

Effectiveness of an Employee Wellbeing Coaching Programme Delivered Across Primary Healthcare in England

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Abstract

This study aimed to evaluate the results of a coaching programme, delivered virtually by external coaches, to support the psychological wellbeing of primary healthcare workers in England including general practitioners, dentists, pharmacists, and optometrists. Changes in perceived wellbeing and resilience were measured using the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) and Brief Resilience Coping Scale (BRCS). 662 participants completed pre- and post-coaching surveys. Of these, 216 also completed a follow-up survey. 20 interviews were conducted. Average scores significantly improved between pre-coaching and post-coaching on both SWEMWBS (partial $\eta^2=0.149$) and BRCS (partial $\eta^2=0.134$) and significantly declined between post-coaching and follow-up. Wellbeing scores at follow-up were greater than at pre-coaching. Increased wellbeing led to less intentions to leave (individual level) and increased most following multiple sessions. From interviews, wider impact was indicated (team and sector levels) which included supporting others and managing rising demand. This study increases our understanding of coaching as an intervention for employee wellbeing. Impact beyond individual level has emerged (e.g. improved team relationships). Previous research utilizes smaller samples or excludes follow-up data. Employers of time-pressured employees should consider short coaching sessions and how to sustain outcomes for longer.

Keywords

workplace coaching • evaluation • primary care • wellbeing • resilience • intention to leave

Introduction

There has been a publicly funded healthcare system across England for seventy years, the National Health Service (NHS). The wellbeing of its 1.5 million employees has been put under the spotlight since an independent UK government review (Boorman, 2009) reported a clear relationship between staff health and wellbeing, and patient satisfaction. West and Coia (2018) subsequently found that low employee wellbeing was associated with impaired decision-making, resulting in medical errors, slower reactions to cognitive tasks, and accuracy in task performance; all having an impact on patient outcomes. NHS organizations have therefore been urged to improve the experience of staff at work (Department of Health 2021). The potential for work and the working environment to exacerbate mental ill-health presents a challenge for human resource development teams (HRDs) across healthcare looking to sustain employee performance, wellbeing, and positive patient outcomes.

Literature Review

Employee Wellbeing and Resilience in Healthcare

Healthcare staff report higher rates of absence due to psychological distress and burnout than workers in other sectors (Cohen et al., 2023; NHS Digital, 2024). Low resilience and burnout have led to intention to leave within healthcare settings (Kelly et al., 2021; Sinsky et al., 2017). General Practitioners (GPs), family doctors based in local communities, have reduced their working hours or clinical caseload to mitigate burnout (Baird et al., 2016). A review of international evidence found that the COVID-19 pandemic further adversely affected GPs' psychological wellbeing (Jefferson et al., 2022). Health seeking behaviours among GPs are uncommon (Clough et al., 2019), increasing their potential for experiencing reduced wellbeing at work. During the COVID-19 pandemic, extremely busy staff witnessed ill patients in high numbers amid demand pressures and media scrutiny. Healthcare staff experienced

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greater anxiety, depression, and burnout (Siddiqui et al., 2021) and 26% of healthcare survey respondents considered their wellbeing to be 'low' (Blake et al., 2020), compounding concerns about the wellbeing of all NHS staff (Collings et al., 2021). This is similar to the negative effect on healthcare workers' wellbeing following a previous SARS outbreak (Maunder et al., 2006).

Intention to leave in primary healthcare is a particularly important issue due to a sector-wide staff shortage. Data on turnover estimates that in the year December 2020 to December 2021, one in 12 (8.4%) qualified permanent GPs left, although this has since reduced to 6.6% in December 2023 to December 2024 (NHS Digital, 2025).

