Project5

HERE FOR HEALTH CARERS

Single Page: Impact statement

Wellbeing impact for NHS staff using the service

- Project 5 opened to clients on July 1st 2020. By 7th April 2022 it had supported 2935 NHS clients, with a total of 5064 sessions recorded, and an expected total session delivery in excess of 9,000 sessions.
- Clients have 3 sessions with wellbeing practitioners. The first session demonstrates the most significant improvement.
- After 3 sessions there is a statistically significant reduction in mental health symptoms and a significant increase in wellbeing.
- Qualitatively, clients report meaningful change.

Experiences of the service

- An online platform has been developed that service users find easy and quick to access.
- Service users value the confidentiality of accessing a service not tied to the NHS

Volunteer impact

- We screened and selected approximately 1,000 coaches and wellbeing practitioners (coaches, Psychologists, Counsellors) from 4,500 applications.
- We have developed a selection and training standards framework and a 3-session evidenced based approach that has potential national impact.
- We offer ongoing training, discussion, and support to facilitate the practice and engagement of volunteers
- Project5 has developed a community approach to training
- There are regular volunteer workshops that support the development of volunteers and high-quality skills and training

Research and Evaluation

- Project5 is constantly evaluating its approaches and has developed a best practice model of triage for wellbeing need
- Thorough evaluation has evidenced our approach.

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Executive Summary

In March 2020 as the full scale of the Covid 19 pandemic and its implications for health services began to emerge, a team of psychologists with a deep understanding of the NHS recognised the need for a rapid, early intervention service to support wellbeing and to help staff to cope with personal stress. Project 5 was created, a not-for-profit organisation offering a fast access, free, digital service, staffed with highly professional volunteers delivering a solution focussed intervention to NHS staff.

Impact on NHS service users wellbeing

Key Impacts

- Project5 opened to clients on July 1st 2020. By 7th April 2022 it had supported 2935 NHS clients, with a total of 5064 sessions digitally recorded, and an expected total session delivery in excess of 9000 sessions.
- Clients have 3 sessions with wellbeing practitioners. The first session demonstrates the most significant improvement.
- After 3 sessions there is a statistically significant reduction in mental health symptoms and a significant increase in wellbeing.
- Qualitatively, clients report meaningful change.

Experiences of the service

Easy Read findings

On Arrival

- People coming to Project5 who complete assessments are above clinical cut off for having poor mental health, have significant wellbeing concerns, and lower work engagement.
- CORE 10 : showed the highest level of need with people often feeling anxious or that talking to people is too much, they struggle with sleep and feeling unhappy
- Wellbeing: People felt less optimistic about the future when arriving and struggled to feel close to others or deal with problems well. They did not feel relaxed.
- Of these, as rated on the CORE 10, clients have a high level of mental health need that would be considered above the clinical threshold for almost 90%, in a mental health service.
- In particular, in terms of work engagement people self-report lower levels of vigour (energy) though dedication and absorption may remain.

After support has been received

- Greatest symptom difference appears to occur between session 2 and 3.
- Some mental health symptoms may be reported as higher at session 3, but this is not statistically significant, and may be an effect of having to wait for further service.
- Significant change is seen in wellbeing and work engagement improvement, and mental health reduction. This is a large effect size across all areas.

Service Users' Experience

Key Impacts

Who is being supported?

- People come from a range of job roles from administrative to senior medical staff.
- 81% have a White British Background, representing 19% from diverse backgrounds who are being supported.

Why are people using the service?

- Recommendations – because of positive experiences of others for example
- Because waiting lists for NHS or other services are very long, and P5 provides a short and fast service.
- Because the service is easy to access and is free.
- Because the service is independent and confidential.

What are people getting from the service?

- People are getting lots of things from our service:
    - Support with getting on at work
    - Support with relationships outside of work
    - Strategies to help manage anxiety
    - Feeling Validated
    - Tools to help them get through difficult times
    - The opportunity to be listened to

Sector Impact

Key impacts

- Development of a volunteer coach/wellbeing practitioner selection system
- Development of skilled coaching, wellbeing, and supervision provision around supporting the wellbeing of NHS staff.
- Development of a 3-session approach to support staff wellbeing, that is evidenced to have impact.

Volunteer Impact

Impact Highlights

- Delivered 6 volunteer workshops
- Development of feedback systems from workshops
- Development of volunteer networks to support discussion of practice
- Opportunities for supervised practice

Supervision impact

Key Impacts

- Supervisors gain regular communication and reflective spaces
- Supervisors are involved in the development of Project5 thinking

Organisational Impact

Key Impacts

- Project5 has developed an organisational structure that supports internal volunteers and external queries.
- It provides opportunities for students to develop research experience and experience in business development and set up, and 6 students have so far partaken in different projects within Project5.
- Provision of skills development and maintenance opportunities to people on Furlow or people who need these opportunities to move to paid employment.
- The development of organisational functions that support the wellbeing of their own internal staff and the negotiation of personal challenges.
- The development of an organisation that can be trusted for its high standards through its adherence to rigorous process, despite being run solely by volunteers.

1.0 Introduction and Background to Project5

This document aims to take a broad approach to provide some insights into the multiple areas of impact that Project5 has had since its foundation in March 2020.

1.1 About the purpose of Project5

Project5 was conceived at the beginning of Covid 19 pandemic in response to the immense pressure that NHS staff were facing during this time. The team of psychologists who founded Project5 have a deep knowledge and understanding of the NHS and the pressures experienced by staff. They recognised the need for a rapid, early intervention service to support wellbeing and to help staff to cope with personal stress.

The Project5 service offers confidential, convenient, rapid free access to online coaching and wellbeing consultations, for up to 3 sessions. Clients are guided in identifying their needs and then matched to the right professional for them. All our support volunteers are professional coaches or therapists and have been onboarded and trained using our own validated, solution-focused approach.

The service continues to evolve as the challenges for NHS staff shift, with our current focus on early intervention and support for staff at risk of burnout.

Our ongoing mission is to facilitate a well-connected team of skilled and caring volunteers to create meaningful impact on the wellbeing of NHS healthcare workers.

1.2 About the Project5 organisation

Project5 is run by volunteers comprising:

1) The 'board' (CEO, organisational director, wellbeing and standards director, technical director, marketing director (non-exec), Safeguarding lead (non-exec)
2) Core Operations Volunteers (research assistants, administrative assistants, 3 currently)

3) Wellbeing practitioner volunteers, coaches and wellbeing or mental health registered professionals (approx. 200)
4) Wellbeing practitioner supervisors (approx. 50)
5) The Standards Advisory Group. A volunteer monitoring and standards committee involving senior clinicians, NHS leadership lead and other sector advisors (approx. 6-8 across the period).

In addition, from funds raised, we pay for the technical costs of hosting the platform and website, and administrative support currently 1 day per week.

