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Improving staff wellbeing through psychological support: An audit and service evaluation

AUDIT

Elea Bond and Nick Groves

University Hospitals NHS Sussex Foundation Trust

SUMMARY

Staff psychological wellbeing is essential to a resilient NHS workforce. This service evaluation and retrospective audit assessed the reach and impact of psychological support services for staff at University Hospitals Sussex. Analyses revealed:

- Significant reductions in anxiety and depression, with large effect sizes.
- Consistent outcomes across staff groups once care was accessed.
- Higher referral rates among white, atheist, female, and disabled staff.
- Staff praised support but highlighted structural limitations.
- Significant incomplete data limited analysis.

Findings highlight the clinical effectiveness of the service, the need to improve data quality and equity of access to ensure all staff benefit from available support.

Key Words: Staff wellbeing; Psychological support; NHS workforce; Equity of access; Mental health

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Corresponding Author: Elea Bond (elea.bond@nhs.net): University Hospitals NHS Sussex Foundation Trust, Brighton, East Sussex, UK

ABSTRACT

Staff psychological wellbeing is essential to ensuring a resilient workforce in the United Kingdom's (UK) National Health Service (NHS). This service evaluation and retrospective audit assessed the reach and impact of psychological support services for staff at University Hospitals Sussex. Analysis of referrals, outcomes, and demographic patterns revealed significant reductions in anxiety and depression, with large effect sizes, thought to be associated with engagement with the psychological support service. While outcomes were consistent across groups, referral rates varied, suggesting unequal access. Qualitative feedback highlighted meaningful care, shaped by structural limitations. Incomplete data limited analysis. Findings highlight the clinical effectiveness of the service, and the need to improve data quality and equity of access to ensure all staff benefit from available support.

BACKGROUND

Psychological wellbeing is fundamental to sustaining a resilient healthcare workforce. Evidence indicates that healthcare staff are exposed to substantial occupational stress, anxiety, and emotional burden arising from clinical pressures and the demands of patient care, which may place them at increased risk of psychological distress.[1–3] Poor wellbeing is, in turn, associated with reduced workforce performance and

patient safety.[4] While psychological support and resilience-focused interventions may contribute to reductions in stress and depression amongst healthcare workers, the certainty of the evidence is low, and implementation and longer-term effectiveness appear variable.[3,5] Across sectors, organisational wellbeing strategies are receiving increasing attention, with HR-led mental health initiatives recognised as essential for engagement, performance, and the creation of psychologically safe workplaces.[5]

In-house psychological support services have expanded across the NHS, and early evaluations indicate that they can provide flexible, responsive, and clinically beneficial support to staff, with improvements reported across depression, anxiety, post-traumatic stress, and functional impairment.[6–8] However, there remains limited understanding of which individuals are able to access these services, how the services are experienced, and whether they deliver meaningful clinical improvement across the diverse workforce they aim to support.

The Staff Psychological Support Service at University Hospitals Sussex NHS Foundation Trust (UHSussex) offers short-term therapeutic interventions, including counselling, cognitive behavioural therapy (CBT), and eye movement desensitization and reprocessing (EMDR), delivered through self-referral and management or occupational health referral routes. As demand has grown, understanding the reach, equity, and impact of the service has become essential to strengthen its design and ensure it meets staff needs effectively.

This clinical audit and service evaluation uses retrospective data across the full period for which outcome measures were available (2019–2024) to examine whether, among UHSussex staff who accessed the Staff Psychological Support Service, engagement is associated with improvement in anxiety and depression severity compared with pre-intervention status (intervention effectiveness). In addition, the evaluation examines whether staff satisfaction levels vary by staff group or service characteristics (staff satisfaction), and whether access to, engagement with, and experience of the service differ across staff groups (equality of access*).* Together, these analyses provide an opportunity to assess both the effectiveness of current provision and any disparities in access across staff groups, informing future improvements to service model and delivery.

METHOD

Sample

This evaluation included data for any UHSussex staff members referred or self-referred to the Staff Psychological Support Service from the earliest data available—01 March 2019 to 31 November 2024—spanning both pre- and post-COVID-19 contexts. Data across this period were included to maximise statistical power; analyses focused on within-subject change following service engagement rather than comparisons of baseline distress across time. During this period, 4,545 staff were referred to the service. Pre-and post-intervention data were available for 761 staff members, exceeding power calculations for the multivariate regression model analyses, which identified a minimum required sample size of 246 (Appendix 1).

Procedure
Retrospective data were collected from the service's internal spreadsheets. These spreadsheets contained information from referrals through to post-intervention, and included demographic details, outcome measures, and both qualitative and quantitative data on staff satisfaction collected through client feedback forms. Intervention allocation followed clinical assessment within the scope of a short-term psychological service; pharmacotherapy was not provided, and onward referral was supported where needs exceeded service remit.

Data analysis
Intervention effectiveness
A paired-samples t-test assessed overall change in depression and anxiety from pre- to post-intervention. Intervention effectiveness was further evaluated using a multivariate multiple regression model examining changes in both outcomes while evaluating eleven predictors (including baseline severity, intervention type, referral characteristics, waiting and treatment times, and demographic factors), selected a priori based on clinical relevance, service configuration, and availability in routinely collected data. Wilks' Lambda assessed overall model significance, and significant predictors were followed by Bonferroni-corrected univariate F-tests. Key predictors were then entered into Bonferroni-corrected exploratory linear regressions for each outcome.

Staff satisfaction
Quantitative responses were analysed descriptively using measures such as frequencies and percentages. Where feedback included qualitative data, responses were summarised using content analysis. This involved identifying recurring themes and categorizing responses accordingly. As feedback was collected anonymously, responses could not be mapped back to individual service users for further analysis.

