadership provided a space and opportunity to meet and share experiences and belong. They felt that this was critical given the impact of COVID-19 which led to lockdown and isolation, particularly for those who needed to shield themselves.

> "*If this group was not there I would not have known anyone else shielding, honestly the group provided a rare opportunity that one can get especially during a pandemic period...it was a good feeling to know that I was not alone"...* (Staff 13)

5.3.3. Supportive line managers

Research participants highlighted the positive support they received from their line managers once they received shielding letters. Among colleagues who did not receive shielding letters, some reported that managers were supportive through the COVID risk assessment exercises and were removed from high-risk/front-line duties into less risky areas.

> *"My manager was very supportive during the COVID-19 pandemic, they always made sure that I was protected from working in risky environments...for example when the government shielding letter arrived, I was quickly asked to shield" ... staff 3*

> *I am asthmatic but did not receive a shielding letter, however, my manager supported me through the risk assessment and offered to redeploy me out of my unit into a lesser-risk area. I*

informed my manager that I was anxious to be moved as there were reports of a shortage of PPE in other areas. My manager supported me further by allowing me to stay in my unit and moved me into less risky parts of my role. Overall, I felt really supported. Staff 4

5.3.4. Allies

Increasingly during the COVID pandemic, staff networks appeared to encourage and include allies in their titles and promotion outlets. Although the label had been used previously by a few staff networks, "and allies' was added to at least 3 more staff networks within the three NHS provider Trusts.

"*Allies were considered as giving people the opportunity to have that peer support with other people that identify with a certain characteristic such as B.A.M.E, LGBT or MAPLE" Staff 7*

A key informant who had helped form a couple of staff networks within their organisation and across Trusts pointed out that while there were benefits to the inclusion of allies, they suggested that some caution was required.

"While allies have a great place and purpose, our networks were telling us that sometimes when you're surrounded by your allies, you don't always feel safe to raise certain things. And actually, you might want that chat with somebody that you know knows what it feels like to be in your shoes". Staff 4

There were also calls to agree on the definition of an alIy as a way of inviting interest among those who are inclined to register their interest as allies in staff networks.

"I think it's about understanding what the term "ally" really means and how people can demonstrate that...I think what's been missing is, we use the term and people say "I'm an ally" but actually don't really understand in practical terms what that means and what they're signing up to by saying that. It can mean different things to different people, but we need to agree a role brief so that people know these are the things I should be doing if I say, "I'm an ally." Staff 6

5.3.5. Executive sponsorship and visible lead

Research participants said that having executive sponsorship where a member or more from Trust leadership took visible interest and attendance of staff wellbeing/networks was an encouragement to

attend. Furthermore, having an executive sponsor was reported to showcase the leadership focus and commitment to staff wellbeing in general and to staff networks.

> *"Our Trust Board and/or leadership usually has representation in our meetings. For me, it speaks volumes about how seriously we are supported and that whatever issues we air, someone out there is bound to hear about* it" *Staff 5*

5.3.6. Combatting isolation

Research participants felt that access to staff wellbeing in general and staff networks was helpful especially during the COVID lockdowns as they provided contact with other colleagues.

> *"As someone who lives alone and was shielding during the 1st and 2nd lockdowns, I cannot begin to tell you just how lonely it was for me. The 1st lockdown was especially bad because the Trust had not figured out what to do with us once our shielding letters came through. Most of us were sat at home and not set up to working from home and it was dreadful, I tell you. I did not know at the time that these groups were running…especially the shielding group" Staff 9*

5.3.7. A Visible Helping Hand

Participants remarked that it was easier for them to seek help from someone who worked with them or turned up at their place of work rather than to dial a number to get an appointment for access later. Staff-to-staff support was also emphasised as a ready and available buddy support structure that colleagues relied upon in their areas of work. Additionally, wellbeing offers that were provided at staff members' workspaces were seen as more accessible.