The organisation operates entirely online, with most members having never met, or only coming together during the pandemic.

1.3 About this impact statement

This impact statement is designed to highlight key impacts in each of the areas reported, and to demonstrate the evidence that the organisation has acquired to support this. It is our mission to continuously make best use of the resources that we have to ensure that all claims made about our service can be evidenced. This reflects our collective eclectic background including Researchers, Coaches, senior NHS clinicians, Organisational Psychologists and Clinical Psychologists, to name but a few. For those who want to know the highlights, these are included in summary boxes in each section. We have also included some of the detail around the evidence supporting these claims, for those who want more detail. Further reports are available on request.

2. Impact on Service User Wellbeing

Project5 developed in response to the COVID-19 pandemic, to provide additional support to NHS staff in times of exceptional workload. However, it continued, as we have continued to have people access the service, and feedback suggests that there is a clear need for this form of support.

This has raised a number of questions including how to measure impact for service users. We have currently done this based on the number of recorded sessions entered onto our system, and through the optional use by service users of symptom measures of wellbeing. These include the CORE 10, Warwick and Edinburgh Wellbeing inventory and the Utrecht Work Engagement Scale.

In summary, based on our evidence the key impacts are found in Table 1. The section below accounts for the evidence supporting these claims.

Table 1: Impact on NHS service users of Project5 Wellbeing

Key Impacts for NHS workers accessing the service

- Project 5 opened to clients on July 1st 2020. By 7th April 2022 it had supported 2935 NHS clients, with a total of 5064 sessions recorded, and an expected total session delivery in excess of 9000 sessions.
- Clients have 3 sessions with wellbeing practitioners. The first session demonstrates the most significant improvement.
- After 3 sessions there is a statistically significant reduction in mental health symptoms and a significant increase in wellbeing.
- Qualitatively, clients report meaningful change.

2.1 Evidence

2.1.1 Booking monitoring

Project 5 opened to clients on July 1st 2020.

By 7th April 2022 it had supported 2935 NHS clients, with a total of 5064 sessions booked.

In the year 2022 we have had a mean weekly use of 20 NHS staff.

The highest usage was 22 February 2021 when we had 59 in one week, 57 of which were new service users.

The lowest usage was over Christmas 2021, with 9 new referrals in that week.

2.1.2 Wellbeing Change Studies

Project5's mission has included being to ensure high standards of support provision. This has included examining carefully what improved wellbeing might be for staff attending the service, in order to best understand what the benefit of the service is. The service is a unique combination of coaching and wellbeing/mental health trained practitioners, and attendance is triaged through a series of questions. These questions are designed so that those people coming to the service will be referred to people who are most able to offer help to those individuals. All attendees receive solution focused interventions and are offered up to three sessions.

The definition of wellbeing has been one that we have struggled with, as there seem to be multiple uses and interpretations of this within the sector, and it is generally unclear. We have held discussions within our board and with all of our volunteers around this, and our best hope is that service users can perceive a benefit from the service. In order to capture these qualitative benefits we have also examined peoples experiences of the service (reported in section 3).

In this section our focus is on the quantitatively tangible impacts that we have currently identified, derived from our attempts to measure symptom change.

In selecting our scales to assess what symptoms that people were arriving with, and where they may show change, we wanted to ensure that the scales would match the types of challenges that people were arriving with. In the first instance we were not sure what people would come with, and so our decision making was guided by:

1) Free to access and use within not-for-profit organisations
2) Scales that had previously demonstrated high validity – that is that they are reliable measures, and they measure what they purport to measure.
3) Scales that measure attributes relevant to our service. We knew at the beginning that it may be related to mental health, may be related to wellbeing, and may be related to work engagement experiences.
4) Scales must not be overly lengthy, and therefore preventative or off putting for people wanting to complete them, or to get in the way of accessing the service in any way.

Scales used.

Utrecht Work Engagement Scale

Rationale: This scale has been widely used to examine how people are getting on with their work – what their level of enjoyment is. We were hopeful that through having 3 solution focused sessions people's engagement with work would increase. Because the scale was widely used we could be confident that our outcomes would be comparable to other groups of people.

Validation: The shortened scale (used here) has been well validated including for use in the UK general population (Ng Fat, et al., 2017).

Warwick and Edinburgh Wellbeing Scale

Rationale: This scale focuses on the construct of wellbeing, which is generally were we wanted to aim the service – looking at positive rather than negative aspects of people's experience. It examines both happiness in terms of emotions, and in terms of people's positive wellbeing practices, addressing the two forms of wellbeing traditionally emphasised. In addition it includes a relational aspect.

Validation: The scale has been validated in over 23 countries. It also shows an inverse response to mental health scales, though where they level off, wellbeing demonstrates the capacity to improve.

CORE – 10

This is a short version of the CORE repertoire of scales. This is a long standing well used psychiatric assessment of symptoms, which provided us the opportunity to also monitor the mental health of our service users. Although mental health was not the primary aim of interventions, and Project5 is in no way considered as an alternative solution for counselling or other psychotherapy, it was able to provide useful indication of the breadth of symptoms that our participants were experiencing.

Validation: CORE-10 is widely used in the NHS and seen as a practical tool to assess people presenting common mental health concerns such as anxiety and depression. It also has good psychometric properties and reliability (Barkham et al., 2013).

Two pilot studies are reported here using these measures, which were conducted at different time points. Both studies aimed,

- To examine whether there was any change on any of the scales from initial completion and booking through to the final intervention session that was conducted.

- We predicted that there would be improvement in mental health symptoms, engagement, and wellbeing.

Method

Data collection

All participants are sent out an initial booking invitation that includes a link to the survey. Follow up emails are sent approximately 6 monthly to service users inviting them to go back and complete the questionnaire again. We encourage volunteers to remind clients to go back and complete the measures again in order to capture the follow up data.

Two key data collection periods have been conducted. One that ran between September and December 2021 (termed study 1), and a subsequent study including all data up to and including February 2022 (termed study 2).

Easy Read findings:

On Arrival

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Study 1 Findings (time period: June 24th 2020 to 31st December 2020)

In the time period from 24th June 2020 to 31st December 2020 there were 156 responses to the service user questionnaire. 15 questionnaires were excluded for being incomplete (for

example, participants gave consent but did not answer any questions) and one questionnaire was excluded on the basis of the participant selecting multiple responses to the number of sessions completed, leaving 140 questionnaires for analysis. 85 responses (60.7%) were from service users who had not received any intervention, 9 responses (6.4%) were from service users who had received one session, 9 responses were from service users who had received two sessions, and 37 responses (26.4%) were from services users who had completed all three sessions. Table 1 displays the number of completed responses, mean scores, and standard deviations for participants at each stage.

