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Implementing psychological support for health and social care staff affected by the COVID-19 pandemic: a qualitative exploration of staff well-being hubs ('Resilience Hubs') using normalisation process theory

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ABSTRACT

Objectives Evaluate the implementation of Hubs providing access to psychological support for health and social care keyworkers affected by the COVID-19 pandemic.

Design Qualitative interviews informed by normalisation process theory to understand how the Hub model became embedded into normal practice, and factors that disrupted normalisation of this approach.

Setting Three Resilience Hubs in the North of England.

Participants Hub staff, keyworkers who accessed Hub support (Hub clients), keyworkers who had not accessed a Hub, and wider stakeholders involved in the provision of staff support within the health and care system (N=63).

Results Hubs were generally seen as an effective way of supporting keyworkers, and Hub clients typically described very positive experiences. Flexibility and adaptability to local needs were strongly valued. Keyworkers accessed support when they understood the offer, valuing a confidential service that was separate from their organisation. Confusion about how Hubs differed from other support prevented some from enrolling. Beliefs about job roles, unsupportive managers, negative workplace cultures and systemic issues prevented keyworkers from valuing mental health support. Lack of support from managers discouraged keyworker engagement with Hubs. Black, Asian and minority ethnic keyworkers impacted by racism felt that the Hubs did not always meet their needs.

Conclusions Hubs were seen as a valuable, responsive and distinct part of the health and care system. Findings highlight the importance of improving promotion and accessibility of Hubs, and continuation of confidential Hub support. Policy implications for the wider health and care sector include the central importance of genuine promotion of and value placed on mental health support by health and social care management, and the creation of psychologically safe work environments. Diversity and cultural competency training is needed to better reach under-represented communities. Findings are consistent with the international literature, therefore, likely to have applicability outside of the current context.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study uses a well-used theory of implementation, normalisation process theory, to inform an understanding of the barriers and enablers to the implementation of Resilience Hub services to support health and social care staff affected by the COVID-19 pandemic.

⇒ The research brings together findings from a large number of participants (N=63), to explore the perspectives of four different groups (Hub clients; non-Hub keyworkers who did not access Hub support; Hub staff and wider stakeholders).

⇒ Particular efforts were made to interview individuals from minority ethnic communities and other under-represented groups, as well as keyworkers who did not engage with Hubs, which provided an understanding of access barriers to Hub support.

⇒ Interviews were cross-sectional, therefore, unable to capture change across individual participants' experiences of the Hubs or other support accessed.

⇒ Although efforts were made to recruit widely, some groups eligible for Hub support remained under-represented within the interview sample, such as care home staff.

INTRODUCTION

The COVID-19 pandemic has been associated with stress, anxiety and depression among clinical staff within health and social care.[1–5] Non-clinical staff may also be disproportionately affected.[6] Levels of mental health difficulties and burnout among these keyworkers have remained high 2 years after the start of

the pandemic.[7] Many support offers have been initiated, including helplines, apps and therapy,[8 9] but their uptake and impact has not been well evaluated.

During the pandemic, National Health Service (NHS) England, the executive body which oversees commissioning, funded 40 well-being Hubs to support staff, with a focus on outreach and timely access to interventions.[10 11] Hubs were modelled on the Greater Manchester Resilience Hub, set up originally following the Manchester Arena bombing (2017).[12 13] This Resilience Hub used evidence-based 'screen and treat' approaches that were used after the London 2005 terrorist attacks.[14] Crucially, it was designed as an adaptive model which could be redeployed in response to future crises and large-scale trauma events. The Greater Manchester Resilience Hub was already expanding their offer of trauma-informed services, including staff well-being work, so was well placed to support health and social care staff during the pandemic. The Hubs offer a range of support, including outreach, mental health screening, assessment, and provision of individual and team-based psychological interventions.

This qualitative study was part of a wider mixed-methods evaluation,[15] and the first study to evaluate the repurposing of the Hub model to (A) respond to a novel crisis, the COVID-19 pandemic and (B) support a new population: health and social care keyworkers. The qualitative study aimed to evaluate the implementation of three Hub services by identifying potential barriers and enablers to embedding the service model, its fit within the wider care system, and uptake by keyworkers.

METHODS

Theoretical frameworks

Keyworker interviews were based on Sekhon's Acceptability Framework,[16] with additional questions drawn from the Theoretical Domains Framework[17] and the Behaviour Change Wheel.[18] Hub staff and wider stakeholder interviews were based on normalisation process theory (NPT), a widely used theory to explain the processes by which an intervention—in this case the Hub service model—becomes, or fails to become, embedded into routine practice.[19 20] Topic guides can be found in online supplemental file 1–4.

Participants

Interviews were conducted in three regions with: Hub clients; keyworkers who had not accessed Hubs (hereafter, 'non-Hub keyworkers'); Hub staff and wider stakeholders. Participants were purposively sampled for maximum variation from each site, considering professional background and demographics. Additional criteria are described below.

