A review of HWB Leads' development and support needs

Codesign Report (Phase 2 of 3)

August 2022

What this document is

This document is the codesign report of the review of HWB Leads' development and support needs. This report concludes the second of three phases of work. Its purpose is to organise findings from a series of engagements with HWB Leads and staff who support their roles.

Delivered in partnership

Academic Health Science Network North East and North Cumbria

Oxford Academic Health Science Network

Spark the difference

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1. Executive Summary

NHS England commissioned a review of Health and Wellbeing (HWB) Leads' development and support needs in the NHS across England (excluding primary care). This document is the codesign report (the second of three phases). Its purpose is to organise findings from a series of engagements with HWB Leads and staff who support their roles. This is not the review's final product. Rather, it will be used to set orientations for the work of Phase 3: Pilot.

This codesign report has six sections:

1. **About this document**: covering the document's purpose and who the delivery team are.

2. **What we did (codesign activities)**: detailing the codesign activities and recruitment methods used to engage staff directly and to collect data in this phase of work. An overview of staff reach across the project (n=503) and representation is provided, along with approach limitations.

3. **What we heard (codesign conversation and data results)**: presenting data and insights from codesign activities including: the lived experience of HWB Leads now and what's changing for the better; variation across HWB Lead work activities, in terms of time spent and self-reported confidence levels; the shift from work activities (in the Phase 1 scoping report) to HWB Lead skills and knowledge; the identification of enabling organisation values and behaviours; what HWB Leads have found helpful in their past development and support, and identified needs for the future.

4. **What we know now (codesign findings):** drawing together findings on the widespread variation in the HWB Lead role, alongside opportunities to develop positive and fulfilling HWB roles. We reflect on the boundary between "health" and "wellbeing"; the emergence of health and wellbeing as a current, long term workforce priority; and the future-focussed value of the Lead role as an enabler and change agent. We explore the positioning of an effective HWB function at organisation/system level as requiring more than one HWB lead; and propose a model that sets out six functions and potential role functions. Finally, we recommend the testing and iterative development of this organisation/system-wide HWB function and associated skillsets/competencies before defining options for future HWB Lead development and support needs.

5. **Where to next (options for a pilot)**: setting out three options for a pilot to test enablers and constraints to achieve policy intentions for an effective HWB function at organisation/system level. The three pilot options are: (a) Minimum Viable Pilot (MVP): 1 site for 3 months, (b) Depth: 1-2 sites for 8 months, and (b) Depth and breadth: 5 sites for 14 months. We welcome a discussion and reflections from your perspective.

Acknowledgements

We are grateful for the time, energy, candidness, and passion in more than 500 staff contributions to this project so far. The continued interest, contributions, and support from HWB Leads, colleagues and stakeholders have enriched this codesign phase.

We also wish to acknowledge the invaluable support from existing national and regional networks in sharing messaging and engagement opportunities. Particularly to NHS Employers and Regional Heads of Staff Experience Leads who actively promoted opportunities across their networks.

2. About this project (Phase 2: Codesign)

NHS England commissioned a review of Health and Wellbeing (HWB) Leads' development and support needs in the NHS across England (excluding primary care).

We undertook to provide evidence-based and codesigned answers to:

- What is an inspiring, engaging and appropriate way to develop those who lead on NHS staff wellbeing in organisations/system?
- What competencies, support and system structures will enable these individuals to effectively lead the wellbeing agenda? How will these mechanisms enable them to co-create cultures of wellbeing with their staff, to feel cared for and pass that care onto patients?
- How can this new approach be tested at manageable scale and generate maximum effective learning?

This document is the codesign report of the review of HWB Leads' development and support needs. This report concludes the second of three phases of work. Its purpose is to organise findings from a series of engagements with HWB Leads and staff who support their roles.

This is not the review's final product. Rather, it will be used to set orientations for the work of Phase 3: Pilot. Three options for the pilot are set out in Section 6, along with suggested timeframes.

About the project delivery team

This work is delivered in a partnership between the North East and North Cumbria AHSN, Oxford AHSN and Spark the Difference. Together, we bring experience and considered understanding of staff needs and experiences from board level, to Wellbeing Leads and across front lines in different health contexts.

3. What we did: codesign activities

This section details codesign activities and recruitment methods used to engage staff directly and to collect data in this phase of work.

3.1 Range of activities

The intention of this codesign phase is to: (1) engage wider groups of staff to test the scoping report's assumptions, and (2) iterate future-focussed assertions with a wider range of HWB Leads and their colleagues.

We have brought an Appreciative Inquiry approach to our work in this phase. We sought to support the transition of people's current 'worldview', to explore a future focus of what an engaging, inspiring, and appropriate role could be – and what support will most helpfully enable individuals coming into, and currently within, these roles.

This was supported by the following codesign activities:

- **A HWB Leads survey,** to rapidly seek HWB Leads' experiences, needs and aspirations.
- **Two codesign workshops**, for: (1) HWB Leads with day-to-day responsibility for health and wellbeing and (2) staff with strategic responsibility for health and wellbeing.
- **Group discussions and regional presentations** (face to face and online), including:
    - NHS Employers network meetings (attended two meetings)
    - Workforce Issues Group (attended two meetings)
    - NHS England team (one meeting)
    - A regional Wellbeing Conference (one meeting)
- **1:1 interviews** with HWB Leads and colleagues to complement and clarify the above activities.

<u>About the survey</u>
We used a survey to collate standardised feedback from HWB Leads across England. The survey was informed by emerging insights from the scoping report and desk-based research from publicly available HWB Lead job descriptions. We incorporated feedback from several HWB Leads. The survey design was reviewed by NHS England before distribution. Survey responses were open between 7th - 31st July 2022.

The survey asked HWB Leads about:

- how support to Health and Wellbeing is set up in their organisation/system,
- their past and future development and support needs,
- a self-reported review of work activities (focussed on recurring activities),
- how their organisation is approaching health and wellbeing in practice, and
- their background and role.

Notes on survey analysis
For assessing statistical difference in quantitative data, we used the *Cohen's d* measure. Where this is a clear and observable difference based on the multiple of standard deviations across data, this is noted in the data tables throughout the report.