Table 1

Mean scores and standard deviations for participants at each stage of intervention

Sessions	UWES-9			CORE-10			SWEMWBS		
completed	*N*	Mean	*SD*	*N*	Mean	*SD*	*N*	Mean	*SD*
0 sessions	83	3.25	1.08	81	20.25	7.55	83	18.83	4.83
1 session	9	3.12	.92	8	17.13	5.82	8	20.88	2.53
2 sessions	8	3.44	.68	8	9.00	6.44	9	23.11	3.33
3 sessions	36	3.61	.86	36	14.67	6.80	36	21.94	4.54

Table 1 shows that the greatest differences for UWES was between 0 and 1 session, for CORE-10 was the SWEMWBS, after session 2. A slight rise in mental health symptoms was shown at 3 sessions. There are issues with the study design such as how long post session service users conducted the test.

Schaufeli and Bakker (2004) collated group norm data for the UWES-9 from 12,631 participants who completed the scale in various languages, finding a mean of 4.05 out of 6 (*SD*=1.19), where higher scores indicated greater engagement with work. While the results of this evaluation show a trend towards this norm, with scores increasing by .36 over the course of three sessions, the mean scores within the sample still fell below this norm,

indicating that they were less engaged with work than would be expected. Cronbach's alpha for this sample was .89, indicating high internal consistency.

Barkham et al. (2013) established a clinical cut-off score of 11 out of 40, with high scores indicating greater psychological distress, for the CORE-10 using a sample of 1,835 participants. While mean scores decreased by 5.58 points from pre-intervention to post-intervention, they remained above the cut-off indicating a clinical level of need. The large standard deviations indicate a degree of overlap between scores from sessions 0 and 3, limiting the conclusions that can be drawn from this decrease, particularly with the disparity in sample sizes. However, the high scores on this measure indicate that there is clinical need for an intervention targeting the mental health of healthcare workers during the Covid-19 pandemic. The data suggest high internal consistency within this scale, with Cronbach's alpha of .86.

Finally, Ng Fat et al. (2017) surveyed 11,948 participants from England to establish national norms for the SWEMWBS. They found a mean of 23.67 (*SD*=3.92) of a maximum of 35, with high scores indicating greater wellbeing. Post-intervention scores were higher than pre-intervention scores, although wellbeing remained below the national norm. In addition to the means from the CORE-10, this provides a rationale for why a service such as Project5 is needed to improve the wellbeing of service users. Cronbach's alpha of .87 in this sample suggests high internal consistency.

Overall, the results suggest that Project5 may offer interventions that change outcomes for service users in work engagement, psychological distress, and wellbeing. Results on all measures were closer to non-clinical levels from pre-intervention to post-intervention. However, this should be taken lightly as the methodology, such as data not being linked to the same participant and possible subject attrition, does not allow for conclusions on improvements to be drawn. Additionally, these changes do not bring service users' scores into the normal or non-clinical ranges. There may be a number of reasons for this, such as: the effectiveness of Project5's service, the design of the service evaluation, or the level of need being higher than the norm due to the extraordinary circumstances of the Covid-19 pandemic. The implications of the final point may need to be considered at the broader systemic level in terms of what this means for the workforce in practice.

Study 2: Repeated analysis (cut-off date 1 March 2022)

This study included the total data available at March 1st 2022. This study was differently conducted in order to analyse change statistically from pre to post analysis. Notably, all post questionnaires were treated as the same, and this may have been significantly confounding in effect.

Power and Sample

Of the 382 responses to the survey, 64% were completed on registration, before having received any sessions (N1) with the remainder completed after having received *at least* one session, up to a total of three sessions (N2). A priori power analysis using G-Power 3.1.9.7 showed that for a two-sided test to find difference between two independent means (given a ratio of N2/N1 = 0.57), a sample size of 228 would be required to find a statistically significant effect with $\alpha = 0.05$, power = 0.95. Therefore the sample was sufficient to conduct the necessary statistical analysis.

Wellbeing impact

For this larger sample the 3 components of the UWE Scale were broken down. Vigour was initially the lowest score, and this showed greatest improvement over sessions. Dedication and Absorption were within normal ranges throughout. Again, greatest mean change was identified between sessions 1 and 2. There was a slight increase in mental health symptoms after session 3.

Table 3: Wellbeing scores over time

Number of sessions		Vigour	Dedication	Absorption	UWES	SWEMWBS	CORE-10
0	**Mean**	**2.58**	**3.64**	**3.51**	**3.24**	**18.28**	**20.28**
	Std. Deviation	1.19	1.22	1.08	1.02	3.06	6.65
1	**Mean**	**2.77**	**3.73**	**3.61**	**3.37**	**19.05**	**17.76**
	Std. Deviation	.79	.98	1.08	.80	2.31	6.33
2	**Mean**	**3.27**	**4.03**	**4.00**	**3.77**	**21.01**	**11.25**
	Std. Deviation	1.07	1.17	.95	.98	2.35	5.53
3	**Mean**	**3.33**	**4.15**	**3.96**	**3.81**	**21.23**	**12.54**
	Std. Deviation	1.12	1.11	1.02	.97	3.37	5.86

There was a statistically significant difference in the combined 'wellbeing' dependent variable between those participants prior to receiving the service and after having received at least one solution-focused wellbeing session, F (5 , 290) = 13.64, p < .001, Wilks' Lambda = .81 and Partial eta squared = .190. The analysis suggests that of the variance in the combined wellbeing dependent variable measured before and after having received the intervention, 19% can be explained by the Project5 solution-focused service. This indicates a large effect as it exceeds the guideline Partial eta squared value of .14 (Cohen, 1988).

When the results for the dependent variables were considered separately, all dependent variables reached statistical significance using a Bonferroni adjusted alpha level of .01. The full results can be found in Appendix 2, a summary is listed below:

CORE-10 - F (1, 294) = 66.66; p < .001; Partial eta squared = .185
SWEMWBS - F (1, 294) = 39.60; p < .001; Partial eta squared = .119
Vigour - F (1, 294) = 18.97; p < .001; Partial eta squared = .061
Dedication - F (1, 294) = 7.04; p = .008; Partial eta squared = .023
Absorption - F (1, 294) = 7.78; p =.006; Partial eta squared = .026.

In terms of the effect size, the results show a large effect of the intervention on CORE-10, a medium effect on the dependent variables SWEMWBS (psychological wellbeing) and Vigour, and a fairly low effect on Dedication and Absorption (Vacha-Haase and Thompson, 2004).

Number of sessions impact

In order to analyse the impact of the number of sessions received on the different aspects of wellbeing, a second MANOVA was performed with the same dependent variables used for the above hypothesis (CORE-10, SWEMWBS, Vigour, Dedication and Absorption) but using a new independent variable - the actual number of sessions received – from 0 to 3 sessions. A statistically significant MANOVA effect was obtained, $F (15 , 795.44) = 5.54$, $p < .001$, Wilks' Lambda = .76 and Partial eta squared = .087.