Previous studies have suggested that the resilience and wellbeing of NHS staff can be improved and, with it, the delivery of patient care (West & Dawson, 2012) and perceptions of safety (Salyers et al., 2017). There are a range of workplace wellbeing interventions available in healthcare. These might be at a treatment level i.e. interventions implemented once a health and wellbeing issue had been identified. Alternatively, interventions at a preventative level i.e. to prevent the likelihood of negative physical or mental health and wellbeing occurring. However, a scoping study found no high-quality, theory-based interventions for the wellbeing of healthcare workers during a crisis (Cairns et al., 2021) and a UK review across healthcare found evidence on the impact of wellbeing interventions to be patchy (Bajorek & Holmes, 2020). This highlights a 'what works' gap in the evidence base, if effective change in healthcare staff wellbeing is to be achieved.

Coaching and its Impact on Employee Wellbeing

There is a growing evidence base to suggest that coaching can have a positive impact on wellbeing outcomes and so could be a useful intervention for healthcare staff. For example, Cohen et al., (2023) in their systematic review of workplace interventions to improve wellbeing and reduce burnout in nurses, physicians, and allied health professionals, included a randomized control study of a professional coaching intervention, aimed to strengthen personal resilience and develop positive mindsets. The results indicated that participants reported decreased emotional exhaustion, improved quality of life and improved resilience, in comparison to the control group. Wang et al., (2022) undertook a systematic review of primary research studies to look at how psychologically informed coaching approaches effected workplace outcomes, such as learning, performance, and psychological wellbeing. The results found that individuals developed a better understanding of their internal motivators, emotions, and unconscious assumptions. There were also positive effects on an individual's perceived efficacy, goal attainment, and workplace psychological wellbeing. In addition, evidence suggested that coaching

had an impact on attitudes to work including organizational commitment, job satisfaction, and intention to leave. Boet et al., (2023) undertook a systematic review of coaching on physician wellness, finding that coaching helped to decrease emotional exhaustion and overall burnout, imposter syndrome, and interpersonal disengagement. There was also evidence of increases in work engagement, emotional wellbeing, job retention, coping, job satisfaction, and quality of life. These reviews provide further support to an earlier meta-analysis (Theeboom et al., 2013) on the effects of coaching on individual level outcomes in the workplace. They argued that the overall goal of coaching is to optimize a person's work-related functioning, by helping people cope with stressors and facilitating a 'reframing' of their perceived work experiences and attitudes. The meta-analysis found that coaching has a positive effect on performance and skills, wellbeing, coping, work attitudes, and goal-directed self-regulation. Interestingly, the research reported that coaching can be effective when the number of sessions is small, which could make coaching an attractive option in time pressured occupations.

Other studies have highlighted the efficacy of coaching as a potential workplace wellbeing intervention. In a randomized controlled trial of a coaching intervention to improve wellbeing, stress, and burnout, involving 59 physicians in primary care in the USA, McGonagle et al., (2020) concluded that it was an effective method for alleviating burnout and improving wellbeing. Jeannotte et al., (2021) conducted longitudinal research investigating the effectiveness of a virtual professional coaching programme provided by employers, to improve employee mental health and wellbeing. Results indicated improved positive mental health and psychological wellbeing within three months, and continuous benefits when users engaged in professional coaching over longer periods of time (up to six months). There were also significant positive changes in life satisfaction and resilience during the programme. The authors concluded that coaching was able to help people understand factors that would enable their development, help identify potential obstacles, and provide belief that they could achieve goals, providing the foundation for mindset and behavioural changes needed to support positive wellbeing. Lungu et al., (2021) evaluated the efficacy of a video and telephone-based cognitive behavioural coaching programme (CBC) for 289 people who had requested wellbeing support in their workplace. The research showed that over three-quarters of employees who received coaching for stress saw significant stress reduction. In qualitative research by Van Nieuwerburgh et al., (2021) studying the impact of virtual coaching for wellbeing, results highlighted that coaching provided an important vehicle for self-reflection, increasing awareness of emotions, alleviation of negative emotions, renewed confidence, and a re-energized way of moving forward.