For analysis of qualitative data from the survey, we coded common themes from free-text responses. This was reviewed alongside themes from the workshops and group discussions.

When disaggregating data (for example, by organisational type, banding level, region), we do not include sample groups of less than 12 responses.

About the codesign workshops

We hosted two virtual workshops for (1) HWB Leads with day-to-day responsibility for health and wellbeing and (2) staff with strategic responsibility for health and wellbeing. Each workshop was two hours long and hosted on Zoom. Workshops were interactive with a mix of presentations and breakout sessions. Each breakout session was hosted by a trained facilitator, and included use of the online collaboration tool, Jamboard. This enabled all participants to contribute their experiences and views in real time. Time for two *reflection sessions* in each workshop was allocated for participants to review their colleagues' feedback, and to clarify/contribute further. Access to the Jamboards remained open for 24 hours after the session to allow for additions to be made post workshop.

About the group discussions and regional presentations

To extend reach beyond the above two codesign activities, we attended six group discussions and regional presentations. We used a semi-structured interview approach to guide our discussions. We invited participants to add written feedback of the Chat function of MS Teams/Zoom, as well as providing verbal feedback.

About the 1:1 interviews

Finally, we held 12 1:1 interviews for individuals who were unable to attend an existing group forum, or who wanted to clarify their contributions further. This included several introductions from NHS England to link up existing programmes of work.

3.2 Recruitment methods

To support recruitment and sampling, we are grateful for the support of existing national and regional networks in sharing messaging and engagement opportunities. Particularly to NHS Employers and Regional Heads of Staff Experience Leads who actively promoted opportunities across their networks, including sharing an information page hosted on the Oxford AHSN website.

While this approach of cascading information through existing networks did increase our project reach, we note several limitations in using this approach:

- Generally, requests to share information were processed alongside existing network meeting dates and distribution list timeframes. This meant that staff across the country received and accessed the information at different points in time.
- We did not have access or control over the distribution lists, nor the number of follow-up reminders that were sent. Staff in some regions may have only received the information once, alongside numerous other communications and high workload pressures.

3.3 Reach and representation

This section sets out the project's reach to staff and representation by organisation type, banding and region.

Project reach to date

A summary of engagement activities and number of staff involved in this codesign phase is in Table 1.

Table 1: number of staff contributions, by engagement activity

Engagement activity	**Staff contributions**: Scoping report (Phase 1)	**Staff contributions**: Codesign phase (Phase 2)
Group discussions and regional presentations	18 staff	268 staff
Codesign Workshop 1: Leads with day-to-day responsibility	-	42 attendees (62 RSVPed)
Codesign Workshop 2: Staff with strategic responsibility for wellbeing	-	35 attendees (60 RSVPed)
HWB Leads survey	-	106 staff responses
1:1 interviews to complement/clarify group discussions, including staff unable to attend group discussions/regional presentations.	22 staff	12 staff
Phase total	40 staff contributions	463 staff contributions
Total	**503 staff contributions**	

Representation of staff contributions

We did not collect demographics data in group discussions, workshops, or depth interviews. However, anecdotally, it was encouraging to see/hear broad representation across regions and organisation types, and to confirm this where this data was available.

About representation of survey responses

We received 106 survey responses. Of these respondents, approximately 70% chose to provide requested demographic information. When the survey was initially released, anonymised demographic questions were marked as mandatory (to enable analysis); and the survey experienced a 50% drop-off rate. Changing these demographic questions to become optional increased overall survey completion rates (to 70%).

Based on the available survey data, the following tables and figure set out a breakdown of respondent profiles below for: (i) organisation type; (ii) banding levels; and (iii) regional representation.

(i) In terms of the **organisation type** that survey respondents were from, there was a representative **mix of Trust types**, when compared to the overall Trusts nationally.

Table 2: Organisation type respondents were from

	Number of respondents in survey	*Portion of trusts nationally*[1]
NHS Trusts		
Acute trust	47 (65%)	*152 (65%)*
Ambulance services trust	3 (4%)	*10 (4%)*
Community trust	9 (13%)	*17 (7%)*
Mental health trust	13 (18%)	*54 (23%)*
Integrated Care System (ICS)	14	
Integrated Care Board (ICB) (*previously CCG*)	2	
'Other', incl NHSE, social services, primary care and integrated/community trust	18	
Total	106	

(ii) We asked survey respondents about their **Agenda for Change banding** to test the wide variation identified in the scoping report, and in ongoing codesign conversations.

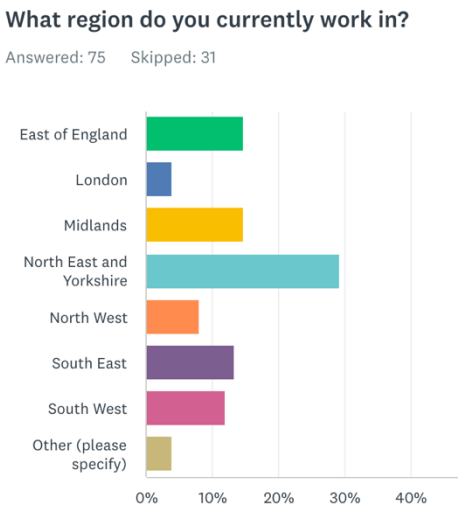
The survey was specifically intended for completion by the HWB Lead of an organisation/system. Of the 75 people who responded to the request for information on their banding level:

- Bandings 4-6 represented 24% of survey respondents (n=17)
- Bandings 7-8a represented 47% (n=35)
- Bandings 8b-8d represented 21% (n=15)
- Other (for example, Band 9/Medical/Non-Execs) represented 8% (n=6)
- Preferred not to say 3% (n=2).

(iii) In terms of **regional representation**, survey respondents were broadly representative across regions (see Figure 1), except for under-representative in London. This may be due to earlier engagement through the NHS Employers network during the scoping phase (i.e., respondents had already contributed these views) or limitations of our dissemination approach (see Section 3.2).