Post-hoc comparisons were carried out using the Tukey HSD test, and a Bonferroni adjusted alpha level of .01 was used to assess significance. The results indicated that for CORE-10 the mean scores were significantly different between 0 and 2 sessions - Mean Difference (MD) = 9.07, $p < .001$; between 0 and 3 sessions - MD = 7.48, $p < .001$; between 1 and 2 sessions – MD = 6.51, $p = .003$; and between 1 and 3 sessions – MD = 4.91, $p = .005$. Between sessions 2 and 3 and between 0 and session 1, there was not found to be any significant difference in mean CORE-10 scores. For the SWEMWBS the mean scores were significantly different between 0 and 2 sessions – MD = -2.73, $p < .001$; between 0 and 3 sessions – MD = -2.96, $p < .001$; and between sessions 1 and 3 – MD = -2.19, $p = .008$. Again, there was not found to be any significant difference in the mean score of SWEMWBS after just one session. For the sub-components of the work engagement score (UWES) the only significant difference in the mean scores was found for Vigour, where the analysis shows a significant difference in the mean scores between 0 and session 3 – MD = - 0.75, $p < .001$. The full results can be found in Appendix 3.

3.3 Service Users' Experience

In addition to quantitative evaluation of impact, we have also collected data around the qualitative experiences of people who attend the service. This is so that we can understand what it is like, what people value and where to develop.

Data around experiences are collected through two routes. Firstly, a brief question about why they have used the service rather than NHS services is added to the quantitative measures survey. Service users are also asked to complete an evaluation of the service. Findings from these two sources are reported separately here.

Key Impacts

Who is being supported?

- People come from a range of job roles from administrative to senior medical staff.
- 81% have a White British Background, representing 19% from diverse backgrounds who are being supported.

Why are people using the service?

- Recommendations – because of positive experiences of others for example
- Because waiting lists for NHS or other services are very long, and P5 provides a short and fast service
- Because the service is easy to access and is free

What are people getting from the service?

- People are getting lots of things from our service:
    - Support with getting on at work
    - Support with relationships outside of work
    - Strategies to help manage anxiety
    - Feeling Validated
    - Tools to help them get through difficult times
    - The opportunity to be listened to

3.1 Evidence

3.1.1 Feedback from service users completing wellbeing measures

Service users are asked a single free text question in the survey: Why have you accessed Project5 rather than NHS services?

This question was only introduced in December of 2021. Since then we have had 159 completed responses to this question.

The data are summarised below in Figure1.

Survey answers were coded into 11 main reasons. The main reason was through recommendation (28%). This included from a friend who had used the service, a manager, GP, or Occupational health, where quality and positive experiences were emphasised.

The next main reasons were waiting time and ease of access which often overlapped. People commented on the immediate appointment, the process being easy and not needing to speak to people.

The third main reason for access was that the service was separate from the NHS, and people felt that it was designed to understand the NHS, but also was important to be separate from this.

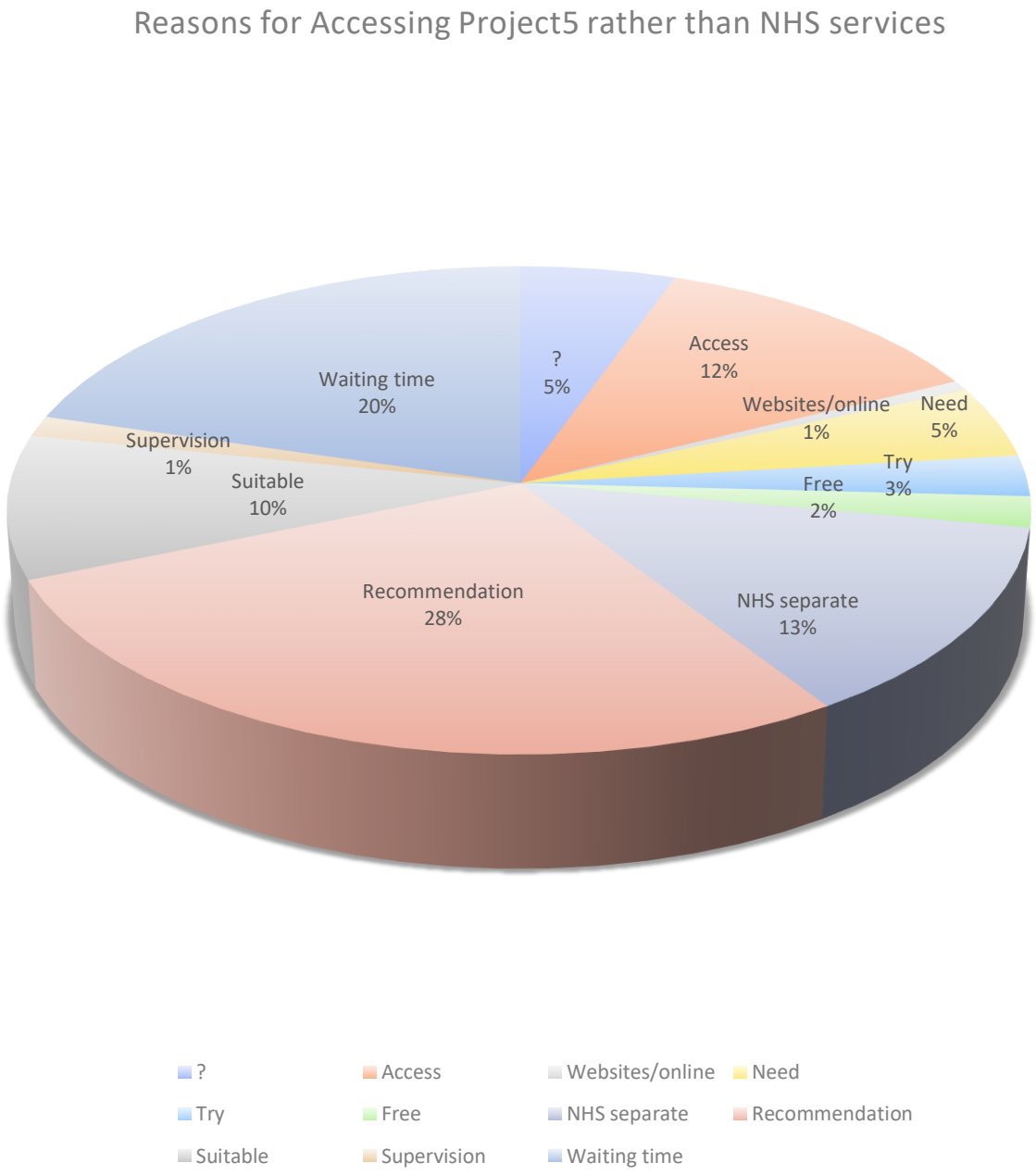
Fourthly, people described the service as suitable – they suggested that it was a different type of support not offered from counselling, or that they did not really feel that they had a mental health need or their need would be met in other services.