Equality of access
Referral data from the Staff Psychological Support Service was summarised descriptively. Relative likelihoods were calculated where possible to compare the plausibility or likelihood of an outcome (eg, accessing or using a service) between two groups. The closer the relative likelihood is to one, the greater the equality between the two groups. Access rates were compared to the entire UHSussex workforce, and attendance rates were evaluated in relation to access.

Measures
Depression was assessed using the Patient Health Questionnaire (PHQ-9) (0–27) and anxiety using the Generalized Anxiety Disorder scale (GAD-7) (0–21), repeated pre- and post-intervention. Additional predictors included referral type (manager, occupational health, or self-referral), pre-intervention assessment (optional practitioner-led call), waiting time, intervention type (counselling in person/phone/online, CBT, EMDR), and intervention duration. Demographic variables (age, gender, ethnicity, disability, religion, sexual orientation) were self-reported; due to less robust and consistent evidence linking religion and sexual orientation to therapeutic outcomes, these were not included as predictor variables in regression analyses but were retained in descriptive summaries and relative likelihood calculations. We provide full details of variable definitions (Appendix 2).

RESULTS

Our findings reveal that 43 per cent (N=1,939) of all referrals were by management, while 42 per cent (N=1,887) referred themselves, and 7 per cent (N=303) were referred by occupational health services. Referral source data were missing for approximately 8 per cent of cases, indicating heterogeneity in pathways into the service. Fifty-five per cent of referrals (N=2,497) attended the service. Non-attendance was in large part due to incomplete documentation, with few instances of voluntary withdrawal or clinical redirection to specialist care. Of those, 2,434 (98 per cent) received counselling, 50 (2 per cent) received EMDR therapy, 12 (0.5 per cent) received CBT, and 1 (0.04 per cent) received another type of intervention, not recorded. Of all attendants, 761 (40 per cent) completed all relevant pre- and post-intervention outcome measures.

Demographics

Of 437 referrals with a recorded theme, 50 percent mentioned anxiety, depression, or stress; 16 per cent related to work issues; and 4 per cent referenced bullying, discrimination, harassment, or violence, while 88 per cent of all referrals did not specify a referral reason. Most referrals came from Royal Sussex County Hospital (31 per cent), Worthing Hospital (30 per cent), and St Richard's Hospital (26 per cent). Referred staff were predominantly female (56 per cent), White (39 per cent), non-religious (18 per cent), heterosexual (34 per cent), not disabled (23 per cent), and aged 30–39 (17 per cent). Data completeness was poor, with missingness ranging from 31 per cent for gender to 60 per cent for disability, and over 50 per cent missing for ethnicity, religion or belief, and sexual orientation (Table 1).

Table 1: Summary of demographic distributions across staff referred to the service, staff who attended at least one session, and the overall UHSussex workforce, including counts and percentages for each characteristic category

		Staff referred to service		Staff who attended service		All UHSussex staff November 2024	
Characteristic	**Category**	**N**	**%**	**N**	**%**	**N**	**%**
Gender	Female	2,540	56%	1,399	56%	13,018	72%
	Male	555	12%	280	11%	4,999	28%
	Non-binary	13	0.3%	*	*	N/A	N/A
	Another gender	*	*	*	*	N/A	N/A
	Prefer not to say	21	0.5%	*	*	N/A	N/A
	Unknown	1,413	31%	803	32%	N/A	N/A
Ethnic group	Asian or Asian British ethnic group	138	3%	76	3%	2,764	15%
	Black or Black British ethnic group	33	1%	22	1%	727	4%
	Mixed ethnic group	43	1%	27	1%	461	3%
	Another ethnic group	32	1%	21	1%	892	5%
	White ethnic group	1,757	39%	1,130	45%	12,516	69%
	Prefer not to say	30	1%	15	1%	N/A	N/A
	Unknown	2,512	55%	1206	48%	657	4%

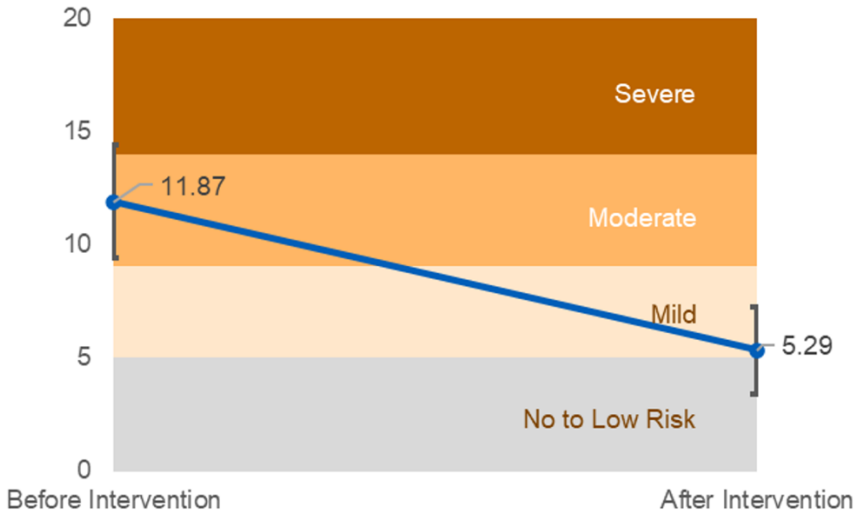
Religion and belief	Any other religion	292	6%	181	7%	2,397	13%
	Buddhist	16	0.4%	12	0.5%	195	1%
	Christian	629	14%	396	16%	7,798	43%
	Hindu	19	0.4%	*	*	488	3%
	Jewish	*	*	*	*	44	0%
	Muslim	10	0.2%	*	*	562	3%
	No religion	839	18%	533	21%	3,519	20%
	Sikh	*	*	*	*	28	0.2%
	Prefer not to say	140	3%	96	4%	2,986	17%
	Unknown	2,594	57%	1262	51%	N/A	N/A
Sexual orientation	Bisexual	129	3%	87	3%	418	2%
	Gay or lesbian	125	3%	79	3%	690	4%
	Other sexual orientation	29	1%	16	1%	106	1%
	Straight/heterosexual	1,546	34%	978	39%	14,157	79%
	Undecided	*	*	*	*	34	0.2%
	Prefer not to say	129	3%	85	3%	2,612	14%
	Unknown	2,586	57%	1,252	50%	N/A	N/A
Disability status	Disabled	681	15%	440	18%	1,170	6%
	Not Disabled	1,049	23%	691	28%	15,219	84%
	Prefer not to say	72	2%	36	1%	1,616	9%
	Unknown	2,743	60%	1,330	53%	12	0.1%
Age group	Below 19	24	1%	11	0.4%	N/A	N/A
	20–29	587	13%	282	11%	N/A	N/A
	30–39	767	17%	417	16%	N/A	N/A
	40–49	583	13%	343	13%	N/A	N/A
	50–59	530	12%	317	12%	N/A	N/A
	60–69	152	3%	77	3%	N/A	N/A
	Over seventy	12	0.3%	*	*	N/A	N/A
	Unknown	1,890	42%	1,177	45%	N/A	N/A