In the survey analysis, we disaggregated all responses by region, but in general, the sample sizes are too small to make region-specific findings with confidence. As the survey was anonymous, we are unable to identify whether all survey respondents from one region were from the same Trust or different Trusts, and do not draw inferences on this basis.

Figure 1: a regional breakdown of survey responses



[1] NHS Confederation, *Key statistics on the NHS*

4. What we heard: codesign conversations and data results

This section sets out the main themes from codesign conversation and data results, as follows:

- The lived experience of HWB Leads now
- HWB Lead work activities: time spent and confidence levels
- HWB Lead skills and knowledge
- Organisation values and behaviours
- HWB Lead development and support needs

4.1 The lived experience of HWB Leads now

The scoping report (Phase 1) described the lived experience for many HWB Leads across the country. These themes arose again in most codesign discussions and in the survey results. There are complex contributing factors for this. A summary of the variations found in the HWB role definition, placement and scope are below.

In summary, many HWB Leads experience/have experienced variation in:

- **Department(s) / team(s)** the Health and Wellbeing function is hosted in, including:
  - Human Resources (HR) (41% n=43)
  - Organisational Development (OD) (32% n=34)
  - Occupational Health (OH) (28% n=30)
  - Workforce (20% n=21)
  - 'Other' (13% n=14) including Public Health, Finance, Corporate Business and Employee Health & Wellbeing Service (as a standalone team).
    [Respondents could select more than one option]
- **Funding sources** that made up their health and wellbeing budget, including
  - Recurring funding / annual budget (40%, n=42)
  - Charitable funds (34%, n=36)
  - There is no budget (32%, n=34)
  - Project / programme funding (25%, n=27)
  - I don't know (12%, n=13)
    [Respondents could select more than one option]
- **Role banding levels**, from Band 4 through to Band 8c.
- **Role security** due to secondments and temporary contracts which started during the pandemic.
- **Staff backgrounds**, with 26% of survey respondents stating that they held a clinical qualification(s) (n=19), with the two most frequently identified qualifications being registered nurses (50% n=10) and psychologists (25% n=5). (The remaining 25% were a mixture of qualifications).
- **Clarity of role objectives and focus of work**, with a focus of HWB Leads' work being reactive and unplanned, rather than on developing longer-term proactive and preventative initiatives and measures. Coupled with unclear role boundaries with colleagues, in group discussions and depth interviews some HWB Leads shared feelings of isolation, uncertainty and overwhelm at the scale of responsibility and challenge.

What's changing for the better

In addition to the above reflections, with a broader reach in the codesign phase, we also heard some very positive themes and opportunities for growth and development. These enablers for the health and wellbeing agenda were a focus of the codesign workshops and emerging themes include:

1. **Cultural shifts:** towards proactive/preventative wellness culture in strategy creation and prioritisation of work activities. Executive buy-in is a core enabler for this, as is support for data informed decision making and Health Needs Assessments to understand staff need (and the variation and equity drivers within this).
2. **Organisational alignment and role support:** that lead to improvements in the support and recognition for the role/work within their organisations; either by direct line managers, colleagues across the organisation (including clinical colleagues), and/or their Wellbeing Guardians and Executive team.
3. **Increasing investment:** in building a comprehensive service for staff and effective wellbeing function. These teams also acknowledge the support (financial/resources/ networks) and opportunities (funding/pilots) made available, and received, by NHS England.
4. **Joined up ways of working:** resulting from above enablers, a growing number of HWB Leads are experiencing a shift from "*it's me and 12,000 staff*" to engaged, collaborative, multi-disciplinary teamwork, widespread organisation communication and ownership.

4.2 HWB Lead work activities: time spent and confidence levels

In this section, we share survey data on the levels of self-assessed confidence and time HWB Leads spend on a closed list of work activities and alignment with domains of the HWB Framework.

The scoping report (Phase 1) shared the top eight self-reported work activities by HWB Leads (see Annex A). We refined these work activities through group discussions with HWB Leads in the codesign phase, before we included this topic in the survey.

We note the potential for self-assessment bias in collecting this data through a survey, i.e. a tendency for some people to be less than objective about their own skills and behaviours. However there are still a number of interesting relative differences between tasks and between sub-groups of respondents. We explore these below for: (i) survey respondents as a single group; (ii) different department/teams, (iii) clinical training, and (iv) banding levels.

Self-assessed confidence for recurring work activities

(i) For respondents as a whole: the overall proportion who felt "somewhat confident" or "very confident" was relatively high, with a mean of 82% across all eleven activities / task areas in Table 3. However this proportion was observably lower for four specific activities / task areas:[2]

- Developing a health and wellbeing budget: 57% of respondents (34/60).
- Influencing executive ownership for HWB: 72% of respondents (57/79).
- Commissioning / managing outsourced providers (including training and HWB interventions): 76% of respondents (52/68).
- Collecting and analysing data on staff wellbeing needs and experiences: 78% of respondents (56/72).

[2] There is an observable difference based on the multiples of standard deviations (*Cohen's D* measure). See Section 3.1 ('About the survey') for details.

All survey respondents identified 100% confidence with work activities/tasks to *"raise awareness and signpost staff to health and wellbeing resources"*.

Table 3 sets out self-assessed confidence for a range of identified work tasks and activities.

Table 3: All survey respondents: *How confident do you feel working in each of these work activities / tasks? (83 responses, sorted by level of confidence)*

Recurring work activities and tasks identified for the role of HWB Leads	"Somewhat confident" or "very confident"
Raise awareness and signpost staff to health and wellbeing resources	100%
Manage one-off health and wellbeing projects / programmes	97%
Provide support and resources for managers and leaders	94%
Coordinate in-house delivery of support services / referrals for staff (such as psychological support)	88%
Develop a health and wellbeing strategy	81%
Prepare reports and business cases for executives	80%
Personally deliver HWB services or training (e.g. smoking cessation, MHFA)	80%
Collect and analyse data on staff wellbeing needs and experiences	78%
Commission / manage outsourced providers (including training and HWB interventions)	76%
Seek to influence executive ownership about health and wellbeing	72%
Develop a health and wellbeing budget	57%

(ii) Differences[2] are noted when reviewing the data **by department/team** who host the HWB Lead. Indicatively:

- For "developing a budget": 42% of respondents (5/12) located in Occupational Health teams were "somewhat confident" or "very confident"; versus 75% of respondents (9/12) located in Workforce teams.
- For "influencing executive ownership": 47% of respondents (8/17) located in OH teams were "somewhat confident" or "very confident"; compared with 81% of respondents (11/14) located in Human Resources teams.
- For "collecting and analysing data": 94% of respondents (16/17) within Organisational Development teams were "somewhat confident" or "very confident"; versus 64% of respondents (9/14) located in Workforce teams.