Hub clients who had given consent to be contacted for research were emailed invitations to take part in an interview. They were purposively sampled according to access to individual psychological support (both taken up and declined), severity of mental health symptoms and other relevant characteristics.

Non-Hub keyworkers who had not accessed Hub support and reported struggles with well-being during the pandemic were identified through posters and indirect emails sent out by organisations supported by the Hubs (eg, NHS Trusts; care homes), and direct emails were sent to participants from a related study (IRAS ID 282827), or emails to individuals who had completed Hub screening without self-referring but given consent to be contacted about research opportunities. Groups with low Hub uptake were targeted for recruitment, for example, through care homes and Black, Asian and minority ethnic staff networks.

Hub staff were directly employed by Hubs, and invited by email. Potential participants were sampled to represent a range of roles.

Wider stakeholders had involvement in the organisation or delivery of staff well-being support, for example, occupational health or Human Resources leads. Wider stakeholders were identified through Hub Expert Reference Groups and Hub staff, sampled according to role, organisation, and ability to give local vs regional perspectives on the Hubs. Wider stakeholders were emailed invitations to take part.

Procedures

Semistructured, one-to-one interviews were conducted by video call. Interviews were audiorecorded using encrypted digital recorders and transcribed verbatim. Interviews were conducted by five trained graduate research assistants (RAs) and a qualitative researcher (KA). Four site RAs (PC, AAH, S-AW and EY) were based in and employed by Hub sites; one central RA (HW) was based within the research team. Hub staff interviews were conducted by the central RA between April 2021 and January 2022. Keyworker interviews, including Hub clients and non-Hub keyworkers, were conducted by site RAs between October 2021 and January 2022. Wider stakeholder interviews were conducted by KA between January and March 2022. All interviewers identified as women.

KA had prior working relationships with teams at two Hub sites, having worked on other Hub evaluations, however, she did not complete any Hub staff interviews. Therefore, there were no prior relationships between interviewers and participants. A small number of Hub staff participants had been involved in facilitating the evaluation at their sites and so had had some contact with the research team prior to participation.

Sampling, interviews and analysis continued iteratively until data saturation was thought to be satisfactorily achieved. Within each participant group, coded data and participant characteristics were examined to ensure that a wide range of perspectives were reflected, reaching thematic saturation across NPT constructs. Further recruitment was conducted to gather data in areas felt to be lacking (eg, greater inclusion of participants who identified within under-represented demographic and

occupational groups, including men, people from Black, Asian and minority ethnic groups, and emergency services). Additionally, further review of Hub keyworkers' coded data revealed that the majority interviewed had reported relatively positive experiences, therefore, a further round of recruitment was conducted towards the end of data collection to specifically invite Hub clients who had discontinued their support from the Hubs, to better understand barriers to sustaining engagement.

Analysis

The National Centre for Social Research 'Framework' analysis approach was used.[21] Following initial transcript review, it was decided to code all interviews deductively to NPT constructs to create a more efficient and concise narrative. Although multiple frameworks were originally used to guide interviews with different participant groups, it was felt that NPT would best capture (A) the sequential nature of implementation components across all interviews and (B) the distinction between Hubs and other forms of support, and their fit within the wider system. Coding was completed by HW and KA, who independently coded a sample of the transcripts, before conferring with each other and DH to resolve discrepancies in coding. Analysis took place in the latest version of NVivo.

Patient and public involvement and experience

The patient and public involvement and experience group for the overarching study included health and social care staff who had accessed Hub support. Hub client and keyworker recruitment materials and topic guides were reviewed and refined to ensure they were meaningful. RAs completed practice interviews with group members as part of their training and to refine topic guides. Local NHS Trust networks, such as Black, Asian and minority ethnic staff networks were consulted to further refine recruitment materials, and advice including using targeted emails was implemented. Emerging findings were presented to the group and their feedback integrated.

RESULTS

Interviews were conducted with 19 Hub clients, 20 non-Hub keyworkers, 14 Hub staff and 10 wider stakeholders (N=63, see tables 1 and 2). Of Hub clients, 10 (53%) had clinical roles, 84% worked within the NHS, 2 (11%) within local authority and 1 (5%) within education; 58% identified as women. Of non-Hub keyworkers, 50% had clinical roles and 50% non-clinical; 70% worked within the NHS, and 20% in fire or police services, and 10% worked in social care; 60% identified as women. Mean interview duration was 62 min (range: 21–101 min). To preserve anonymity, site identifiers were removed.