These findings suggest that coaching could be a suitable wellbeing intervention. However, questions remain about its applicability during a crisis and whether outcomes are sustained. There is a paucity of studies exploring the impact of coaching for employee wellbeing beyond a pre-and post-coaching research design. A notable exception is McGonagle et al., (2020) who used four repeated assessments in their randomized controlled trial including two post-coaching at three and six months after completion. However, their intervention necessitated six sessions (potentially impractical during a crisis) and their sample was small with 59 primary care doctors (30 in the intervention group and 29 in the waitlist group).

Health Coaching and its Impact on Patient Wellbeing

There is a history of health coaching for patient wellbeing as part of clinical practice in England, especially among GPs (The Evidence Centre, 2014). Coaching of healthcare staff, however, has tended to target elite groups as part of a human resource development (HRD) strategy e.g. leadership, talent, or diversity initiatives (Sinclair et al., 2008).

The term 'health coaching' refers to a diverse set of interventions, but all with a shared aim of helping people set goals and take action to improve their health or lifestyle. Health coaching is considered particularly beneficial to people with, or at risk of, one or more long-term condition(s), where behaviour and lifestyle are a risk factor especially where people would benefit from increasing their knowledge, skills, and confidence to manage their condition (NHS England, 2023). Health coaching is a behavioural intervention that taps into people's potential to self-manage and increasing their self-awareness, confidence, and motivation to take action to achieve their goals. It is an approach that encourages proactive prevention (Olsen, 2014). There is already a substantial evidence base which demonstrates that health coaching services have a positive impact on patient health and wellbeing (see, for example, Sforzo et al., 2018).

Health coaching differs from performance or developmental coaching because it involves coaching specifically about topics relevant to a person's health and/or wellbeing. Health practitioners who utilize health coaching are often intricately involved in the delivery of health services. They must therefore navigate both directive and non-directive coaching styles in the provision of relevant information and advice, in the delivery of services, and in some cases manage risk.

There are three gaps in the literature to be addressed. Firstly, there is a paucity of studies exploring the impact of coaching for employee wellbeing beyond pre- and post-intervention designs. We need more studies with follow-up time points. Secondly, there is a 'what works' gap in the evidence base of employee wellbeing interventions specifically within the healthcare sector. Thirdly, whilst our review suggests that

coaching could be a suitable scalable wellbeing intervention for healthcare workers (not patients), questions remain about the applicability of coaching during a crisis. Any sector can face a crisis, so it is important to grow the evidence about coaching programmes targeting staff under extreme time and work pressures. Analysing data collected during the COVID-19 pandemic therefore has utility today.

Research Aims

The authors conducted evaluation research, from April 2020 to July 2021, on the impact of a virtual coaching programme, known as Looking After You Too (LAYT), designed to support primary healthcare workers at all levels including GPs, pharmacists, dentists, opticians, and their teams.

The research question guiding the evaluation inquiry was: To what extent does the LAYT coaching programme have an impact on employee psychological wellbeing and resilience?

The study aimed to investigate if participating in the coaching programme (independent variable), influenced employee perceptions of their own wellbeing and resilience levels (dependent variables).

Based on previous discussion in the literature review, the present study sought to expand the research question in three ways. Firstly, the study sought to identify if the coaching had an impact on the intention to leave of the individuals coached. Secondly, this study sought to include a follow-up assessment. Finally, enough variation in the number of sessions received was expected for the evaluation to explore any differences by number of sessions.

Method

Overview

The study was designed as multi-method evaluation research with perceptual quantitative surveys at its heart, designed to be administered before and after participants took part in the coaching programme and at follow-up. A matched data approach was designed, using the same survey measures at each time point and assigning an individual ID number to each participant at the outset. Supplementary qualitative data was also collected (interviews).