(iii) For survey respondents with **clinical training**, there were several differences. These included:

- For "developing a budget": 42% of clinically-trained respondents (5/12) were "somewhat confident" or "very confident"; versus 60% of non-clinically trained respondents (25/42). Clinically-trained staff were also significantly less likely to respond to this optional question, with a 60% response rate versus 76% response rate for non-clinically trained staff.
- For "developing a strategy": 73% of clinical staff (11/15) were "somewhat confident" or "very confident"; versus 82% of non-clinical staff (40/49).
- Banding: Respondents holding a clinical qualification (n=19) held higher bandings on average, with 37% (7/19) in the 8b-8d group; versus 15% of non-clinically trained respondents (8/53).

(iv) There are clear differences[3] in confidence levels when the data is viewed **by banding levels**. Indicatively:

- For "developing a budget": 50% of respondents (18/36) in bands 4-6 and 7-8a were "somewhat confident" or "very confident"; versus 73% of respondents (8/11) in bands 8b-8d.
- For "preparing reports and business cases": 69% of respondents (9/13) in bands 4-6 were "somewhat confident" or "very confident"; versus 85% of respondents (11/13) in bands 8b-8d.

When reviewing these differences, it is important to note the survey was intended to be completed by the identified HWB Leads for an organisation/system. When reviewing the variation of confidence levels with a range of tasks, the data shows there isn't a standard profile for a HWB Lead and the development needs are not the same across a range of factors.

Survey findings: relating to an organisation's Health and Wellbeing Offer

This section explores survey respondents' time spent (n=80), and confidence levels of working within/across (n=79), the HWB Framework domain areas. The survey questions, and therefore the resulting data, is less granular than the question on confidence levels of work activities.

We asked these questions to identify the relevant emphasis in work activities between HWB Framework domain areas and resultant Health and Wellbeing offer at organisation/system level. What the data may reflect are potential areas of need for development and support for HWB Leads.

Table 4 sets out survey respondents' time spent, and confidence levels of working within, the HWB Framework domain areas.

Table 4: All survey respondents for (1) *In my day-to-day work I spend a lot of time on this health and wellbeing topic area (n=80); and (2) To what extent do you feel confident working in these health and wellbeing topic areas (n=79)? (sorted by amount of time spent)*

HWB Framework domain areas	(1) % agree or strongly agree "I spend a lot of time in this area"	(2) "Somewhat confident" or "very confident"
Improving personal health and wellbeing	95%	96%
Professional wellbeing support	86%	87%
Managers and leaders	83%	85%
Relationships	79%	85%
Fulfilment at work	72%	83%
Data insights	71%	74%
Environment	67%	71%

For all survey respondents, the domain areas HWB Leads spent a lot of time in – and had the highest levels of confidence in – are: (1) improving personal health and wellbeing, and (2) professional wellbeing support. Domain areas of 'data insights' and 'environment' received less attention and had lower levels of self-reported confidence.

This is suggestive of significant differences [3] in emphasis/prioritisations of work activity (and required competencies/development needs) across a HWB function.

[3] There is an observable difference based on the multiples of standard deviations (using *Cohen's d* measure). See Section 3.1 ('About the survey') for details.

4.3 HWB Lead skills and knowledge

As set out in Section 4.2, one focus of the codesign activities was to evolve the description of HWB Leads' self-reported work activities (from the scoping report, see Annex A), to the definition of skills and knowledge. We started by testing/refining these work activities in group discussions and heard:

> ***"It's all of this, and more. A challenge for many of us is the lack of boundaries on our role. The amount, and variation, of unplanned, incoming work and requests on us is incredible."*** *- HWB Lead*

To support the transition to HWB Leads skillsets (which can be applied to multiple work activities/tasks) and the development of role 'boundaries', we reviewed all relevant data from the codesign activities. A total of 241 coded skills were identified.

Table 5 sets out these skillsets, grouped by 'people skills' and 'technical skills'. Feedback from two group discussions and 12 depth interviews indicates that the definition of these skillsets is representative and clear. In the pilot phase, we will capture practical experiences of 'who does this well' for each skillset.

Table 5: identified skills for the role of HWB Leads (focussed on 'wellbeing')
(analysis of 241 coded skills, ordered by frequency of mention)

People skills	Technical skills
1. Interpersonal skills (n=61) 2. Strategic alignment and influencing (n=37) 3. Communication and engagement (n=27) 4. Collaborative ways of working (n=25) 5. Leadership and management (n=19)	1. Health needs assessments (n=21) 2. Data informed decision making (n=20) 3. Project/programme delivery / implementation (n=13) 4. Business cases and funding (budgets & proposals) (n=14)

The main areas of work activity currently undertaken by most HWB Leads (see Section 4.2, Table 3), but are not included as key enabler skills are:

- Raise awareness and signpost staff to health and wellbeing resources, and
- Personally deliver HWB services or training (e.g. smoking cessation, MHFA).

Table 5 also does not include skills for delivering clinical services/referrals, which some HWB Leads currently deliver. We suggest these are aligned through the Growing OH programme work.

The importance of interpersonal skills

HWB Leads and their colleagues identified 'interpersonal skills' as one of the most important skillsets required for their role. Figure 2 shares a visual description of feedback captured on these skills.