Table 3 outlines the results' thematic structure, reflecting NPT constructs. Figures 1 and 2 illustrate these constructs and the links between them, concerning,

Table 1 Occupational and demographic characteristics of Hub clients and non-Hub keyworkers Interviewed

Participant ID	Occupation	Ethnicity
Hub client 01	Clinical laboratory lead	White other
Hub client 02	Consultant anaesthetist	White British
Hub client 03	Healthcare assistant	White British
Hub client 04	Manager	Black British
Hub client 05	Nurse, Intensive Care Unit (ICU)	White British
Hub client 06	Clinical research nurse	White British
Hub client 07	Adult social worker	Pakistani
Hub client 08	Adult social worker	White British
Hub client 09	Nurse, stroke ward	White British
Hub client 10	Ward manager, cardiology	White British
Hub client 11	Pharmacist, ICU	White British
Hub client 12	Pharmacy management	Mixed—White and Afro Caribbean
Hub client 13	Consultant anaesthetist	White British
Hub client 14	Teacher	White British
Hub client 15	IT administrator	White British
Hub client 16	Patient advice and liaison services	White British
Hub client 17	Advanced clinical practitioner, ICU	White British
Hub client 18	Employment services	White British
Hub client 19	Occupational therapist	Black
Non-Hub keyworker 01	Organisation development manager	Mixed – White and Black African
Non-Hub keyworker 02	Counsellor, Improving Access to Psychological Therapies (IAPT)	White British
Non-Hub keyworker 03	Care home manager	White British
Non-Hub keyworker 04	Student nurse	White British
Non-Hub keyworker 05	Equality, diversity and inclusion role	Pakistani
Non-Hub keyworker 06	Emergency medical technician	White British
Non-Hub keyworker 07	Healthcare assistant	Black African
Non-Hub keyworker 08	Cognitive Behavioural Therapy (CBT) practitioner, IAPT	White British
Non-Hub keyworker 09	Administrator, cancer services	White British

Continued

Table 1 Continued

Participant ID	Occupation	Ethnicity
Non-Hub keyworker 10	Vaccinator	White British
Non-Hub keyworker 11	Civilian investigator, police service	White British
Non-Hub keyworker 12	Administrative assistant	Indonesian
Non-Hub keyworker 13	Dietician, diabetes	White British
Non-Hub keyworker 14	Senior carer, residential home	White British
Non-Hub keyworker 15	Manager, chemotherapy services	White British
Non-Hub keyworker 16	Police support staff	White European
Non-Hub keyworker 17	Firefighter	White British
Non-Hub keyworker 18	Police officer	White British
Non-Hub keyworker 19	Administrator	Somali British
Non-Hub keyworker 20	Staff engagement and inclusion practitioner	Bengali British

Table 2 Occupational descriptors of Hub staff and wider stakeholders interviewed

Participant ID	Occupation
Hub staff 01	Psychological therapist
Hub staff 02	Clinical lead
Hub staff 03	Senior clinical psychologist
Hub staff 04	Clinical pharmacist
Hub staff 05	Clinical lead
Hub staff 06	Non-clinical manager
Hub staff 07	Assistant psychologist
Hub staff 08	Non-clinical staff member
Hub staff 09	Psychological therapist
Hub staff 10	Counsellor
Hub staff 11	Clinical psychologist
Hub staff 12	Assistant psychologist
Hub staff 13	Senior practitioner
Hub staff 14	Clinical lead and psychological therapist
Wider stakeholder 01	Director, mental health services
Wider stakeholder 02	Senior HR personnel
Wider stakeholder 03	Occupational health lead
Wider stakeholder 04	Senior HR personnel
Wider stakeholder 05	Commissioner
Wider stakeholder 06	Non-executive director
Wider stakeholder 07	Clinical psychology lead
Wider stakeholder 08	Regional lead
Wider stakeholder 09	Occupational health lead
Wider stakeholder 10	Well-being practitioner

HR, human resources.

respectively, positive and negative factors associated with the successful embedding of the Hub model.

Sense making

Hub staff clearly distinguished the Hub approach from other staff support. However, Hub staff and wider stakeholders identified some challenges in communicating this understanding to the wider health and social care system. Some non-Hub keyworkers felt overwhelmed by different support offers available across the system, and consequently, failed to differentiate between these and the Hubs (*differentiation*). Understanding what the Hubs offered was an important precursor to valuing the services (*individual and communal specification*). Both non-Hub keyworkers' and Hub clients' valuing of the Hubs was also intrinsically linked with the value they placed on mental health support more generally, as well as the value placed on mental health by their managers and organisations (*internalisation*). Key influential factors included keyworkers not feeling that they warranted support compared with others, or feeling that workplace stress was 'part of the job' (*internalisation*).

> How can I honestly say that I'm feeling acutely stressed or anxious […] the same as a clinical member of staff or somebody who was shielding? (Non-Hub Keyworker 01)

> It's kind of expected that if you're choosing [acute care] as your speciality that you can cope with the mental side of it […] getting help is still seen as a sign of weakness rather than coping. (Hub Client 17)

Some non-Hub keyworkers felt that systemic issues were the cause of their difficulties, and therefore felt the Hubs' individual support was not relevant (*legitimation*).