** Data not displayed due to insufficient sample size (<10).*
N/A No directly comparable data available.

Intervention effectiveness

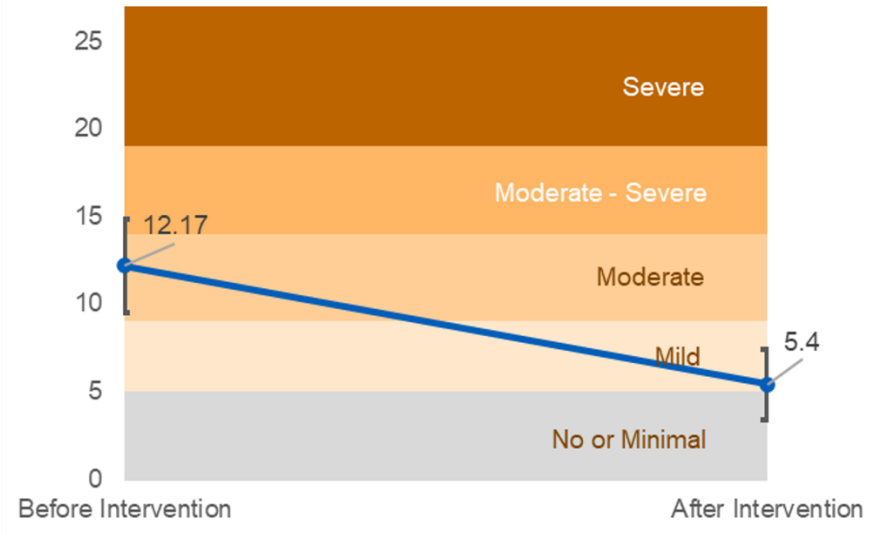
Depression ($t(763) = 38.37$, $p < 0.001$, $d = 1.41$, 95% CI [1.31, 1.51]) and anxiety ($t(762) = 37.74$, $p < 0.001$, $d = 1.45$, 95% CI [1.34, 1.56]) scores reduced from moderate to mild post-intervention, with paired t-tests showing significant, large-effect improvements (Figures 1–2). Multivariate regression identified referral type, waiting time, intervention time, gender, ethnic group, and baseline symptom scores as significant predictors (Table 2). Univariate analyses showed baseline depression predicted post-intervention depression, while referral type and baseline depression and anxiety predicted post-intervention anxiety (Table 3).

Figure 1: Mean Generalized Anxiety Disorder (GAD-7) scores with standard deviations at pre- and post-intervention



Note: Background shading reflects established GAD-7 clinical severity categories (no to low risk, mild, moderate, severe).

Figure 2: Mean Patient Health Questionnaire (PHQ-9) scores with standard deviations at pre- and post-intervention



Note: Background shading reflects established PHQ-9 clinical severity categories (no or minimal, mild, moderate, moderate – severe, severe).

Table 2: Multivariate multiple regression using Wilks' Lambda to assess whether eleven predictor variables collectively had a statistically significant effect on combined depression (PHQ-9) and anxiety (GAD-7) outcomes

	Df	F	Wilk's λ	Sig (*p*)
Type of intervention	4	1.406	0.98	0.189
Pre-intervention assessment	1	2.956	0.99	0.523
Referral type	3	4.591	0.96	**<0.001***
Waiting time	1	3.373	0.99	**0.035***
Intervention time	1	0.181	0.99	0.834
Age group	7	1.598	0.97	0.072
Gender	5	1.983	0.96	**0.032***
Ethnic group	6	2.252	0.96	**0.008***
Disability	3	1.754	0.99	0.105
Pre-intervention PHQ–9	1	111.164	0.75	**< 0.001***
Pre-intervention GAD–7	1	76.309	0.82	**< 0.001***
Residuals	683			

Table 3: Univariate Bonferroni-adjusted follow-up F-tests from the multivariate multiple regression examining the individual effects of each predictor on depressive symptoms (PHQ-9) and anxiety symptoms (GAD-7)