Figure 2: word cloud presenting feedback on 'interpersonal skills'

4.4 Organisational values and behaviours

"A future vision: wellbeing is everyone's responsibility in the organisation" -HWB Lead

In a codesign workshop, HWB Leads and their colleagues identified the following organisational values and behaviours as enablers for delivering effective health and wellbeing (n=63):

1. **A culture of openness, kindness, compassion and care for staff,** led by positive, supportive senior leaders who role model behaviours and enable a dedicated focus on health and wellbeing across the organisation (n=26)
2. **Widespread ownership,** positioning health and wellbeing as a proactive fundamental way of working/being, not a 'bolt on' for 1-2 people to deliver (n=13)
3. **Organisational alignment and joined up ways of working,** with sustainable behaviours, transparency, and support across/between teams (n=11)
4. **Data informed decision making,** based on understanding the evolving needs of staff groups, aligned to evidence informed practice and initiatives (n=8).

These themes were further tested and confirmed in group discussions, particularly with strategic groups.

4.5 HWB Lead development and support needs

This section shares insights from HWB Leads on what development and support needs (1) have been most helpful in developing their roles so far, and (2) are most needed going forward.

Responses to this question are combined from open-text feedback the survey data (n=254) and contributions from the workshop with HWB Leads (n=138). Data is provided in aggregate as no demographic data was captured during the workshops.

What HWB Leads have found more helpful so far

The top five development and support factors that HWB Leads have found most helpful when arriving in to their roles, and developing their skills include:

1. **Access the networks and the time/space to network,** in attending events, webinars and focus groups to share good practice and develop links with colleagues regionally and nationally. Communities of Practice run by NHSE and NHS Employers were both highlighted as very helpful, along with opportunities to network outside the NHS (n=44)
2. **Developing their skills in working with people,** such as communication, engagement, and facilitation (n=31)
3. **Role support to do their job effectively**, including clarity of objectives and support from peers, line managers, clinical and non-clinical colleagues, and the executive team (n=25)
4. **Training courses**, for wellbeing specific content (such as Mental Health First Aid, menopause, financial health), alongside project management and data analysis (n=24)
5. **Developing their technical skills,** including data informed decision making, developing business cases and funding proposals, and project delivery/implementations (n=18)

What HWB Leads have identified needs for their future development and support needs

Thinking about their future development and support needs, HWB Leads identified needs in the following five areas:

1. **Developing their technical skills**, including strategy development and business planning, data informed decision making, project delivery/implementation, policy implementation, business case development and funding proposals (n=57)
2. **Access to networks, central guidelines, and resources,** to discuss different approach, share good practice and access national/regional templates and policies that can be adapted locally (n=39).
3. **Developing their skills in working with people,** with a focus on ways of collaborative working, communication, and engagement (n=22)
4. **Role support,** including clarity on role and objectives, options for coaching and mentoring, as well as executive/leadership support (n=21)
5. **Investment/funding,** for recurring budgets for wellbeing initiatives and activities, for securing substantive posts, for hosting events and accessing training opportunities (n=18)

5. What we know now: codesign findings

As planned, the focus of codesign engagement activities built upon insights from the scoping report (Phase 1). In this section, we share emerging findings from the codesign activities (Phase 2), including:

- The boundary between "health" and "wellbeing"
- A clear priority in an evolving policy landscape
- The value of the Lead role: a future-focussed view
- Beyond one HWB role: towards an effective health and wellbeing function
- Defining a HWB Lead's development and support needs

5.1 The boundary between "health" and "wellbeing"

The focus for many of the discussions in this co-design phase has been on "wellbeing" rather than "health". A frequent question, in both group discussions and 1:1 interviews, was "*what do you mean by health and wellbeing – what does it cover and what is expected of me?*". Strategic discussions, for example, at the national Workforce Issues Group, also raised the challenge of defining the boundaries between workforce health, and workforce wellbeing, functions and how these could be best described organisationally.

Inevitably, there is a tension in producing a prescriptive set of functions/roles for all organisations, against the need for local solutions that respond to specific needs and context. In Section 5.4, we propose a model for health and wellbeing functions across an organisation/system, with a focus on the "wellbeing" side.

An additional focus for discussion between workforce health and workforce wellbeing relates to the evidence-base, which is perceived as different. For some, it seems that an evidence base isn't "as important" for wellbeing interventions. It seems, at times, that this may have led to relevant experience[4], expertise and evidence being overlooked in the design and delivery of wellbeing programmes. In defining a model for health and wellbeing functions we embed the importance of needs assessment and evidence-based decision making.

5.2 A clear priority in an evolving policy landscape

The increased focus on both health and wellbeing within national policy and local practice was recognised and welcomed in our discussions. There are emerging pockets of good – and excellent – practice. Forward-thinking organisations are asking:

- How can health and wellbeing become a core driver for us?
- How can we develop widespread ownership?
- How can staff be supported to evaluate and build on what is working well?
- How can staff develop, and implement, practical interventions, informed by evidence and local need?

[4] Including contributions from occupational health, nursing, physiotherapy and associated therapies, as well as mental health workers.

A key enabler within each organisation – the "glue" – for connecting and supporting the delivery of effective health and wellbeing are HWB Leads. Our co-design conversations suggest that to be effective they need:

- Clear role descriptions and objectives
- Certainty of tenure in post
- Personal development plans to support individual growth and career progression
- Organisation-wide strategy and commitment
- Budgets to develop and sustain wellbeing activities
- Alignment with Wellbeing Guardians and Wellbeing Champions

5.3 The value of the Lead role: a future-focussed view

Emerging from the policy context, identified good practice and needs/experienced shared through the codesign phase, comes a clearer *USP (Unique Selling Proposition)* for the role of a HWB Lead:

> ***An enabler and change agent, moving beyond the role of reactive disseminator***
> *(which many fulfilled/responded to during the unprecedented pandemic)*

In Section 4.3, we shared the evolving skillsets identified for HWB Leads to develop and thrive with this focus. Of particular note are strong interpersonal skills and influencing behaviours required to drive organisational culture change through the work that services and/or individuals' support. In addition to this is a shift to data informed decision making and strategic alignment to deliver evidence-informed initiatives that meet the varying needs of different staff groups.