> *"I sought help from the Chaplains only because they showed up on the unit often in a time of need, I doubt I would have sought help otherwise…" Staff 6*

> *"My colleague is a wellbeing champion; I have recently found out and I have spoken to her. The discussion was quite informal, but I found it helpful…I think it helps that she is available most times and that we face the same challenges…" Staff 7*

"When you are drowning you tend to grab whatever you see first right, we need help here where the need is, right here in the trenches so to speak" Staff 11

5.4. Challenges faced by staff in accessing wellbeing and networks

5.4.1. Lack of opportunity due to workload

Research participants emphasised their appreciation of wellbeing services. However, they also raised serious challenges in attending staff wellbeing services in general and staff networks in particular due to pressure of work. This concern was shared by both administrative and clinical staff in one-to-one interviews although focus group interviews appeared to take the consensus that clinical staff face a greater challenge in accessing wellbeing and staff networks.

"Some work pressure always crops up... I have lost count of the number of times I have set out to attend the network meeting...at this rate, there is no chance that I will be able to attend anytime soon" Staff 14

"My manager simply said no! not in work time...I have not asked again since..." Staff 19

5.4.2. Lack of awareness on the wellbeing offers.

Some research participants expressed ignorance on the existence of staff networks in their organisation One colleague who had attended a staff network for the 1st time since taking up work in Lincolnshire three years ago felt that they had not come across publicity about the group until a colleague who attends one informed them about it.

"I am not aware of the staff network, but I am aware that all this stuff that has been going on should somehow be supported through a staff network....to be honest I never took time to find out about it" Staff 8

5.4.3. Branding of wellbeing offers

Some research participants highlighted that most wellbeing offers in Lincolnshire are advertised as mental health and wellbeing services and are mostly offered by the County's mental health NHS Trust. There appeared to be hesitation among some of the research participants that this was a different

Trust to their employer, and they worried about confidentiality and stated that their worries and/or anxieties were not so severe as to be addressed by a mental health service.

One service lead commented on this and highlighted the issue of trust and confidentiality.

> *"what our services need is to be inclusive of NHS Lincolnshire, or wider than just those working in the NHS, how do I have an identity that this is for me? How do I feel safeit? How do I know that my data is going to be kept confidential because I think that's the other thing that plays out for people?" Staff 9*

5.4.4. Normalising personal difficulties

Some research participants who faced challenges in their health and wellbeing that impacted their day-to-day work experiences did not feel entitled to access long-term conditions or women's groups. For example, a couple of staff reasoned that menopause is a natural experience for every woman and that support groups would not help in their situation. One of the ladies said.

> *"I suffer with debilitating headaches and at times feel unable to work through the whole working day ever since I started the menopause...I do not feel it's something that warrants attending a support group...those are for people with long-term conditions" Staff 10.*

5.4.5. Inconsistent messages and provisions for shielding

The research participants felt that there was inconsistency in who received a shielding letter and who did not for example some people received letters for shielding while others who met similar published criteria for shielding did not receive letters and were therefore not eligible for shielding

> *I just noticed that my colleagues were withdrawing themselves from the frontline following their shielding letter...because I did not have a shielding letter, I remained at the frontline, yet all the guidance at the time deemed me as at high risk of COVID" Staff 8*

5.4.6. COVID vaccination uptake

Although the study had been conceived before the vaccination program was initiated and sought only to explore access and uptake of staff wellbeing offers including staff networks, the interviews were carried out when the COVID vaccination program was well underway. The issue of vaccination

hesitancy featured among both the key informant and lived experience interviews including focus groups.

The research participants acknowledged that historical experiences contributed to hesitancy and suggested the need for positive messages to be networks led rather than Trust leadership led. Some research participants said they came to the meetings because they felt they could get clarity regarding vaccine safety etc.

> *"There seemed to be opposing messages around the COVID vaccination such as will I be able to travel back home if I do not get the vaccination...I found it helpful to share some of my fears with others" Staff 11*

> *"I think it's likely to be perceived as just patronizing. Even though I'm proudly an ally across the whole of equality, we've had this around the vaccine uptake, that people don't need me as a white ally telling them to take the vaccine. What they need is people from their different communities, whether they're living with a disability, whether they're from LGBT groups, whether they're from different Black, Asian Minority Ethnic groups" Staff 11.*

5.4.7. Religion/Having no religion

Accessing the chaplaincy service for wellbeing support was seen by some research participants as inappropriate as they felt it was a religious service.