Others considered the referral methods directly – these included from the BMA website, and other online trust and google wide links.

Some gave their need as a rationale (anxiety, falling out with other staff members, for example). 5% did not complete the question or wanted to try something else.

2% valued that it was free.

Figure1


Reasons for Accessing Project5 rather than NHS services
?
5%
Access
12%
Websites/online
1%
Need
5%
Try
3%
Free
2%
NHS separate
13%
Recommendation
28%
Suitable
10%
Supervision
1%
Waiting time
20%
? Access Websites/online Need
Try Free NHS separate Recommendation
Suitable Supervision Waiting time

3.1.2 Service Users Evaluation Survey

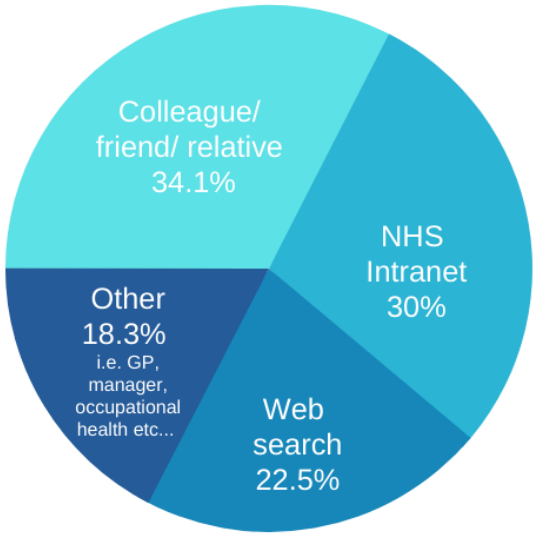
123 users of the service have completed the current service evaluation form (March 2022). From this, common reasons for attending include:

- People wanting help with stress / work challenge / anxiety
- Wanting an independent service
- Wanting rapid support

These reasons are similar to those found in the measures related survey.

Completions were from 16.7% people who registered. Of these 22.5% had booked one session, 17.5% had attended one session, 15.8 had attended 2 sessions, and 63.3% had attended 3 sessions.

Figure 2



n=123 service user evaluations

Percentage of referrals to the service from differing routes

Key challenges included:

- To increase confidence at work
- Anxiety / stress feeling unsafe at work

- Team challenges

Things that helped:

- ‘taught me strategies to help both now & in the future’
- ‘compassionate and helped me to gain focus and clarity’
- ‘gave me time to think things through and reflect’
- ‘listened in a non-judgemental and curious way’

Website

Service users opinions were sought on whether there needed to be changes to the Project5 website, to ensure fit for purpose.

- Most people felt nothing needed to change
- Some people wanted clearer information about the support being offered and whether they could select coaching or mental health support themselves

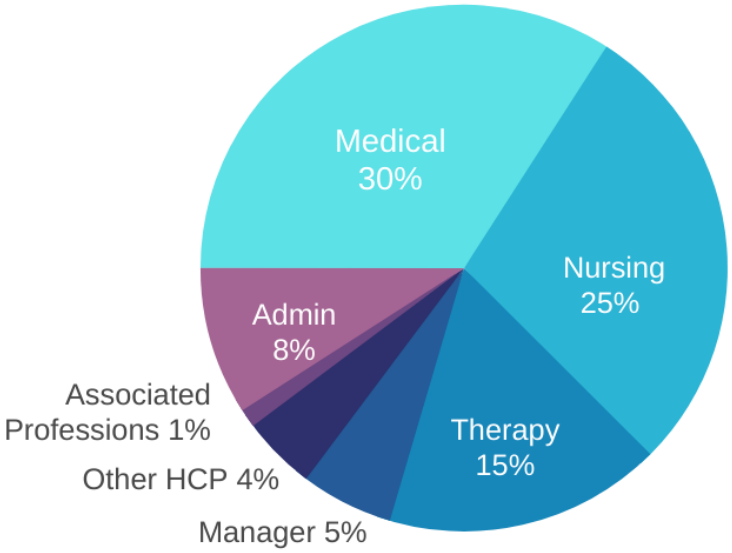
Of evaluation completions:

- 75.6% Female
- 45% between aged 30 -49, 33% 25-34, 22% 50-60, none older and 4 under 25
- 78% British, 7% European, 3% Asian, remainder, other
- Sexuality 90% heterosexual, 2% Gay/Lesbian, 4%, Other sexual orientation.

Figure 3

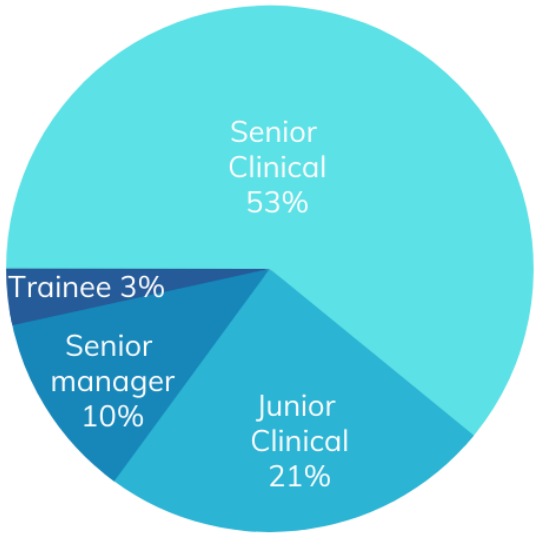
Percentage of service evaluations by occupation and by role.

Service evaluations by occupation



n=123 service user evaluations

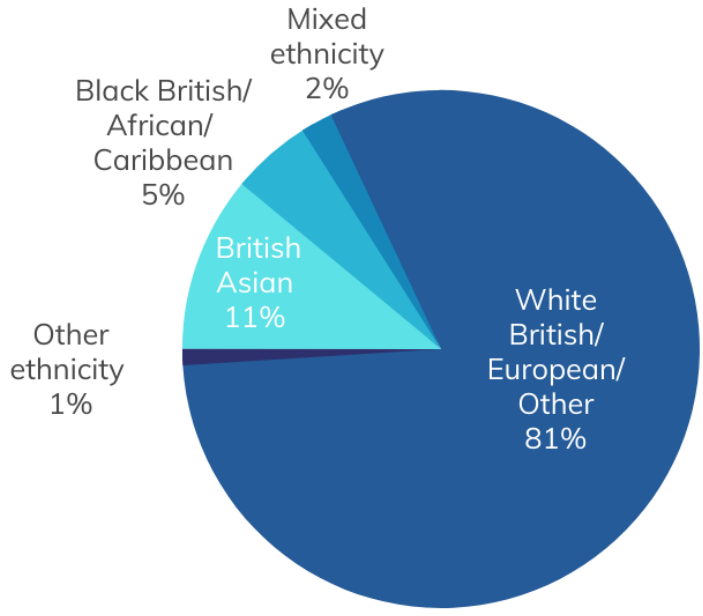
Service evaluations by role



n=123 service user evaluations

Figure 4

Percentage of service evaluations by ethnicity.



n=123 service user evaluations

People experienced the service as culturally and professionally relevant
68% rated the service 5/5, 20% as 4/5.