5.4 Beyond one HWB role: towards an effective health and wellbeing function

In this section we share a model for further exploration and development in the pilot: the definition of six health and wellbeing functions across an organisation/system. This model has been tested with 80 staff in national forums and in eight depth interviews with HWB Leads and colleagues.

A clear through-line of feedback from the codesign phase is that in most contexts, most of the time, multiple roles need to be considered to deliver an effective health and wellbeing function. There isn't one type of HWB Lead role to deliver this for the wide range of organisations/systems across England.

In addition, depending on where the HWB / Wellbeing function sits within an organisation, will determine the relationships and access to the 'health' functions such as Occupational Health, psychological wellbeing, and mental health (specialist services), physio and rehab and immunisations and vaccinations. These functions may be delivered in-house or commissioned/managed externally (or a combination of the two).

Most HWB Leads expressed a need for guidance and clarity on role structure and objectives. Leads framed this guidance as 'factors for consideration' for local adaptation in moving towards a preventative wellness culture. Alongside this, Leads shared that being overly prescriptive was not helpful and did not consider the different organisational structures, the work content and reach, service types, staff or where services based.

Figures 3 and 4 provide a summary of health and wellbeing functions across an organisation/system.

Figure 3 sets out six common health and wellbeing functions across an organisation/system: defining the "essence" of these functions. These common functions can be used as a set of considerations for an organisation/system to inform decisions on what elements are appropriate for local adaption, when strategically reviewing their health and wellbeing function.

Figure 3: common health and wellbeing functions across an organisation/system

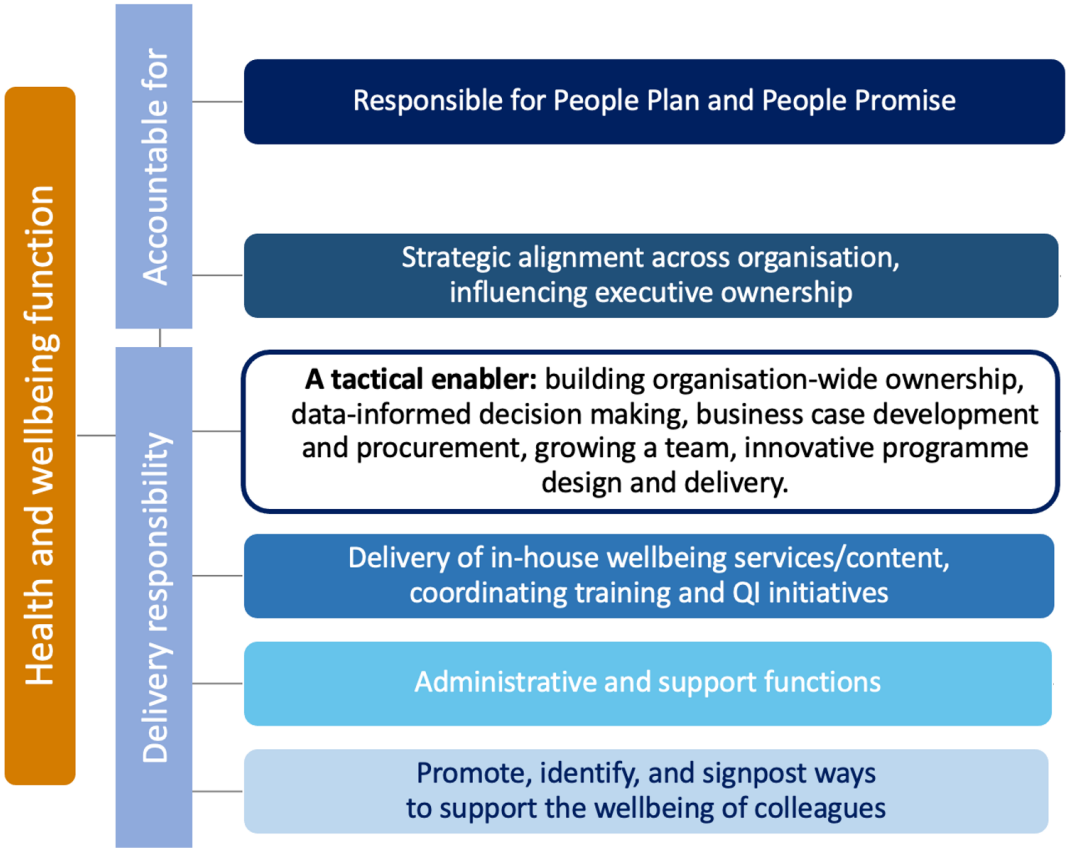
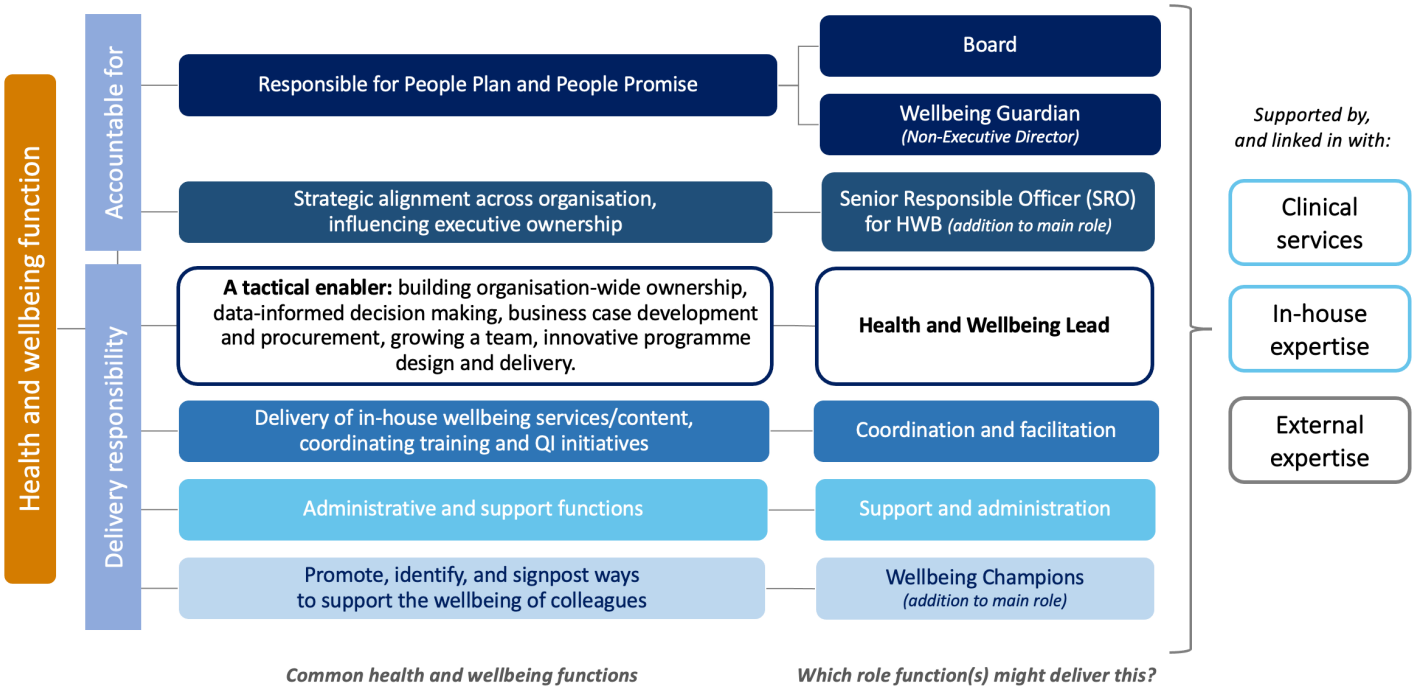