	PHQ-9			GAD-7		
	Df	F	Sig (*p*)	Df	F	Sig (*p*)
Type of intervention	4	1.32	0.261	4	0.64	0.631
Pre-intervention assessment	1	5.92	0.015	1	3.52	0.061
Referral type	3	4.13	0.006	3	8.60	**< 0.001***
Waiting time	1	1.73	0.189	1	6.08	0.014
Intervention time	1	0.34	0.558	1	0.12	0.726
Age group	7	1.60	0.132	7	2.31	0.025
Gender	5	2.22	0.050	5	1.60	0.157
Ethnic group	6	1.51	0.173	6	0.84	0.541
Disability	3	2.75	0.042	3	1.44	0.229
Pre-intervention PHQ–9 scores	1	216.12	**< 0.001***	1	88.17	**< 0.001***
Pre-intervention GAD–7 scores	1	0.54	0.461	1	75.24	**< 0.001***
Residuals	683			683		

Reduced models were significant for both outcomes, explaining 25 per cent (depression, ($F(19, 744) = 14.61$, $p<0.001$)) and 22 per cent (anxiety, ($F(24, 717) = 9.87$, $p<0.001$)) of variance, largely driven by baseline scores. Self-referral, pre-intervention assessment, female gender, and shorter waits were associated

with lower post-intervention symptoms but did not survive Bonferroni correction. Younger staff (<19 years) showed higher post-intervention anxiety (b = 7.7577, t = 3.05, p = 0.0024); other predictors showed minimal impact.

Staff satisfaction

Forty-three staff completed the client feedback survey, representing a small, self-selected subset of service users. Waiting times varied as 44 per cent of respondents suggested they were seen within six weeks, while 53 per cent waited longer. Overall, approximately 95 per cent of respondents rated the service as helpful, and 96 per cent reported being satisfied with their experience. In their qualitative feedback, staff described the service as compassionate and emotionally safe, with empathy, impartiality, and NHS-aware therapists helping many feel understood and supported. Flexible, free, and quick access was valued for fitting around work, particularly as an alternative to accessing psychological support through usual primary care routes, though some found navigation unclear and wanted faster entry or longer-term options. However, experiences varied; a few felt the support did not meet their needs, especially for complex issues. While confidentiality was trusted, limited privacy and physical space sometimes left staff feeling exposed. The environment and visible trust backing shaped perceptions of care. We present six major themes revealed in the content analysis (Tables 4 and 5).

Table 4: Summary of themes 1–3 generated from content analysis of staff feedback, with associated subthemes and representative quotations demonstrating how each theme was expressed by participants

Theme	Subtheme	Related quotes
(1) A service that helps—feeling safe, seen, and human	Emotional safety fostered by empathy and compassion, supported by a nonjudgemental, impartial, and validating environment	*"[It] was incredibly helpful to have a safe space and a warm and empathic therapist to share your issues with."* "*It very much helps to be counselled by another person who is somewhat removed from the situation and yourself as a person, who can be both compassionate and objective.*" *"I felt listened to, gently challenged and not judged."*
	Gentle challenge and personalised support helped staff understand their difficulties, shift perspectives, and find ways forward	*"It has helped me understand things in a different way and cope with things better and more productively."* *"It is supportive and individually driven dependant on the reason for referral."* *"Gained an understanding what I needed to do, moving forward."*
	Therapists who understood the NHS context added to a sense of emotional safety	*"I could speak openly to someone that knew about the NHS however not in my department."* *"I feel like the [in-house] counsellors are more likely to understand the context in the workplace."*
(2) Not what I needed	Occasional dissatisfaction linked to mismatched expectations about the nature of the service	*"I still would prefer to have more guidance or psychological analysis of personality and own situations. I would prefer to hear what I need to change in order to get out of the situation."*

		"I would have liked the sessions to be a bit more structured. […] I would have liked a bit more practical advice."
	Perceived lack of benefit when the support did not meet individual needs or expectations	*"I do not feel it was suited to my issues and has not helped improve my mental health or given me enough coping mechanisms to work on myself."* *"It didn't feel as though there was any process or benefit sadly"*
	Support not always suited to complex or ongoing needs	*"I did not feel the counsellor had a good knowledge of ADHD or neurodivergent conditions. […] I felt myself explaining my issues/symptoms a lot."* *"I don't feel it's suitable for me and could not cater to someone with long-term mental health issues or neurodevelopmental disorder."*
(3) Designed for convenience	For some, the speed and simplicity of access made a real difference	*"The service was easy to access, confidential and professional."* *"Probably quicker than if I went through the GP. Free. On-site."* *"It was available when I needed help relatively quickly."*
	Helped to stay in work and fit support around duties	*"Easier to work it around job."* *"It helped me to sustain work."* *"Having the service meant I did not take any sick days."*
	Free access made the service feel more realistic and reachable	*"I could not have afforded an external service in either cost or time."* *"I am unsure if I would [have] paid [to access counselling] externally due to money constraints."* *"It's free, I couldn't afford to pay."*
	Flexibility in how support was delivered helped staff engage in a way that worked for them	*"I was able to have sessions by Teams in work time without disrupting the daily schedule too much."* *"I valued being able to do the sessions remotely."* *"[Liked] the opportunity to see someone face to face."*

Table 5: Summary of themes 4–6 generated from content analysis of staff feedback, with associated subthemes and representative quotations demonstrating how each theme was described by participants