> I have complicated reasons for not accessing [the Hub]. I wanted [my] organisation to […] step up and acknowledge what they do to damage people's mental health and do something about that […] rather than put a plaster on something. (Non-Hub Keyworker 08)

> [Staff] were saying that they feel they're being gaslighted. It's all this around […] 'you need to be resilient'. Everything's getting pushed towards them as though this is their fault if they're feeling tired, or they're not managing, and they're not coping. (Wider Stakeholder 09)

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Table 3 Overview of themes and subthemes (constructs of normalisation process theory, NPT)

NPT construct	NPT subconstruct	NPT definitions—as operationalised for this study
Sense making		
	Differentiation	Do participants see the Hubs as different from other types of mental health/well-being support available for health and social care staff?
	Communal specification	How have participants come together to make sense of, understand, or operationalise the Hubs, the support they offer, and the work involved?
	Individual specification	How do participants individually make sense of and understand the Hubs?
	Internalisation	What do participants see as the values and benefits of the Hubs? Do they have any reservations?
Relational work		
	Initiation	In what ways and to what extent have managers/leads been involved in driving forward the setup of the Hubs, and getting people engaged with Hub support?
	Enrolment	Have participants got involved with the Hubs? What relational work has been needed among staff teams to enact the Hub model?
	Legitimation	Do participants see the Hubs as the 'right' way to support health and social care staff during the pandemic? Do participants feel that the Hubs, and their role within them, are appropriate?
	Activation	What processes and relational work are required to sustain the Hubs and engagement in the Hubs once they have been set up?
Operational work		
	Interactional workability	What is the work needed to operationalise the Hub model and translate it from paper into practice? How do the Hubs fit within the wider mental health system and other support available for health and social care staff?
	Relational integration	Do participants have trust and confidence in the Hubs?
	Skillset workability	Do participants feel they have the skills needed to be involved with the Hubs?
	Contextual integration	Are Hubs sufficiently resourced? How do the Hubs fit into the wider context of the resources of the mental health/staff support system?
Appraisal work		
	Systematisation	What methods do participants use to evaluate the effectiveness of the Hubs?
	Communal appraisal	What are participants' evaluations of the Hubs from a communal, team or group perspective?
	Individual appraisal	At an individual level, to what extent do participants feel the Hub is effective?
	Reconfiguration	In what ways have the Hubs been refined or modified over time? What would participants like to see done differently to improve the Hubs?

Relational work

Hub staff agreed that the right people were involved in setting up the Hubs (*initiation*). Participants from all groups identified that when engaged, senior leads and managers within the wider system played a crucial part in legitimising Hub support, promoting the Hubs, and encouraging keyworkers' enrolment (positive *initiation*, leading to *legitimisation* and *enrolment*). However, Hub staff, Hub client and non-Hub keyworkers sometimes reported that managers' engagement was lacking. Hub staff at times struggled to persuade managers and senior leads of the importance or legitimacy of Hub support. Likewise, many non-Hub keyworkers and Hub clients reported feeling that their managers did not genuinely value mental health or well-being support (*internalisation* and *initiation*), which subsequently deterred some non-Hub keyworkers from enrolling in Hub support.

> … it'll be a forwarded email. The email will be, 'see below', it won't be, 'I'd really like you to try and access it'. […] they won't engage with it, it feels like they're doing their job, like they're ticking a box, as opposed to genuinely being behind it. (Hub Client 17)

> We so desperately want to engage these people and we so desperately want to support them, and it almost feels that this manager level almost feels more key than the individual staff. (Hub Staff 13)

The length of online screening questionnaires was off-putting to some non-Hub keyworkers (*enrolment*). Flexibility in rearranging appointments helped Hub clients to stay engaged in Hub support (*activation*). However, limited out of hours appointments prevented some Hub clients from sustaining their engagement. Some reported having to disclose accessing support to their manager to