Figure 4 expands upon this, adding in common role functions for consideration.

It is important to reiterate that this report is *not* suggesting that every organisation/system must have at least six substantive posts to deliver the wellbeing function. Rather, what we are inviting is consideration of how these role functions are delivered and relevant to the local context. It is likely that many Leads will have elements of 'coordination and facilitation', and 'administration and support' within their roles – and it may be appropriate for this to stay.

Figure 4: how different role functions might deliver effective wellbeing across an organisation/system



We note that a growing number of organisations have invested in separating these functions into new posts, advertising 'Wellbeing Advocates' and 'Wellbeing Facilitators' to deliver core wellbeing services and facilitation activities. Alongside this, a growing number of 'Wellbeing Coordinators' are supporting HWB Leads with administrative tasks such as managing emails, booking sessions, delivering staff information, and supporting Wellbeing Champion sign-ups and information sessions.

Whether the delivery roles of '*coordination and facilitation*' and '*support and administration*' are additional to the Lead roles or represent a portion of protected time with the overall HWB Lead role – this model intends to provide decision support for HWB Leads and colleagues to consider the factors that will contribute to effective enabler role.

5.5 Defining a HWB Lead's development and support needs

As set out in Section 2, the purpose of this review is to: *define an inspiring, engaging, and appropriate way to develop those who lead on NHS staff wellbeing in organisations/system.*

The focus of work in the scoping report (Phase 1) was in setting out a baseline of who HWB Leads are, what they do and what their development and support needs are.

In relation to HWB Leads' development and support needs, the codesign activities (Phase 2) identified:

- variation in self-identified confidence levels on a closed list of work activities,
- what's worked (*access to networking/networks, skills in working with people, role support, training courses and developing technical skills*), and
- identified needs for future development (*developing technical skills, access to networks, central guidelines and resources, skills in working with people, role support and investment/funding*).

6. Where to next: options for a pilot

As set out in Section 2, the overall purpose of this review is to: *define an inspiring, engaging and appropriate way to develop those who lead on NHS staff wellbeing in organisations/system.*

Our scoping report described who HWB Leads are, what they do and what their development and support needs are. This phase 2, co-design report further identified:

- variation in self-identified confidence levels for activities currently carried out by HWB Leads,
- what works to support delivery of their work: *access to networking/networks, people skills, role support, training courses and developing technical skills*
- their perceived needs for future development: *developing technical skills, greater access to networks, central guidelines and resources, skills in working with people, role support and investment/funding*.

We suggest that the phase 3 pilot work takes the HWB functions model (figure 4), expands and tests this with an organisation/s. This would aim to produce:

- A robust description of how health and wellbeing functions can be delivered across organisations
- A detailed description of the future role and required skill set for HWB Leads within this.

Depending on timescales and funding available, there are three possible pilot options set out in Table 6:

- Option A **/ Minimum Viable Pilot (MVP): 1 site for 3 months**
- Option B / **Depth: 1-2 sites for 8 months**
- Option C / **Depth and breadth: 5 sites for 14 months**

The robustness of the model and role description will depend on the depth of work carried out.

Table 6: pilot options

Option	**A / MVP:** *(Minimum Viable Pilot)* **1 site for 3 months**	**B / Depth: 1-2 sites for 8 months**	**C / Depth and breadth: 5 sites for 14 months**
Scope	**Pilot with 1 site** + 2-monthly peer reflective learning process (HWB Leads)	**Pilot with 1-2 sites** + 2-monthly peer reflective learning process (HWB Leads)	**Pilot with 5 sites** + Evaluate changes/outputs at 6 months and 12 months + 2-monthly peer reflective learning process (HWB Leads)
Objectives	• Ensure flexibility in approach • Define role objectives and competencies for each role function • Build a case study on what's worked and arising challenges • Identify future development/support needs	*Option A* + *If 2 sites* • Test differences in organisational context to generate learning in what works where • Test different variations in approach (capturing explanatory process notes)	*Option B* + • Revisit organisations/systems at 6 and 12 months to assess changes, and inputs for future planning