> *"I don't have a faith as such, I wouldn't use the chaplaincy service like that...I was christened but that's all if you know what I mean..." Staff 14*

> *"Because I am not a church person, I did not expect to benefit from the chaplaincy service, yet I tell you they really helped me pull through..." Staff 15*

5.4.8. International new arrival staff

Seven months into their role a group of staff stated during a B.A.M.E Staff network that they had not heard of the existence of the staff support group.

"I speak for myself and members of my group, the international colleagues, this is the 1st time we were informed of this staff network when they talked about the research. We were not told before, otherwise, we would have come here; we are facing challenges at work and we would have come here..." Staff 16

6. Recommendations

The recommendations that were made by all the 3 phases of this study came down to one main recommendation, namely the recognition, introduction and embedding of Staff Wellbeing Protected Time (SWePT) to promote uptake and access of staff wellbeing and networks across the system partner Trusts, Departments as well as service units. This research report proposes that the Lincolnshire Trusts allocate SWePT for staff to attend wellbeing services or staff networks of their choice. This can range from anything between 2-3 hours each month.

While some Trusts have introduced a wellbeing day, an extra annual leave day per year for staff to access wellbeing, this did not appear to have been disseminated across the system as some colleagues reported to be unaware of the wellbeing or extra day facility.The author was not aware of any evidence that the wellbeing day facility had increased access and/or uptake of Trusts' wellbeing offers or staff network attendance.

A SWePT alternative would increase opportunities for staff to access wellbeing and networks support as these would be timed in agreement with the line managers to free up staff from their day-to-day work to attend a scheduled wellbeing service or staff network of their choice.SWePT would also demonstrate the Trust's strong emphasis and priority for staff wellbeing and will therefore offer permission for staff release to attend wellbeing per their allocated SWePT. While the present study is concerned with Staff with ERiC, participants highlighted the need for Trusts to level the playing field for all staff to attend wellbeing and staff networks. This has been further facilitated by widening the suite of wellbeing and networks offers to include women's groups, men's groups, carers, faith groups, etc.

Allyship, there is a need for Trusts to define and specify the role of allies for this to receive the same allocation of SWePT as other network attendances. There is currently a lack of clarity or consensus on the definition and scope of allies, and this has had the effect of colleagues who identify as allies not being able to request time allocation to attend networks they wish to ally with.

Staff wellbeing and network support are expected to play a pivotal role during COVID recovery as such their access and uptake must not only be encouraged but be enabled by the provision of SWePT. For SWePT to be embedded in staff/manager conversations, this report recommends that a SWePT discussion should form part of regular staff appraisals, performance reviews, 1 to 1 Manager support meetings and any other opportunities.

Leaders and staff participants voiced that the recommendations of this study required implementation across the networks so that together the System would benefit from the research. The study was considered to have brought several levels of services and diversity of thoughts together with the common vision of exploring what works and what needs improving in pursuing our goal of improving access and uptake of staff wellbeing. Table 6.1 below lists the rest of the study recommendations:

6.1. SWANS Study: Findings and Recommendation Table

1. Time to Care vs Time to seek Care

Time to attend Staff Wellbeing offers was a real challenge, especially among patient-facing roles. Line Managers as well as Staff felt that the priority should always be on giving care rather than seeking care.

There is a need for the allocation of Staff Wellbeing Protected Time (SWePT) for colleagues to find the opportunity to seek support where this is not always possible due to work pressures. Additional time needs to be agreed upon for network chairs/admin to facilitate network duties during work time.

2. Allyship: A growing usage of the term

Allies had a perceived great value in network strengthening and awareness, yet the term was not clearly defined causing confusion about who constitutes an ally. Defining, recognising and promoting allies/allyship, especially within staff networks can enable greater recognition, uptake, and impact of the role. Allies were seen as having the same impact as executive sponsors at the team and service levels.