Overall people most valued:

- Quality of the service
- Speed of the service

Example Testimonials from Service users

"She made me feel at ease, allowed me space and time to show my emotions. Non-judgemental, kind, compassionate and empathetic which shone through even though sessions were virtual. She really helped me through a difficult time."

"Really understood my feelings, was sympathetic but did not let me wallow in self-pity and gave me direction to rethink and reframe- invaluable"

"She gave me many 'tools in the box' to help me cope with stress every day"

"Helped to reframe my thinking, shared some useful models and how they could be of value to me, coached me to take small steps forward and learn from them to change my perception of the problems."

"Perfect listener and was able to unscramble my thoughts was a wonderful human able to help and connect with me and help my problems"

"When I started I did not know what was causing my anxiety. She asked me questions to unpick the areas I was most struggling with. This enabled me to find out exactly what was causing me the most anxiety. I was then able to work on those key areas."

"She listened, validated my feelings and supported me."

"Encouraged discussion and thinking about strategies, realistic approach, thinking about the problem in third person."

"She was able to identify the problem and give me the courage to look at myself and help me to address the issues."

4.0 Sector Impact

Project5 not only has had impact on the people using the service, but also in terms of supporting a drive towards standards of wellbeing support for NHS volunteers. This has included through the development of a selection programme that could be shared, and through a shared development of knowledge around the needs of our service users and how to support them.

Key impacts

- Development of a volunteer coach/wellbeing practitioner selection system
- Development of skilled coaching, wellbeing and supervision provision around supporting the wellbeing of NHS staff.

Assessment and selection of volunteers

The selection of volunteers for the Project involved them passing a robust set of criteria. This included being a full member of a professional body such as the AC, ICF, EMCC, BPS, BACP, UKCP, they each have an accreditation with one of these organisations demonstrating at least 100 hours of practice, have their own supervisor and Professional Indemnity Insurance of a minimum of £1 million.

Identifying the minimum appropriate standard for coaching volunteers was a challenge as there are many different bodies with different standards required to be a member thus making it difficult for us to take on all of those who applied. However, the decisions made around this process have now led to us having a very experienced and qualified cohort of wellbeing volunteers.

Development of knowledge around wellbeing need and support in the NHS

Project5 volunteers have together developed considerable knowledge about the additional and hidden needs of NHS workers, where people may be reluctant to share these within

their own service. In particular, Project5 represents a service design that is able to combine knowledge across the fields of Coaching, Psychology, Mental Health, Nursing, Medicine and many other careers and backgrounds in a unique way that comes together to consider and reflect on solutions and how to best provide solution focused support.

We have so far achieved this with limited funds and resources, and with all of us working together in a voluntary capacity, but we also have formed the basis of a service that includes learning and development that can be harnessed in the future further by the sector to further improve the wellbeing of those within the NHS and beyond.

5.0 Volunteer Impact

Part of our approach has been to recruit volunteers keen to support the wellbeing of NHS staff. We have recruited and maintained 200 volunteers who deliver coaching, and approximately 28 supervisors.

Part of the challenge has been to not only ensure the standards initially of wellbeing solution focused sessions that are often, but also to best know and understand how to support volunteers.

Impact Highlights

- Delivered 6 volunteer workshops
- Development of feedback systems from workshops
- Development of volunteer networks to support discussion of practice
- Opportunities for supervised practice

Training of Wellbeing and Coaching Volunteers

Project5 has both wellbeing and coaching volunteers. As part of the onboarding process all volunteers received basic training. This was to ensure uniform understanding of the Project5 approach to practice amongst wellbeing practitioners, coaches, and supervisors, and to induct volunteers into a solution focused approach. Training included guidance on using the solution focussed approach.

Training was developed to a set of agreed standards set by Project5

Ongoing training has been used to support volunteers, promote engagement through continuing professional development, and strengthen our connection with volunteers who are all working remotely. Volunteers are requested on receiving a referral to set up a supervision session as soon as possible with a listed Project5 supervisor.

Post initial training

Training is held bi-monthly for volunteers. There have been 6 volunteer workshops to date with further sessions scheduled for July 2022. Initial training was used to introduce Project5, this was followed by a sessions explaining how to use the service and the platform. Two further sessions have focused on burnout, and the most recent training in March 2022 reviewed the Project5 journey to date and involved the volunteers in planning for the future of the service. In May 2022 we explored the construct of wellbeing and how this fits with our service, the delivery of solution focused interventions, and the purpose of the support that we are providing.

Attendance at workshops has varied between 11 and 64 people.

We have enhanced our training so that our volunteers can now have a certificate to show that they have continued to develop.

All volunteers are provided with supervision opportunities. We have responded to volunteers by enabling them to book with the same supervisor, although this does not currently mean that we can log supervision. We are exploring processes so that we can provide further impact for volunteers by providing evidence of supervision.

6.0 Supervision and supervisors

6.1 Overall summary of supervision impact

There are 40-50 volunteers who have registered as supervisors from a multiplicity of health professions, and with a wide range of supervision qualifications and/or experience. Supervisors were originally required to provide supervision qualifications. They were surveyed in 2021 to better understand their needs, as reported in the study below under 'Evidence'.

At this point not all supervisors had been contacted, and we have done considerable work to ensure that volunteers now access supervision within Project5. We have supported supervisors through the provision of 5 reflective drop in supervision of supervisor sessions, initially held monthly.

Attendance has varied but overall low in numbers. Feedback from those attending has been that some would value Project5 setting up monthly in-house supervision of supervision, others have requested bi-annual workshops, others have pre-existing supervision of supervision which they regard as sufficient.

We are intending to run a supervision conference in October/November to provide supervisors with high quality supervision opportunities.

Key Impacts

- Supervisors gain regular communication and reflective spaces
- Supervisors are involved in the development of Project5 thinking

6.2 Evidence

Supervisor evaluation study. In 2020 a survey was conducted to examine the needs of supervisors.

The findings were as follows:

There were 27 responses to the survey. 8 participants (29.6%) provided consent but did not answer any other questions and so were removed from the data. A total of 19 surveys (70.4%) were completed fully. Of the 19 completed surveys, 12 respondents (63.2%) had completed at least one supervision and so were able to answer all questions on the form. Of the 12 completed forms, two participants did not complete all answers, and so *N* for some mean scores was 11 (see table 1). A summary of answers to the single and multiple choice survey questions can be found in table 2 and table 3.