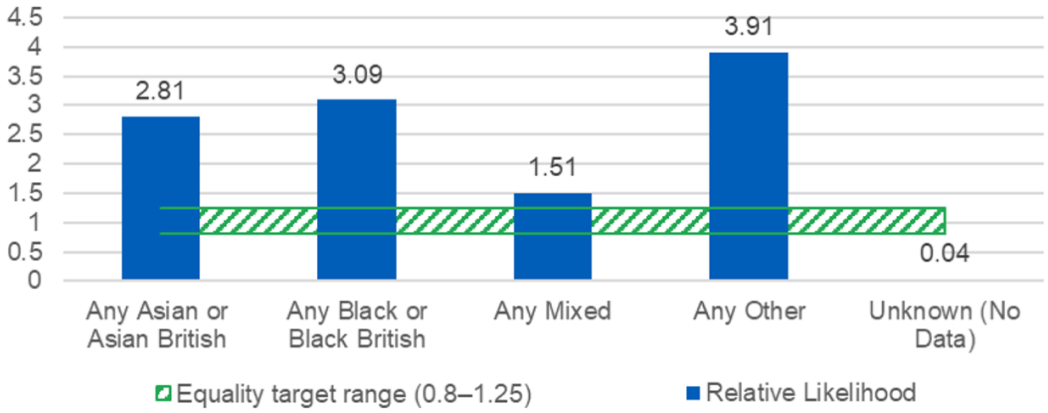
Theme	Subtheme	Related quotes
(4) Wanting a clearer way in and room for longer lasting support	Need for better awareness of the service and clearer guidance on what to expect	*"Provide [a session] where someone explains what to expect from the sessions […], how they work – any techniques (eg, CBT), and have resources the patient can take away with them."* *"Mak[e] it more widely known that it is available."*

	Hoping for quicker access when support felt urgently needed	*"Reduce the waiting time; I was emotionally quite fragile during the wait, but still just about managing to work; others may not be able to stay functional."* *"Employ more counsellors to reduce waiting time."*
	Desire for extended or additional sessions, tempered by concern about overburdening the service	*"I think that longer sessions may be useful."* *"There should be more scope for more sessions if required."* *"Wouldn't want to overburden the service if I wanted more."*
	Lack of follow-up left some unsure where to turn next for ongoing support	*"A 3 or 6 month follow up/ review would be great"; "I feel I would have benefited from […] following up appointment with the counselling service."* *"Lack of know-how [is a barrier to accessing services]; no knowledge of alternatives."*
(5) Confidential, yet exposed	Confidence in the service as a safe, independent, and confidential space	*"A safe space to feel supported."* *"Giving me a safe space to talk openly, freely and to an unbiased person."*
	The physical setting created a lack of privacy and feelings of being expose	*"I could hear someone discussing topics thought if I can hear them, they can hear me."* *"Waiting outside an office dedicated clearly as a counselling space […] I would not like to provoke questions or concern among people I work with directly."*
(6) The setting matters–comfort and organisational care	Environment and facilities shaped the experience of care	*"No waiting area in Sussex House."* *"[The room] is in need of a bit of TLC."* *"The room itself was fine, I did find the chairs a bit uncomfortable."*
	Trust endorsement felt real and tangible	*"Support from work to attend." (Response to: "What made you choose to use the in-house service?")* *"Felt like the trust cares."*

Equality of access

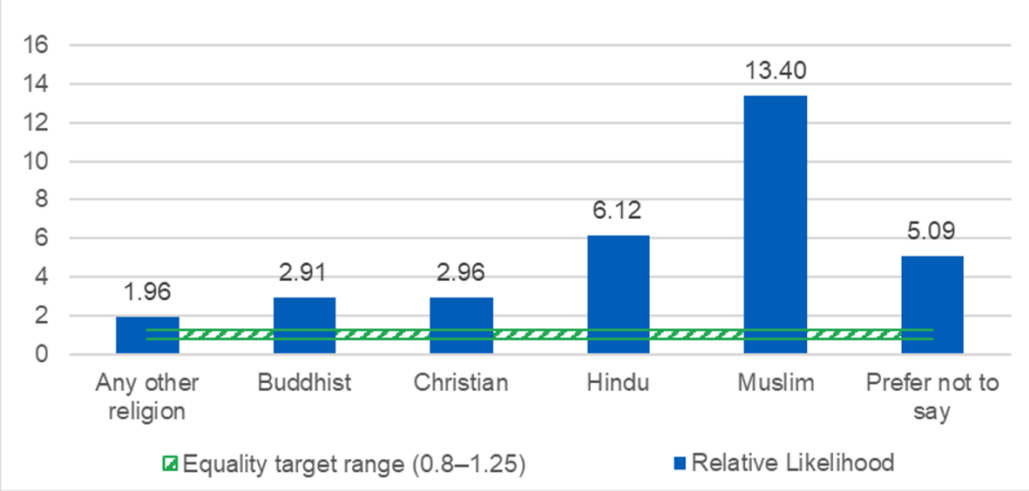
Relative likelihood analyses showed substantial access disparities compared to the overall UHSussex workforce. These analyses were conducted across all referral routes combined and found that White staff were 2.76 times more likely to refer than minority ethnic staff, rising to nearly fourfold compared with those identifying with another, unlisted ethnicity (Figure 3). Atheist staff were 2.82 times more likely to refer than those from other religions, with rates up to thirteen times higher than for unlisted religious groups (Figure 4). Female staff were 1.76 times more likely to refer than males, disabled staff 8.44 times more likely than non-disabled staff, and staff identifying as bisexual, gay, or lesbian, undecided, or another orientation were 2.08 times more likely to refer than heterosexual staff. However, once referred, attendance rates were similar across all groups.

Figure 3: Relative likelihood ratios comparing rates of self-referral or referral to the service



Note: Relative likelihood ratios comparing rates of self-referral or referral to the service for White staff versus staff identifying as Asian or Asian British, Black, or Black British, Mixed ethnicity, or Any Other ethnicity. The equality target range (0.8–1.25) is shown for reference. "Unknown" refers to referrals with no ethnicity data recorded.

Figure 4: Relative likelihood ratios comparing rates of self-referral or referral to the service for atheist staff versus staff identifying with other religion or belief groups



Note: The equality target range (0.8–1.25) is shown for reference. Categories include Any Other Religion, Buddhist, Christian, Hindu, Muslim, and Prefer Not to Say.