3. Mental Health vs Wellbeing

The Mental Health branding of some wellbeing offers caused worry and stigma. The Mental Health Trust is the main provider of Wellbeing support was also felt to add to the stigma of seeking help.

The need for the rebranding of wellbeing support services from being mental health provider services to system-wide wellbeing support was discussed due to the persistent stigma of mental health.

4. Chaplaincy as Staff Wellbeing

Patient care or Staff care: There was a transformation of chaplaincy service from being predominantly patient-focused to staff-focused offer during the pandemic. There is a need to define and recognise the role of chaplaincy services as a robust staff wellbeing service beyond COVID-19. This would be facilitated by either a dedicated chaplaincy staff support rota and/or a dedicated staff chaplain/unit of the chaplaincy services.

5. Streamlining wellbeing presence in Teams

Colleagues felt that Mental Health First Aiders and Wellbeing Champions were a valuable part of staff wellbeing services though some raised the issue of their invisibility in some teams. Additional visibility/promotion of the roles could be beneficial. Furthermore, the development of the roles into more proactive activity within teams has been a welcome addition to meeting the wellbeing needs of staff where they are. The anonymous logging of these proactive activities will help to evaluate the reach and efficacy of the programmes.

6. Cultural competency training

Cultural competency was rolled out among leadership and team managers and was raising the potential for dialogue between staff and their managers on staff needs for cultural networking and the value of connectedness. Cultural awareness and competency training needed to be further rolled out across the Trusts and encourage an environment where colleagues feel able to speak up on incivilities and/or acts of racism within teams, departments, and organisations.

7. System working in Wellbeing and Staff Networks

Colleagues felt that the opportunity to work as a system during the COVID pandemic had been mutually beneficial and served to strengthen ties among the system partners. The integration of staff networks across the Trusts had been further strengthened by ICS working and this offers a strong opportunity to explore broader access to staff wellbeing and networks irrespective of the employer within the system partnership.

8. Shared learning among Organisational Development (OD) wellbeing and networks training

OD is seen as playing a key role in aligning the Trust's day to day business with the strategic aspirations of the services. OD would therefore be instrumental in driving the wellbeing and belonging agendas into training, awareness, and staff induction of new starters. The involvement of Organisational Development teams as key stakeholders in the improvement of access and uptake of staff wellbeing and networks access needs to be promoted.

9. The role, responsibility, and value of the executive sponsor

Executive sponsors were identified as leadership-level allies offering a valuable link between networks and Trust leadership teams. Colleagues felt valued and listened to and assured by the executive sponsor's presence in staff networks. The attendance of executive sponsors needs to be reinforced and cascaded into middle management roles where managers can attend staff networks and where possible feed into their respective management meetings. This can further emphasise the value that Trusts place on staff networks and promote shared learning between staff networks and management. This would need to be planned in collaboration with staff networks.

10. Actioning the recommendations

From the study onset, participants enquired if the SWANS study would involve the facilitation of stakeholder implementation of the recommendations: An Action Research phase of the SWANS Study is now being proposed

to Plan, Implement and Evaluate the Recommendations in order to record and measure the effectiveness of actions geared to improve access and uptake of staff wellbeing and networks.

7. From Recommendations to Action

The purpose and focus of the Staff Wellbeing and Networks Support Study was to explore barriers as well as enablers to staff taking up the suite of wellbeing offers as well as staff networks available to them. The study has highlighted several determinant factors and recommendations that would showcase an improved acceptance and use of wellbeing services and staff networks as a vital part of staff feeling that they belong and are cared for. A recurring reference point throughout the research was the need to not only stop at finding out the participants' answers and coming up with recommendations but to develop those recommendations into action plans. Therefore, in answer to that call, it is proposed to extend the present study into an action research phase.

The Study extension is aimed at collaborative planning, implementing, and evaluating the recommendations of the initial Staff Wellbeing and Network Support (SWANS) study, chiefly the introduction of a Wellbeing Networks Rota for members of staff that contains scheduled meeting links for the available wellbeing offers and/or staff networks.