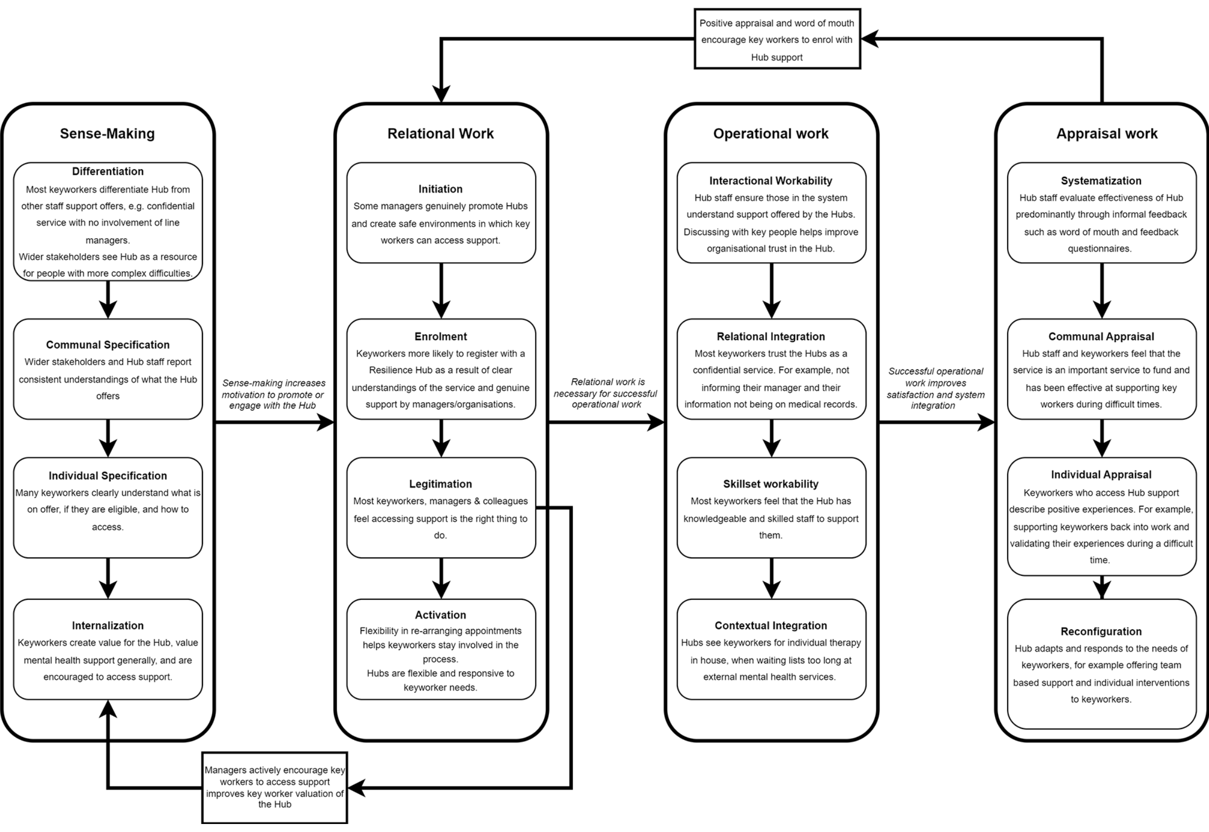

Figure 1 Factors that positively impacted on implementation of the Hubs.

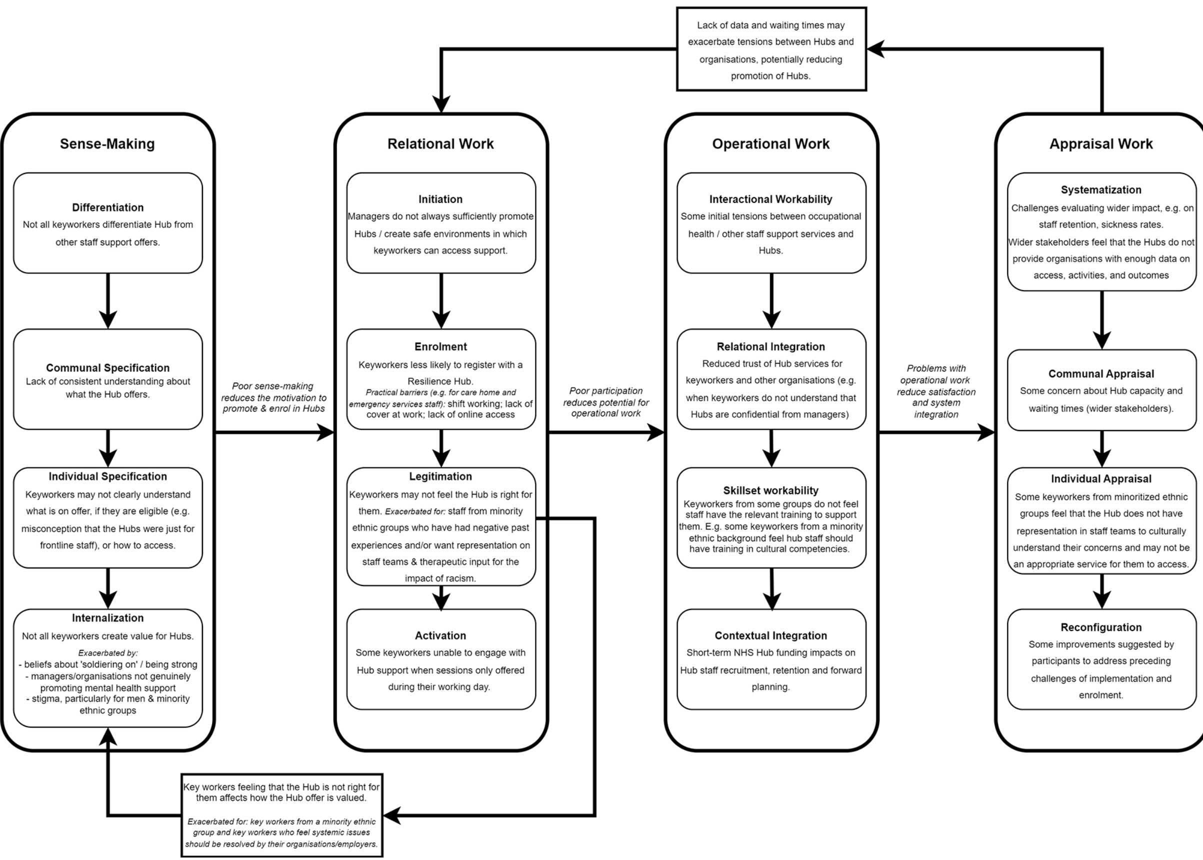

Figure 2 Factors that negatively impacted on implementation of the Hubs. NHS, National Health Service.

arrange time off. In addition, some keyworkers preferred face-to-face support rather than telephone or video call support. Participants from all groups felt that persistent promotion and outreach were required to sustain awareness and understanding of the Hubs within the health and care system.