Table 1

Mean and standard deviation scores for each scaled survey question

Question	Scale	*N*	Mean	*SD*
How easy was it to develop a good supervisory relationship online compared to face-to-face?	0 = More difficult 100 = Easier	11	59.545	24.130
To what extent do you feel you successfully modelled a solution focussed approach during supervision?	0 = Not successfully 100 = Very successfully	12	75.417	12.873
To what extent was your supervisee able to develop their skills using a solution focussed approach in supervision?	0 = No skills developed 100 = Many skills developed	11	69.091	14.802

To what extent did you feel able to manage risk issues that were brought to supervision by the supervisee?	0 = Not well managed 100 = Very well managed	12	75.000	15.076
To what extent were issues of ethnicity and diversity raised in supervision by the supervisee?	0 = None raised 100 = Many raised	11	46.250	33.380
To what extent did you feel able to manage the concerns brought to supervision by the supervisee?	0 = Not well managed 100 = Very well managed	12	79.1667	15.931

Table 2

Answers to single choice survey question: "To what degree do you feel your supervisee was able to work within a solution focussed approach without diverging to alternative models/ methods"?

Answer	*N*	Percentage (%)
The supervisee's approach only used solution focussed	1	9.09
The supervisee's approach was mainly solution focussed but the supervisee used some alternative models/ methods	9	81.82
The supervisee's approach was mainly alternative models/ methods but some solution focussed approaches were also used	1	9.09
The supervisee's approach was only alternative models/ methods and they did not use any solution focussed approaches	0	0

Table 3

Answers to multiple choice survey question: "What were the key concerns of clients brought to the supervision by the supervisee?"

Answer	*N*	Percentage (%)
Concerns returning to work safely	1	8.33
Lack of support at work	8	66.67
Issues regarding personal or home life	7	58.33
Concerns regarding redeployment	0	0
Work related stress	10	83.33
Health concerns	1	8.33
Working as a coach within the project	1	8.33
Lack of confidence adapting to online work general feeling of being overwhelmed	1	8.33

Mean scores to the scaled questions indicate that supervisors felt they were reasonably successful at modelling a SF approach and managing risk issues and concerns brought to supervision. Supervisors also indicated that supervisees were able to develop some skills within a SF approach. Both of these suggest that supervision is of benefit to the wellbeing volunteers and coaches.

Results indicate that some issues of ethnicity and diversity were raised during supervision, however the large standard deviation of scores (*SD*= 33.380) suggests a high

variability to the extent at which these were raised. A review of raw scores supports this suggestion, as scores were polarised to “many issues were raised” or, “none were raised”.

Another answer of high variability was whether online supervision makes development of a supervisory relationship easier than face-to-face (*SD*= 24.130). The mean score suggests that online supervision is neither more or less effective for developing a supervisory relationship; however the high variability of answers suggests that predilection for online over face-to-face and vice versa is highly dependent on personal preference.

Answers to the single choice survey question regarding use of SF approaches (see table 2) indicate that the vast majority of supervisee’s did use a SF approach but this was not in isolation and other models were also used to some extent. Answers to the multiple choice question regarding the key concerns of NHS and care staff using the service provide an insight into where targeted support is needed, namely feeling a lack of support at work, issues regarding personal or home life and work related stress.

Answers to the final survey question: “Do you have any further comments about the supervision process of Project5?” were free text and thus will be interpreted using a brief thematic analysis. A total of 17 comments were recorded; participants who had not completed a supervision session were still invited to comment on the overall process. After reading and re-reading the comment section to promote data immersion (Braun & Clarke, 2006) the following research relevant codes were identified: “book/ed”; “calendar”; “contacted”; “slots”; “difficult” and “time”. The resultant themes that emerged from coding the data were: difficulties with supervision not being booked in; issues around timing of supervision; problems using the Project5 calendar to making bookings; not being able to book in with the same supervisor each time and a lack of communication more generally from Project5 regarding supervision.

7.0 Organisational impacts

Organisational Impacts

- Project5 has developed an organisational structure that supports internal volunteers and external queries.
- It provides opportunities for students to develop research experience and experience in business development and set up, and 6 students have so far partaken in different projects within Project5.
- Provision of skills development and maintenance opportunities to people on Furlow or people who need these opportunities to move to paid employment.
- The development of organisational functions that support the wellbeing of their own internal staff and the negotiation of personal challenges.
- The development of an organisation that can be trusted for its high standards through its adherence to rigorous process, despite being run solely by volunteers.

The development of Project5 has enabled the careful development of a fully online not-for profit organisation, and for this to be reflected on and tracked from its inception. This has included how non businesspeople have developed the knowledge, skills, policies and infrastructure needed to create a sustainable organisation. We have tested the dedication and ability of all of our core staff, and overcome many hurdles developing skills in all volunteers.

7.1 Evidence

Since Project5's inception we have worked hard to develop and implement the necessary policies and procedures for a non-profit organisation. These include:

- GDPR policy and process
- Safeguarding policies and process

- A platform that is able to facilitate connection for our coach volunteers and service users.
- Development of robust structures, processes, policies in all areas.
- Meeting structures
- Online working approaches and reflection

Governance

- Our policies and processes are advised upon and reviewed by our Standards and Advisory Group- a volunteer committee that includes highly qualified and experienced professionals from Clinical Psychology, social work, and the charity sector.

8.0 Overview

In overview, Project5 has been developed with the highest standards in mind – this gives service users confidence. We make ourselves accountable on a monthly basis to our standards group. We also use our resources as best as we can to collect data that supports the work that we are doing, ensuring that we provide an evidence based, free wellbeing support service for NHS professionals.

Having supported now over 3000 NHS staff, it is our mission to continue to develop this impact and ensure that those people who don't feel that they have huge mental health need, but need something, have somewhere to go to help them to function in their work and daily lives.