DISCUSSION

Intervention effectiveness was demonstrated through significant reductions in symptoms of depression and anxiety, consistent with the broader evidence base indicating that brief psychological interventions can produce meaningful improvements for healthcare staff.[17,18] The strong associations observed between

baseline and post-intervention scores align with established patterns in psychological therapy outcomes, where initial severity typically predicts response.[19] Overall, the pattern of outcomes indicates that brief, targeted interventions can provide meaningful symptom relief, particularly when delivered with consideration of individuals' initial levels of distress.

Among respondents to the optional satisfaction survey, staff reported high levels of satisfaction with the psychological support service, and qualitative feedback highlighted the importance of compassionate, confidential, and supportive therapeutic relationships. These findings align with wider evidence showing that psychological safety and the creation of spaces where staff can safely process the emotional impact of their work are critical for protecting staff wellbeing and mitigating further emotional exhaustion in healthcare settings.[9–11] Evaluations of in-house NHS wellbeing services have similarly noted that staff value the therapeutic aspects of support as staff emphasise the value of compassionate, supportive, and emotionally safe therapeutic relationships, with some variation in experience shaped by service capacity, delivery models and individual clinical response.[6–8] Meanwhile, the structural barriers identified in this evaluation, including inconsistent and long waiting times, confidentiality concerns, and uncertainty around referral pathways, reflect challenges reported across mental health services more widely,[12,13] and indicate areas where adjustments could improve access and usability.

Differences in referral patterns showed that inequalities were most apparent at the point of access. White, female, atheist, disabled, and non-heterosexual staff were more likely to refer compared with their counterparts. These results fit with existing research suggesting that help-seeking behaviour varies across demographic groups and that factors such as awareness of support options, perceived stigma—including cultural stigma, fear of disclosure, preference for community-based support, cultural understandings of distress, and a lack of culturally sensitive services can act as key barriers.[14,15] The findings also align with broader evidence showing that stigma, discrimination, and reduced trust in services and systems can limit some groups' ability to seek and reach mental health support,[16] further contributing to persistent inequalities in access. While it was found that attendance was equitable after referral, indicating that the service itself was acceptable across groups, broader organisational and cultural factors may shape who feels able to seek support. Targeted outreach and clearer visibility of the service may help address these disparities.

LIMITATIONS

Limitations of this evaluation include substantial missing demographic data, which reduced the sensitivity of equity analyses. The multivariate model identified several significant predictors, although univariate tests indicated effects were additive. Pre-intervention severity strongly predicted post-intervention scores, and the small size of the youngest age group limits interpretation of their outcomes. Staff satisfaction findings are based on a very small proportion of service users and should be interpreted as exploratory rather than representative. In addition, the inclusion of data spanning pre- and post-COVID-19 periods introduces contextual heterogeneity in baseline stress levels and workplace conditions that cannot be fully accounted for within this service-evaluation design.

CONCLUSION

This evaluation showed that the UHSussex Staff Psychological Support Service was effective and well received by staff. Quantitative data demonstrated significant improvements in depression and anxiety, and qualitative feedback reflected supportive care tempered by structural constraints. The findings highlight the importance of earlier access, improved demographic data, and action to address disparities in referral patterns. Continued investment and targeted improvements will help ensure the service remains equitable, accessible, and impactful for all staff.

REFERENCES

1. Pollock A, Campbell P, Cheyne J, et al. Interventions to support the resilience and mental health of frontline health and social care professionals during and after disease outbreaks. *Cochrane Database Syst Rev*. 2020;2020(11):CD013779. https://doi.org/10.1002/14651858.CD013779
2. Tamminga SJ, Emal LM, Boschman, et al. Individual-level interventions for reducing occupational stress in healthcare workers. *Cochrane Database Syst Rev*. 2023;2023(5):CD002892. https://doi.org/10.1002/14651858.CD002892.pub6
3. Kunzler AM, Helmreich I, Chmitorz A, et al. Psychological interventions to foster resilience in healthcare professionals. *Cochrane Database Syst Rev*. 2020;2020(7):CD012527. https://doi.org/10.1002/14651858.CD012527.pub2
4. Hall LH, Johnson J, Watt I, et al. Healthcare staff wellbeing, burnout, and patient safety: a systematic review. *PLoS One*. 2016;11(7):e0159015. https://doi.org/10.1371/journal.pone.0159015
5. Elufioye OA, Ndubuisi NL, Daraojimba RE, et al. Reviewing employee well-being and mental health initiatives in contemporary HR practices. *Int J Sci Res Arch*. 2024;11(1):828–40. https://doi.org/10.30574/ijsra.2024.11.1.0153
6. Olabi Y, Campbell S, Greenhill B, et al. NHS frontline staff experiences of an in-house psychological support service during the COVID-19 pandemic. *J Health Psychol*. 2021;26(10):131–8. https://doi.org/10.1080/13548506.2021.1954674
7. Cole CL, Barry C, Saunders R, et al. A service evaluation of phased- and stepped-care psychological support for health and social care workers during the COVID-19 pandemic. *BJPsych Bull*. 2023;9(3):e95. https://doi.org/10.1192/bjo.2023.66
8. Meredith F, Banting R, Wilcox D, et al. Evaluating outcomes and experience of Eye Movement Desensitization and Reprocessing through a National Health Service Trust's staff support service. *J EMDR Pract Res*. 2023;17(4):228–241. https://doi.org/10.1891/EMDR-2022-0058
9. Anger WK, Dimoff JK, Alley L, et al. Addressing health care workers' mental health: a systematic review of evidence-based interventions and current resources. *Am J Public Health*. 2024;114(S2):S213–S226. https://doi.org/10.2105/AJPH.2023.307556
10. Robins-Browne K, Lewis M, Burchill LJ, et al. Interventions to support the mental health and well-being of front-line healthcare workers in hospitals during pandemics: an evidence review and synthesis. *BMJ Open*. 2023;13:e073283. https://doi.org/10.1136/bmjopen-2022-061317
11. Delgadillo J, Moreea O, Lutz W. Different people respond differently to therapy: a demonstration using patient profiling and risk stratification. *Behav Res Ther*. 2016;79:15–22. https://doi.org/10.1016/j.brat.2016.02.003
12. Galanti T, Cortini M, Giudice GF, et al. Safeguarding nurses' mental health: The critical role of psychosocial safety climate in mitigating relational stressors and exhaustion. *Front Psychol*. 2024;15:131. https://doi.org/10.3934/publichealth.2024046