Ethical approval for research with patients/service users or NHS staff/volunteers is often required from the Health Research Authority (HRA) but HRA deemed this was not required for the present study. Ethical approval was granted through the ethics committee at the authors' institution. Written informed consent for the evaluation research was sought. A link to a detailed information sheet was provided about the purpose of the research, the people carrying it out, how their data would

be collected, used, and reported and consent sought to opt in or out of the research. Receiving coaching was not contingent on participating in the research and no reason needed to be given for opting out. Informed consent was an on-going process with reminders issued about opting-out as post-coaching and follow-up surveys were sent. Specific verbal consent was sought before each interview.

The pre-coaching survey (T1) was administered when participants registered for coaching. The post-coaching survey (T2) was emailed to all participants two weeks after they completed their final coaching session. The follow-up survey (T3) was emailed in September 2021. The time between T2 and T3 varied between approximately two months and one year, depending on when the participant completed their coaching. Programme activity data was also collected on the number of sessions each participant had, the coaching delivery method they selected (i.e., video-based, audio-based, text-based) and gender.

Semi-structured interviews about employees' perceptions of the impact of the coaching were designed to provide richer, qualitative, data. Interviews took place at the follow-up point in September to December 2021 when participants were asked by their coaches if they would be happy to share their experiences of the coaching. With permission, coaches then passed on contact details of volunteers to the research team. Interviews lasted 42 to 60 minutes and were all conducted and recorded by the same researcher. Interviewees were given a choice of video or audio-based interview. Thematic analysis was conducted by two researchers who coded the data separately and then, through a process of discussion and interrogation of data, produced a final coding framework.

Intervention Design

A series of consultation webinars with primary care staff were undertaken during March 2020. The question asked was "*What will help you manage your own health and wellbeing through the COVID-19 pandemic response while you are looking after others?*" Attendee responses prioritized opportunities to process experiences, develop coping skills, and develop strategies for self-management in difficult circumstances. The preference was something within 24 hours of request; easy to book; virtual, ideally through their personal device; with flexible timings to suit a variety of working patterns; with staff determining how many contacts they needed.

The theoretical foundations of the intervention designed came from health coaching (Department of Health, 2019). The programme design utilized a small multi-disciplinary design team, including representatives from NHS England, Royal College of GPs, TPC Health and the first-named author. Key health coaching principles underpinning the programme were adopted from Olsen *et al.*, (2014) and Van Nieuwerburgh *et al.*, (2021), combining the skills of the coach utilizing

wellbeing resources, with the aim of actively managing the stress response and maintaining individual wellbeing under pressure. The perspective of each individual worker was central to the programme design. The LAYT programme launched on 23 April 2020. Figure 1 summarizes key features.

Quantitative Measures

The surveys included validated measures of wellbeing (Short Warwick Edinburgh Mental Wellbeing Scale; SWEMWBS) and resilience (Brief Resilience Coping Scale; BRCS). A bespoke measure of employee intention to leave, developed by the sector and specifically for use with healthcare staff in England, was also included.

The WEMWBS was developed in 2007 to enable the monitoring of mental wellbeing, influential determinants, and the evaluation of wellbeing interventions at a population level (Tennant *et al.*, 2007). The SWEMWBS was subsequently developed as a shorter scale with superior interval scaling and was validated as responsive to change at population, group, and individual levels in evaluations of clinically depressed and anxious people (Shah *et al.*, 2018). The scale was chosen for its brevity and robust measurement properties ($\alpha = .83$).

The SWEMWBS¹ measures respondents' wellbeing using a 7-item scale, scored from 1 (none of the time) to 5 (all of the time). Respondents were asked to select an answer to the statements based on their experiences in the two weeks prior to undertaking the survey. Statements included "I've been thinking clearly", and "I've been dealing with problems well". The SWEMWBS is scored by summing respondents' answers and then converting the raw score into a metric score. Scores range from 7 to 35, with higher scores reflecting better mental wellbeing.