9.0 Bibliography

Barkham, M., Bewick, B., Mullin, T., Gilbody, S., Connell, J., Cahill, J., Mellor-Clark, J., Richards, D., Unsworth, G., & Evans, C. (2013). The CORE-10: a short measure of psychological distress for routine use in the psychological therapies. Counselling and Psychotherapy Research, 13(1), 3–13. https://doi.org/10.1080/14733145.2012.729069

Carmassi, C., Foghi, C., Dell'Oste, V., Cordone, A., Bertelloni, C. A., Bui, E., & Dell'Osso, L. (2020). PTSD symptoms in healthcare workers facing the three coronavirus outbreaks: what can we expect after the covid-19 pandemic. Psychiatry Research, 292(113312), 1–11. https://doi.org/10.1016/j.psychres.2020.113312

Chen, C. S., Wu, H. Y., Yang, P., & Yen, C. F. (2005). Psychological distress of nurses in Taiwan who worked during the outbreak of SARS. Psychiatric Services, 56(1), 76–79. https://doi.org/10.1176/appi.ps.56.1.76

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., & McGrath, G. (2000). CORE: clinical outcomes in routine evaluation. Journal of Mental Health, 9(3), 247–255. https://doi.org/10.1080/jmh.9.3.247.255

Fiksenbaum, L., Marjanovic, Z., Greenglass, E. R., & Coffey, S. (2006). Emotional exhaustion and state anger in nurses who worked during the sars outbreak: the role of perceived threat and organizational support. Canadian Journal of Community Mental Health, 25(2), 89–103. https://doi.org/10.7870/cjcmh-2006-0015

Franklin, C., Zhang, A., Froerer, A., & Johnson, S. (2017). Solution focused brief therapy: a systematic review and meta-summary of process research. *Journal of Marital and Family Therapy*, *43*(1), 16–30. https://doi.org/10.1111/jmft.12193

Iveson, C. (2002). Solution-focused brief therapy. *Advances in Psychiatric Treatment*, *8*, 149–157.

Kim, J., Jordan, S. S., Franklin, C., & Froerer, A. (2019). Is solution-focused brief therapy evidence-based? An update 10 years later. Families in Society, 100(2), 127–138. https://doi.org/10.1177/1044389419841688

Lancee, W. J., Maunder, R. G., & Goldbloom, D. S. (2008). Prevalence of psychiatric disorders among Toronto hospital workers one to two years after the SARS outbreak. Psychiatric Services, 59(1), 91–95.

Marek, L., Sandifer, D., Beach, A., Coward, R. L., & Protinsky, H. (1994). Supervision without the problem. *Journal of Family Psychotherapy*, *5*(2), 57–64. https://doi.org/10.1300/j085v05n02_04

Maunder, R. G., Lancee, W. J., Balderson, K. E., Bennett, J. P., Borgundvaag, B., Evans, S., Fernandes, C. M. B., Goldbloom, D. S., Gupta, M., Hunter, J. J., Hall, L. M. G., Nagle, L. M., Pain, C., Peczeniuk, S. S., Raymond, G., Read, N., Rourke, S. B., Steinberg, R. J., Stewart, T. E., … Wasylenki, D. A. (2006). Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. Emerging Infectious Diseases, 12(12), 1924–1932. https://doi.org/10.3201/eid1212.060584

Molnar, A., & de Shazer, S. (1987). Solution-focused therapy: toward the identification of therapeutic tasks. Journal of Marital and Family Therapy, 13(4), 349–358.

Muller, A. E., Hafstad, E. V., Himmels, J. P. W., Smedslund, G., Flottorp, S., Stensland, S. Ø., Stroobants, S., Van de Velde, S., & Vist, G. E. (2020). The mental health impact of the covid-19 pandemic on healthcare workers, and interventions to help them: a rapid systematic review. Psychiatry Research, 293(113441), 1–11. https://doi.org/10.1016/j.psychres.2020.113441

Ng Fat, L., Scholes, S., Boniface, S., Mindell, J., & Stewart-Brown, S. (2017). Evaluating and establishing national norms for mental wellbeing using the short Warwick–Edinburgh mental well-being scale (SWEMWBS): findings from the health survey for England. *Quality of Life Research*, *26*, 1129–1144. https://doi.org/10.1007/s11136-016-1454-8

Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the covid-19 pandemic: a systematic review and meta-analysis. Brain, Behavior, and Immunity, 88, 901–907. https://doi.org/10.1016/j.bbi.2020.05.026

Schäfer, T., & Schwarz, M. A. (2019). The meaningfulness of effect sizes in psychological research: differences between sub-disciplines and the impact of potential biases. Frontiers in Psychology, 10(813), 1–13. https://doi.org/10.3389/fpsyg.2019.00813

Schaufeli, W, & Bakker, A. (2004). *Utrecht Work Engagement Scale Preliminary Manual [Version 1.1, December 2014].* https://www.wilmarschaufeli.nl/publications/Schaufeli/Test%20Manuals/Test_manual_UWES_English.pdf

Schaufeli, W. B., Bakker, A. B., & Salanova, M. (2006). The measurement of work engagement with a short questionnaire: a cross-national study. Educational and Psychological Measurement, 66(4), 701–716. https://doi.org/10.1177/0013164405282471

Seppälä, P., Mauno, S., Feldt, T., Hakanen, J., Kinnunen, U., Tolvanen, A., & Schaufeli, W. (2009). The construct validity of the Utrecht work engagement scale: multisample and longitudinal evidence. Journal of Happiness Studies, 10, 459–481. https://doi.org/10.1007/s10902-008-9100-y

Shah, N., Cader, M., Andrews, W. P., Wijesekera, D., & Stewart-Brown, S. L. (2018). Responsiveness of the short Warwick Edinburgh mental well-being scale (SWEMWBS): evaluation a clinical sample. Health and Quality of Life Outcomes, 16(239), 1–7. https://doi.org/10.1186/s12955-018-1060-2

Shechter, A., Diaz, F., Moise, N., Anstey, D. E., Ye, S., Agarwal, S., Birk, J. L., Brodie, D., Cannone, D. E., Chang, B., Claassen, J., Cornelius, T., Derby, L., Dong, M., Givens, R. C., Hochman, B., Homma, S., Kronish, I. M., Lee, S. A. J., … Abdalla, M. (2020). Psychological distress, coping behaviours, and preferences for support among New York healthcare workers during the covid-19 pandemic. General Hospital Psychiatry, 66, 1–8. https://doi.org/https://doi.org/10.1016/j.genhosppsych.2020.06.007

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Einburgh mental well-being scale (WEMWBS): development and UK validation. Health and Quality of Life Outcomes, 5(63), 1–13. https://doi.org/10.1186/1477-7525-5-63

Vaingankar, J. A., Abdin, E., Chong, S. A., Sambasivam, R., Seow, E., Jeyagurunathan, A., Picco, L., Stewart-Brown, S., & Subramaniam, M. (2017). Psychometric properties of the short Warwick Edinburgh mental well-being scale (SWEMWBS) in service users with schizophrenia, depression and anxiety spectrum disorders. Health and Quality of Life Outcomes, 15(153), 1–11. https://doi.org/10.1186/s12955-017-0728-3

Wu, P., Liu, X., Fang, Y., Fan, B., Fuller, C. J., Guan, Z., Yao, Z., Kong, J., Lu, J., & Litvak, I. J. (2008). Alcohol abuse/dependence symptoms among hospital employees exposed to a SARS outbreak. Alcohol and Alcoholism, 43(6), 706–712. https://doi.org/10.1093/alcalc/agn073