13. Wren B. Creating space, clarity and containment in order to sustain staff: Managing the emotional impact of palliative care work. In: Kitchen R, Faull C, Russell S, Wilson J, editors. Handbook of Palliative Care. 4th ed. Wiley; 2024. Chapter 23. https://doi.org/10.1002/9781119784395.ch23
14. Peddie N, Hoegh J, Rice G, et al. Health and social care professionals' experience of psychological safety within their occupational setting: A thematic synthesis review. *Nurs Rep*. 2025;15(4):131. https://doi.org/10.3390/nursrep15040131
15. Sweetman JF. Understanding barriers to patient access of primary care mental health care services in England [PhD thesis]. York: University of York; 2020. https://etheses.whiterose.ac.uk/29102/
16. Turner G, Luce A, Bush-Evans RD. Barriers to staff seeking support before staff reach crisis. In: Workforce Suicide. 1st ed. CRC Press; 2025; p.18–38. https://doi.org/10.1201/9781003501558-2
17. Alam S, O'Halloran S, Fowke A. What are the barriers to mental health support for racially-minoritised people within the UK? A systematic review and thematic synthesis. *Psychological Medicine*. 2024;17:e10. https://doi.org/10.1017/S1754470X24000084
18. Stepanova E, Croke S, Yu, G, et al. "I am not a priority": ethnic minority experiences of navigating mental health support and the need for culturally sensitive services during and beyond the pandemic. *BMJ Mental Health*. 2025;28:1–8. https://doi.org/10.1136/bmjment-2024-301481
19. Lowther-Payne HJ, Ushakova A, Beckwith A, et al. Understanding inequalities in access to adult mental health services in the UK: a systematic mapping review. *BMC Health Serv Res*. 2023;23:1042. https://doi.org/10.1186/s12913-023-10030-8

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PEER REVIEW

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CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

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ETHICS COMMITTEE APPROVAL

This service audit and evaluation was reviewed and registered with the Clinical Audit Team as quality improvement project and with the University Hospitals Sussex NHS Foundation Trust's central data base (ID: 2329).

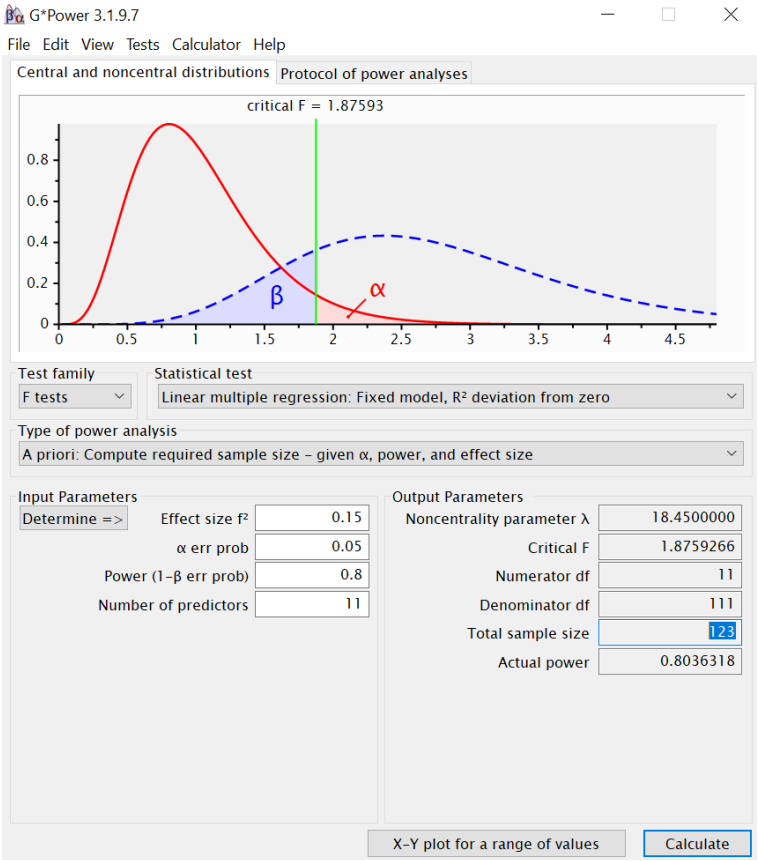
APPENDICES

Appendix 1: Power calculations for determining minimum sample size required for the multivariate multiple regression analyses

Power calculations were undertaken using GPower version 3.1.9.7. F-tests was chosen as the test family, with linear multiple regression: Fixed model, R^2 deviation from zero as statistical test. A priori power analysis was performed for the following parameters:

- Effect size (f^2): 0.15 (medium)
- α (significance level): 0.05
- Power (1 – β): 0.80
- Number of predictors: eleven

This identified a minimum sample size of 123 as necessary for each regression separately to ensure sufficient power, leading to a minimum total sample size of 246 to ensure sufficient power.