Operational work

Despite some initial tensions between the Hubs and existing staff support offers, such as occupational health, wider stakeholders generally saw the Hubs as an important part of staff support within the health and social care system (*interactional workability*). The Hubs fitted within the existing system through provision of a separate confidential service, which at times provided support that keyworkers' organisations could not, such as access to higher intensity therapies and team-based support. However, Hub staff and wider stakeholders noted some challenges in Hubs reaching all corners of the health and care system, for example, care homes. Hub staff worked to liaise between Hub services and the wider system to facilitate the embedding of the Hub model, for example, building relationships with other mental health services (*relational integration*).

> We are continuously trying to ensure that we have a voice around certain tables […] to help people have a clear understanding of the [Hubs' offer] What's actually happening now is those organisations […] are active referrers to our service who would signpost their own staff members to us, because there's a clear understanding of our offer, where historically they might have held onto those people within their services, and those people might have been on extensive waiting lists. (Hub Staff 02)

Team-based support was thought to build trust in Hub support, and team managers had reported that this work led to individual referrals (increased *relational integration*, facilitating *enrolment*). Hub clients typically trusted the Hubs and the therapeutic skills of their clinical teams (*skillset workability*). Hub clients described staff as knowledgeable and skilled in relevant areas, such as trauma and burnout. Hub staff felt recruitment of staff with a variety of clinical skills, combined with availability of additional training and continued professional development to support development of clinical skills for specific and emerging difficulties (eg, long COVID) had appropriately helped Hubs manage these more complex support offers. However, while Hub clients from Black, Asian and minority ethnic communities seeking typical mental health support trusted the therapeutic skills of Hub teams, non-Hub keyworkers and Hub clients specifically seeking support around the impacts of racism and discrimination felt that there was insufficient representation of therapists from different ethnic backgrounds working on Hub clinical teams (poor *legitimation* leading to limited *relational integration*), and that additional training, experience and confidence in cultural competencies and working with the impacts of racism would be beneficial (*skillset workability*).

> I wouldn't want to have to explain myself, which is what I usually do in work when people ask me questions and I try to explain how the experiences are. They say well, that could happen to anyone, how can you say it's racism? So I didn't want that to come into it […] That's why I wanted someone representative there. (Hub Client 04)

> I wanted an Asian counsellor […] it's not something that I look for all the time, but […] I just felt I wanted someone who could actually genuinely culturally understand […] there was all that Black Lives Matter stuff going on […] that brought [up] a lot of stuff that had happened to me, that I'd experienced institutional racism […] it's like post-traumatic […] I know it's hard in the service to meet every single need, however, I think you do need somebody there whose got that background and that real cultural understanding sometimes, just for those 0.1 per cent that want it. (Hub Client 07)

This was not felt to be a Hub-specific issue, but rather a system-wide problem across health and social care services. Some non-Hub keyworkers and Hub clients reported prior negative experience of services around cultural competency or suitability, and this had discouraged them from engaging with NHS-provided support, including the Hubs (poor *internalisation* associated with NHS services in general, leading to poor *enrolment*).

In a system where psychological therapeutic input is a scarce resource, the Hubs were seen by wider stakeholders as an effective way of providing support to health and social care staff with more complex needs across NHS Trusts and other organisations (*contextual integration*). For example, Hub clinicians saw keyworkers for individual therapy in-house when waiting lists too long at other mental health services. However, concerns about the longevity of Hub funding threatened to impact on staff recruitment, retention and ongoing trust in the services.

> I think there's a fear amongst staff and amongst people who access the Hub around the longevity of it, so I think improvement might come with a bit of certainty around this model not just going as quickly as it arrived. I think that would help with people trusting in the service (Hub Staff 09)

Appraisal work

Participants across all groups typically relied on informal feedback to evaluate the Hubs (*systematisation*). The Hubs were both individually and communally appraised as a valuable resource for staff. Hub clients typically described very positive experiences:

> Sometimes it got me through the week knowing that that phone call was coming. It got me out of bed […] I did feel inspired at the end of it. I felt like there was

> something I could do. I had…not just tasks to do, but I had ideas that would help me stay well. (Hub Client 08)

> I think it's been a really beneficial service […] it's been a really valuable resource, especially to people within the NHS that have been, and still are, going through a pretty rough time in a lot of instances. (Hub Client 01)

Exceptions included the previously outlined confusion about Hub provision and problems with specific provision for staff from Black, Asian and minority ethnic backgrounds. Minimal access to data from the wider system meant that Hubs were less able to evaluate their impact on staff sickness and retention (limited *contextual integration* leading to limited *systematisation* and *communal appraisal*). Likewise, wider stakeholders universally wanted more data around Hub access and outcomes, to better assess Hub use and impact (problematic *systematisation* leading to limited *communal appraisal*). Wider stakeholders also felt that greater data flow from the Hubs would help them to identify patterns of support-seeking among their staff. Flexible adaptation of the Hubs to the needs of individuals and local systems (*reconfiguration*) was seen as a strong feature of the Hubs.