Option	A / MVP: *(Minimum Viable Pilot)* 1 site for 3 months	B / Depth: 1-2 sites for 8 months	C / Depth and breadth: 5 sites for 14 months
Outputs for NHSE	1 x case study 1 x recommendations report 1-2 x peer reflective learning sessions 2-3 x information calls with national network (HWB Leads)	1-2 x case study 1 x recommendations report 3-4 x peer reflective learning sessions 6-8 x information calls with national network (HWB Leads)	5 x case study 1 x recommendations report 6-7 x peer reflective learning sessions 10+ x information calls with national network (HWB Leads)
Outcomes for pilot site(s)	• Conversations on HWB function and roles • Light planning support on next steps	• A roadmap for strengthening HWB function and roles • Capturing and celebrating journey and good practice • Troubleshooting organisation difficulties/challenges	*Option B +* • Checking in with teams across pilot orgs at 6 and 12 months, to adjust, iterate and adapt
Timeframes	**3 months** (12 Sept - 16 Dec 2022)	**8 months** (Sept 2022 – May 2023)	**14 months** (Sept 2022 – Nov 2023)
Pros	• Rapidly assess approach, for wider testing • Completed within current budget and timeframes	• Flexibility on pace/schedule of implementation • Bespoke support to address unspecified issues	• Including evaluation • Broader testing using self-assessment tools
Cons	• Potential to lose momentum to sustained engagement • Timing/winter pressures	• Additional budget required • Higher ask of trusts *(might funding be required?)*	• Pilot is more complex • Additional budget required • Higher ask of trusts *(might funding be required?)*

The high-level steps for taking a pilot forward include:

- **Further develop a the HWB model to be tested:** This will include clarity of the ask to each organisation involved and further discussions to ensure alignment with the national Developing OH Programme and local development of HWB Champions and Guardian roles.
- **Establish a Steering Group** for oversight of the planning, design, delivery, and findings of the pilot.
- **Recruit/identify** pilot site(s), securing buy-in from all stakeholders who will be involved in the work.
- **Establish ways of working and support for each pilot site**, along with feedback loops to all key stakeholders.
- **Deliver pilot option A/B/C**.
- **The final report** will set out pilot findings and recommendations for the scale and spread of the outputs of this work.

Annex A: Self-reported work activities (from Phase 1)

Summary of self-reported work activities and tasks

The below table shares a clustering of self-reported work activities and tasks that HWB Leads we spoke with undertake as a priority. This was developed and presented in the scoping report.

Table 7: HWB Leads self-reported work activities and tasks

Work activity/ Work task	Anecdotal prevalence of HWB Leads we spoke with:	Examples
Awareness raising: signposting and comms with staff	All HWB Leads are involved in these activities. Those working at system level noted inequity of information/access depending on who the staff member's employer was and what the employer had signed up for.	- Signposting to services from NHSE / other providers - Internal comms/signposting to resources, including staff intranet, staff bulletins and Facebook feeds - Supporting HWB ambassadors/Champions - Worked on QR small cards for staff to signpost to help - 12-week local radio station campaign to reach NHS staff and their families
Rewards and recognition	All HWB Leads are involved in these activities to some level.	- Writing funding bids for money to deliver services - Examples include: Star awards – nominations and a family dinner, You Shine, designing a competitions photos (which received six entries), printing long service recognition certificates, tea and biscuit baskets, sending £45 'Hug' vouchers, "little wellness bags of love", recognition wall, Thursdays – 'what are we proud of moment' put on Microsoft teams.
Training and workshops: administering/ managing the rollout of (with external providers) and/or delivering the training and workshops ("train the trainer" approach)	All HWB Leads were involved to some level in the administering/ managing of training and workshops. Some had completed "Train the Trainer" courses and managed the network of trainers at Trust level.	- Including coordinating/administrating training for: Yoga, Fitness, Mindfulness, Nutrition, Sessions on Civility, cervical awareness, men's health, MSK, sleep, 'Let's walk and more', TRIM, Mental Health First Aid (MHFA), laughing yoga, desk-based Pilates and menopause (a significant priority for many Trusts) - In addition, several HWB Leads have completed "Train and Trainer" courses for REACT (mental health training) and Smoking Cessation. - Encouraging staff to speak from own experiences

Work activity/ Work task	Anecdotal prevalence of HWB Leads we spoke with:	Examples
Programme management, delivery and reporting	All HWB Leads at System (ICS) and CCG level were involved in programme management such as sourcing and delivery of solutions, and management and reporting on budget. Relatively few at Trust level.	- Programme delivery at Trust level, including: free staff gym - Programmes at ICS level, for example, Hubs or system-wide initiatives - Supporting Communities of Practice
Clinical Services and Referrals: Managing the outsourcing and/or providing 1:1 direct support to staff	Some HWB Leads at Trust level were involved in managing clinical services and referrals. This was more often when they were hosted by/aligned with OH. Some HWB Leads were also trained in short courses (and had protected time) to provide 1:1 direct support to staff.	- Supporting staff 1:1, after undertaking coaching/counselling short courses - 1:1 interactions such as coaching managers and Wellbeing Champions - "Doing domestic abuse work (this is needed even though expensive a lot of staff are in situations of domestic abuse)" - Providing support post violence and aggressive incidents - Managing business-as-usual outsourced services (not part of programme activity), as such EAP and psychological support - Working closely with Safe Space Practitioners
Building executive ownership, and influencing policies and procedures (Trust/CCG/ System)	Some HWB Leads had experience working with Wellbeing Guardians. Only one Lead was able to speak to the experience of developing/presenting a business case.	- Working with Wellbeing Guardians - Board updates and reporting - Presenting business cases based on needs
Data insights and building business cases	Only two Leads were able to speak to the process of collecting data	- Evaluation of existing services - "There is resistance to sharing data and a lack of understanding that it will take 2-3 years until we see ripples from our work now".
Inclusion of and addressing needs of historically less heard groups	No examples were available through this scoping exercise about the engagement and inclusion of <u>all</u> staff groups. One Lead mentioned "alignment with EDI".	- Working with EDI and OD teams to understand needs - "No one understands EDI and WRES. They are not purposefully ignorant, but the proximity effect is real. Many Leads do what they think will work for people like them".
Meetings and writing update reports	We have included this as a separate item to recognise its overwhelming prevalence through interviews. This was referenced by most HWB Leads as the most frequently self-reported work activity and task.	- We recognise that "meetings and reports" will be involved in all of the above tasks areas. Overall, HWB Leads gave task-oriented feedback – "I'm in meetings all day", rather than identifying what was the purpose of meetings. We have attempted to break this down into specific activities as above in this table.