Appendix 2: Definitions of all variables included in the evaluation, including demographic fields, referral characteristics, and clinical outcome measures

Dependent Variables

- **Depression:** Measured using the Patient Health Questionnaire (PHQ–9), scored 0–27, with higher scores reflecting greater symptom severity. Administered at post-intervention.
- **Anxiety:** Measured using the Generalized Anxiety Disorder scale (GAD–7), scored 0–21, with higher scores reflecting greater symptom severity. Administered at post-intervention.

Independent Variables

- **Depression:** Measured using the Patient Health Questionnaire (PHQ–9), scored 0–27, with higher scores reflecting greater symptom severity. Administered at pre-intervention.
- **Anxiety:** Measured using the Generalized Anxiety Disorder scale (GAD–7), scored 0–21, with higher scores reflecting greater symptom severity. Administered at pre-intervention.
- **Referral type:** Categorised as management referral, occupational health referral, or self-referral.
- **Pre-intervention assessment (PA):** A discretionary telephone appointment offered by practitioners prior to intervention start, used to provide an additional point of contact if deemed clinically appropriate.
- **Waiting time:** Number of days from referral to intervention start.
- **Intervention type:** Categorized as in-person counselling, telephone counselling, online counselling (via Microsoft Teams), cognitive behavioural therapy (CBT), or eye movement desensitization and reprocessing (EMDR) therapy.
- **Intervention duration:** Number of days from intervention start to completion.
- **Demographics:** Self-reported to the service, including age group (below 19, 20–29, 30–39, 40–49, 50–59, 60–69, over 70); gender (female, male, non-binary, other, prefer not to say); ethnicity grouped by major ethnic groups due to limited sample size (Asian, Black, Mixed, Other, White, prefer not to say); disability status (disabled, not disabled, prefer not to say), religion or belief (Buddhist, Christian, Hindu, Jewish, Muslim, Sikh, any other religion, no religion, prefer not to say); and sexual orientation (bisexual, gay or lesbian, straight/heterosexual, undecided, other sexual orientation, prefer not to say). Religion and sexual orientation were excluded from regression analyses due to insufficient evidence but were retained in relative likelihood calculations.

Appendix 3: Assumption checks and data cleaning procedures undertaken prior to conducting the multivariate multiple regression analyses

Multivariate Normality

Shapiro-Wilk (PHQ–9, $p<0.001$; GAD–7, $p<0.001$) and Anderson-Darling (PHQ–9, $p<0.001$; GAD–7, $p<0.001$) both rejected the null hypothesis for both outcome variables, indicating that the distribution of both outcome variables was not normal. Histograms and Q–Q plots indicated a minor right skew for PHQ–9 with a plateau/flattened distribution. Furthermore, descriptive statistics confirmed a slight positive skewness for PHQ–9, indicating a longer right tail (Skewness = 1.15) and a slight positive kurtosis, meaning the distribution is somewhat flatter than expected with fewer extreme scores/outliers (Kurtosis = 1.33), suggesting the data deviates slightly from normality. Histograms and Q-Q plots indicated a minor right skew for GAD–7 with two potential outliers at either end of the Q–Q graph. GAD-7 descriptive statistics confirmed a moderate positive skew (Skewness = –1.34), indicating more extreme high scores, yet a close to normal distribution (Kurtosis = 1.98), suggesting the data deviates slightly from normality. Henze-Zirkler testing was used to examine multivariate normality (HZ statistic = 20.26, $p<0.001$) and was found to indicate the data does not follow multivariate normality. However, multivariate tests are robust to moderate violations of normality under the central limit theorem at a large sample size. Due to the sample size exceeding the minimum sample size identified through power calculations three-fold, and skewness and kurtosis indicators suggesting only minor deviations from normality. Therefore, no transformations were necessary.

Multicollinearity

Variance Inflation Factor (VIF) values were examined to assess multicollinearity among predictor variables. Initially, Ethnicity showed a concerning level of multicollinearity for both PHQ–9 and GAD–7 (GVIF = 34.86, GVIF^(1/(2Df)) = 1.11), indicating redundancy in the model. To address this, ethnic categories were collapsed into broader ethnic groups, resulting in a substantial reduction in GVIF (Ethnic Group GVIF = 9.68, GVIF^(1/(2Df)) = 1.21). The highest remaining GVIF values were observed for Disability (GVIF = 5.53) and Age (GVIF = 5.14), but these remain within an acceptable range. All predictors had GVIF^(1/(2*Df)) values below the commonly accepted threshold of two, indicating no strong multicollinearity concerns. As such, multicollinearity was deemed not problematic and no further variable transformations or removals were necessary. All predictors were retained for subsequent analyses.

Linearity

A scatterplot matrix was used to examine the linearity assumption between numeric predictor variables and the outcome variables (PHQ–9 and GAD–7). Strong positive correlations were observed between the two post-intervention PHQ–9 and post-intervention GAD–7 outcomes, indicating that improvements in depressive symptoms (PHQ–9) were associated with improvements in anxiety symptoms (GAD–7). Furthermore, pre-intervention PHQ–9 and pre-intervention GAD–7 scores were positively correlated, reinforcing the co-existence of anxiety and depression symptoms at pre-

intervention. Finally, waiting time and intervention time were positively correlated, indicating that longer waiting times may be associated with longer intervention times. However, the relationships between Waiting Time and PHQ–9/GAD–7, as well as Intervention Time and PHQ–9/GAD-–7, appeared to be weak and unclear. The data for both variables were clustered at low values, with some spread and outliers at higher values, suggesting a potential non-linear trend. To address this non-linearity, quadratic polynomial terms were explored for Waiting Time and Intervention Time in the regression model. However, the addition of polynomial terms did not result in a better model fit, as indicated by Wilks' Lambda, Pillai's Trace and Hotelling's Trace values. As such, the standard linear model (without polynomial terms) was retained for analysis.