Further suggested changes to the Hubs included better promotion of the Hubs, better accessibility, for example, greater flexibility in appointments to accommodate shift workers and more diverse recruitment of Hub clinicians and staff training relating to cultural competencies to better support keyworkers from Black, Asian, and minority ethnic groups.

DISCUSSION

This paper presents the findings of a qualitative study using NPT to explore the implementation of three Resilience Hub services providing psychological support to health and social care staff affected by the COVID-19 pandemic. Sixty-three interviews were conducted with Hub staff, keyworkers who did and did not access the Hubs, and wider stakeholders within the health and care system.

Hubs were generally seen as a valuable, responsive and distinct support offer; Hub clients typically described very positive experiences of Hub support. Keyworkers were more likely to access Hub support when: they could see how it was different to other support, and how to access it; and felt encouraged by their managers and organisations to access support (*enrolment*). Managers and organisations genuinely valuing (*internalisation*) and promoting (*initiation*) mental health support were seen as vital.

Barriers to support access were consistent with prepandemic and pandemic literature nationally and internationally. Professionals may take a long time to seek help, if at all,[22] and being professionally affected by incidents compared with personal involvement has a negative impact on support access.[23] Barriers to help-seeking are not a new issue (internalisation). Stigma and fear of letting down colleagues and patients have been demonstrated among medics.[24] Other studies describe a culture of 'invincibility' within healthcare, whereby traumatic incidents were considered 'part of the job'.[25 26] While not unique to health and social care, these studies identified toxic work cultures similar to examples from the current study, such as bullying, sexism, and racism.[25 26] The traditional focus of individual interventions, symptom reduction, may be at odds with important organisational challenges that contribute to staff distress (*legitimation*).[27] This is consistent with findings that some keyworkers did not access Hubs as they felt their organisations were demanding they 'cope better', rather than addressing workplace stressors, such as workload, staff shortages[28] and disconnection between frontline staff and senior management.[29] Individual support and well-being-focused interventions in the absence of systemic changes[28 30] may be resisted, even resented, by staff.[25]

The staff well-being Hubs and workstreams were mobilised at pace during a level 4 National emergency, the highest incident level for the UK. The Hubs were not established to address existing contextual difficulties that may have been present, from concerns about safe staffing levels to staff experiences of discrimination or bullying within the workplace. Some of our findings appear to support the continued presence of these systemic issues. Participants from Black, Asian and minority ethnic communities specifically seeking support around the impact of racism highlighted a barrier of limited diverse representation which led to perceptions of limited cultural understandings within clinical teams. Consequently, and linked with past experience within work and healthcare, participants expressed concern that their experiences would not be recognised as racism. This reflects concerns raised in the literature whereby racialised staff may be expected to name and explain racism to colleagues,[31] or that once named racism may not be taken seriously.[32] Racial inequality, cultural insensitivity and the exacerbation of racism due to COVID-19 have also been described in the literature.[33–35] Participants described these barriers as system-wide rather than Hub-specific. Consistent with this finding, limited representation of diversity within therapy services, and negative impact on service access, are well documented across many UK mental health services,[36–39] and internationally.[34 40] Indeed, participants' past experiences with other NHS services had an impact on their perceptions of Hubs, highlighting the need for organisations to recognise and actively explore and challenge this problem. In the context of the disproportionate impact of COVID-19 on people from minoritised ethnic groups, the importance of explicit steps to help ameliorate barriers and support access is a heightened consideration for Hubs. Further research is essential to understand and address these processes, as the current study did not seek to explore these experiences in depth.

The study did not systematically collect gender or ethnicity data for Hub staff or wider stakeholders, and

nor was this data available for the overall pool of potential participants, reflecting limited monitoring of this issue for professional groups. A further limitation was that interviews were cross-sectional, therefore, unable to capture change across individual participants' experiences. The different time points of interviews conducted for different participant groups demonstrate the rapidly changing nature of the Hubs, and longitudinal interviews may have better captured these changes. Furthermore, NPT constructs focused on the mechanisms of implementation, but a recently published NPT coding framework expands the context and outcomes preceding and proceeding implementation.[41] Longitudinal interviews combined with a focus on implementation outcomes would be of interest in future research. For example, the extent to which Hubs changed: how people worked together (relational restructuring); or the norms or policies steering staff support (normative restructuring).[41] Other frameworks informed topic guides but were not used in the final coding of transcripts.[16 17] Including aspects of these frameworks may have added to exploration of pre-existing working cultures within health and care organisations that may impact on staff help-seeking. Nevertheless, it was felt that exploration of the implementation mechanisms through NPT provided a thorough understanding of the enablers and barriers to Hub implementation.