The following is the author's proposal for part 2 of the SWANS Study. While additional ethical and governance approval will be sought, the work is expected to be completed over 10-12 months depending on stakeholder capacity. This proposal aims to illustrate that there is scope for the SWANS Study Action Research phase. (SWANS 2).

Having completed the intended exploration of staff experiences of accessing wellbeing and network supports during COVID-19, the author has uncovered some areas requiring collaborative action among the NHS Provider Trusts in Lincolnshire. As such, the objective of the Action Research phase will be to document the collaborative work of implementing and evaluating the recommendations of the current study.

Action research as a study method aims to contribute both to the practical concerns of people in an immediate problematic situation and to further the goals of social science simultaneously. (Reason and Bradbury, 2001).Action research is therefore concerned with working towards practical outcomes

while also creating new forms of understanding. The recommendations of the initial SWANS Study, therefore, stand to be tested through an action research cycle to demonstrate whether they will improve the access as well as uptake of staff wellbeing and networks across the Lincolnshire Trusts.

The purpose of the proposed next stage of Action Research is therefore to bring about the recommended change and simultaneously generate a theory grounded in practice and service provision.

The Action Research cycle consists of four steps: namely planning, acting, observing and reflecting.

7.1. The Action Research Cycle (Adapted from Stewart, 2014)

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Timeline	*Action*	*Outcome*
November - December 2021	*Report dissemination*	*Circulating findings and recommendations*
January 2022	*Stakeholder feedback*	*Agree priority actions + Planning*
January-December 2022	*Deployment of revised Health and Wellbeing Strategy*	*One year testing of drafted Action Plans and initial impact analysis*
January 2023	*Reflect and evaluate progress*	*SWANS 2 Study Mapping*
February -March-2023	*Stakeholders' interviews*	*Cycle reporting and presentation*
April-May 2023	*Stakeholder Analysis*	*Participatory Analysis*
September-November 2022-	*Dissemination of SWANS 2 Action Research Report*	*Stakeholder feedback to SWANS Action Research Report*

7.2. Timeline for proposed Action Research.

The timeline and actions suggested above are guidelines to give the proposal structure and context for the next stage of the research. The implementation and delivery of the Study recommendations will be down to the 3 providers Trust Boards and the Lincolnshire People Board in line with the agreed Lincolnshire Health and Wellbeing Strategy.

8. Conclusion

The SWANS Study has highlighted several strength areas in staff wellbeing offers and network support around Lincolnshire NHS services. While challenges in accessing this considerable suite of offers have been raised, recommendations of the study seek to mitigate identified challenges and improve access and uptake of the services. Chief among the recommendations of the study is the provision of Wellbeing Protected Time that is employee centered and the need to create pathways that allow such a provision.

Several of the recommendations have already been planned and/or actioned across the three provider Trusts as leads who participated in the study shared some of the work that was either planned or recently implemented among their recommendations to the study. For instance, the provision of protected staff wellbeing had been rolled out in some parts of the ICS and colleagues had been able to book an extra day to their annual leave allocation, entitled wellbeing day.While it is unclear what the plans are for the wellbeing day allocation among other partners in the ICS employees, this allocation could be extended and allocated as Wellbeing Protected Time that colleagues can use towards accessing system-wide wellbeing and staff networks.

Additionally, the administrative time allocation for Network Chairs has been successfully trialed by at least a couple of staff networks in the system but remains to be rolled out to other staff networks particularly and in the instance of this study, towards Black Asian and Minority Ethnic and Networks representing Staff with long term health conditions such as MAPLE, IMPACT among others.

It is encouraging that some of the actions that the study recommends have already been rolled out. What remains is widespread implementation, logging, and evaluation of the efficacy of actions across the system. One route to achieving this would be the collaborative efforts of Wellbeing, E.D.I and Staff Network stakeholders being in line with the ambitions and priorities set out in the Lincolnshire Health and Wellbeing Strategy.

Conflicts of interest

The Chief Investigator serves as chair of a local Black, Asian and Minority Ethnic (BAME) Staff Network. Participant recruitment from that group is carried out by the Equality, Diversity and Inclusion (EDI) team and the chief investigator excluded himself from that exercise to address conflict of interest.

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