Remote interviewing may have limited rapport building and opportunities to gauge participants' responses or observe interview context. However, it allowed greater flexibility for participants, particularly where their time was highly pressured, and they may have needed to cancel an in-person interview. Study strengths included efforts to recruit individuals from minoritised ethnic communities and other under-represented groups. Inclusion of non-Hub keyworkers provided an understanding of access barriers. The study also adds to the literature using theory-based approaches in rapidly changing situations, which is particularly valuable in the context of a constantly changing NHS.[42]

Clinical implications

The study findings point towards the potential benefits of the Hubs to the health and social care system, supporting the Hubs' offer, and the feasibility of their repurposing to novel crises and populations. Although the Hubs are embedded within the NHS context, findings are consistent with international literature, suggesting broader applicability of implications for staff support. Key implications for Hubs included: continuation of confidential support, increased promotion and ongoing work to resolve barriers to access. Key implications for the wider health and social care system included: fostering supportive workplace environments, focusing on psychological safety, promotion of well-being support and attendance to systemic challenges negatively affecting staff well-being.

Participants valued a personal approach to Hub promotion that clearly outlined support offered and how to access it, including: testimonials, team presentations and visibility of Hub staff within teams. Confidentiality, specifically around self-referral and the Hubs' use of standalone clinical systems (ie, without reporting to occupational health, but within usual parameters, eg, response to risk) was strongly valued by keyworkers, and should be emphasised.

The study demonstrated the importance of resolving access barriers. Ability to provide out of hours appointments may better accommodate shift workers, and flexible options for completing screening questionnaires may increase access for those in severe distress and/or less able to access digital technology. Earlier and more extensive engagement with stakeholders from minoritised ethnic communities is recommended to design support offers that meet specific needs of these groups. Participants recommended better representation of diverse communities on clinical teams as well as training and experience in cultural competencies and supporting keyworkers with the impact of racism, and promotion of how Hubs can meet these needs. However, organisations seeking solely to increase visible diversity within the workforce may fail to rigorously explore and challenge embedded, normalised and socially reinforced attitudes, behaviours and policies.[43] Ultimately, active engagement in antiracist work is essential to deconstruct barriers.[31]

This work links with the importance of the psychological health and safety agenda within the wider health and care system to prevent staff mental health difficulties. Organisations should attend to potentially psychologically damaging aspects of staff roles. Consistent with National Institute for Health and Care Excellence (NICE) guidance for supporting mental well-being in the workplace,[44] individual support should be offered as an adjunct to, not a replacement for, resolutions to systemic challenges. Health and social care organisations should share the responsibility of promoting Hubs and other well-being or mental health support. The study demonstrated that workplace culture and the involvement of managers and leaders was central to encouraging keyworkers to access support. These recommendations are supported by research demonstrating the positive impact of staff health and well-being on patient outcomes.[45–47]

Research implications

These findings should inform future evaluation of the Hub model to determine its clinical and cost-effectiveness. A randomised trial would incur pragmatic challenges, given the widespread implementation of Hubs across England, and ethical challenges during any future widespread crises. A large-scale naturalistic evaluation using a quasi-experimental design would instead enable a comparison of staff outcome data in regions where Hub support is available versus not available. As well as mental health and health economic outcomes, further evaluation should include occupational outcomes, including staff sickness and staff retention, to understand Hubs' wider systemic impact.

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Competing interests PF has previously been a member of NIHR HTA Prioritisation Committee and is a current member of NIHR HTS Clinical Evaluation and Trials funding Committee. DH has previously been a member of NIHR Research for Patient Benefit, Yorks & NE Regional Advisory Committee, and is a current member of NIHR Health Technology Assessment Clinical Evaluation and Trials Funding Committee (2019-2024). FV has received an NIHR Advanced Fellowship in a clinical research area unrelated to the Resilience Hubs. FV, PF, DH, and GB are Investigators/Co-Investigators in several other NIHR projects funded by various funding streams (RfPB, HTA, EME, HS&DR). AB is an honorary member of the National Mental Health & Wellbeing expert reference group at NHS England and NHS Improvement. AB, JW, KM and FV are members of the Greater Manchester Psychosocial Board, and JW, RW and KM are members of the Greater Manchester Expert Reference Group. GB is Interim co-chair of the National Institute of Health & Care Excellence (NICE) Quality Standards Advisory Committee. PF is clinical advisor to National Clinical Audit of Psychosis at Royal College of Psychiatry and Board member of International Early Psychosis Association. GB, AB, HTC, KM, FH, MS, RW and JW have all held senior clinical and/or operational roles at the Hub sites involved in this study. PF has previously led research to evaluate the original Resilience Hub service set up to support those affected by the 2017 Manchester Arena bombing, in which DH and KA were also involved. KA has also held a research and evaluation role at a second Hub involved in this project.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

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