The BRCS is a validated scale that has the advantage of being short. The BRCS was developed and tested within a sample of patients with rheumatoid arthritis in the USA (Sinclair & Wallston, 2004) and has since been validated in Germany with the general population (Kocalevent *et al.*, 2017).

The scale includes four items scored on a 5-point Likert scale from 1 (none of the time) to 5 (all of the time). Statements included "I look for creative ways to alter difficult situations", and "Regardless of what happens to me, I believe I can control my reaction to it". The BRCS is scored by calculating the sum of each respondent's answers. Scores range from 4 to 20, and guidelines suggest scores of 4-13 reflect low resilient coping, 14-16 shows medium resilient coping, and a score of 17-20 indicates high resilient coping ($\alpha = .72$).

Three questions on intention to leave were taken from an instrument developed by the sector, specifically for use

¹Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

Staff working at all levels and in all roles in the delivery of NHS funded contracts were eligible to self-refer. The programme was available April 2020 to March 2024 with 8,914 staff coached. It provided ‘in the moment’ virtual coaching led by the specific needs and context of each individual.

Employee-led journey

Staff register and book individual session via online booking links. Staff chose session timing, number and frequency of sessions, and delivery mode (audio or visual). First sessions last up to 45 minutes and allow individuals to offload and be supported in developing practical coping strategies. Up to three additional 30-minute sessions are available to aid greater understanding of their situation and set a path forward.

Coaches signpost individuals to other wellbeing support, where appropriate, and provide information about retention incentives and development opportunities. Coaches deploy both directive and non-directive styles. The aim is for the individual to become better connected to on-going support with strengthened self-management and coping skills. Following coaching, individuals receive emails to support them in maintaining psychological wellness.

Coaches

Coaching delivery by external coaches who understand clinical working environments. 22 coaches were initially onboarded and, as demand grew, a further 25 coaches joined them.

Communities of practice offer peer support and embed continuous programme improvement.

Figure 1. Overview of the LAYT Coaching Intervention.

with healthcare staff in England (NHS, 2020). Respondents were asked the extent of their agreement with the following statements: “I often think about leaving this organization”, “I will probably look for a job at a new organization in the next 12 months”, and “As soon as I can find another job, I will leave

this organization”. Scores were made on a 5-point Likert scale from 1 (to a very high degree) to 5 (to a very low degree).

An ‘intention to leave scale’ score was calculated for each respondent as the average of all three item scores combined. Scores range from 1 to 5, with 1 representing that staff are

likely to leave jobs, and 5 representing that staff are unlikely to leave their jobs. As such, a high score in our survey indicates low intention to leave.

Research Participants

The programme was publicized through NHS England's regular bulletin to primary care organizations. Primary care staff self-selected themselves by registering via an online booking system.

Two sets of matched data from participants were analysed separately. The first set included participants who had completed surveys prior to and following their engagement with the coaching intervention. Participants who had not completed both surveys were excluded. As of 28th May 2021, 3,552 participants had completed a pre-coaching questionnaire and been sent the post-coaching questionnaire. Of these, 662 (19%) had completed both a pre- and post-coaching questionnaire and 216 (6%) had also completed the follow-up questionnaire. The 216 comprised a subset of the total sample which were then analysed further.

The first dataset (N=662) who completed the pre- and post-coaching surveys was predominantly female (88%), aged between 35-54 (65%), and of white ethnicity (80%).

An analysis of programme activity data showed 89% of participants in the first sample chose a video-based coaching delivery method (e.g., Zoom, Skype, WhatsApp) with the remaining (11%) opting for an audio-based method. Table 1 shows that 35% of participants opted to receive four sessions.

The second data set comprised participants who completed the follow-up survey (as well as the T1 and T2 surveys) and was also predominantly female (88%), white (84%), and aged between 35 to 54 years (61%). Ninety-one per cent of participants in this second sample chose video-based coaching. Table 2 shows that 44% of participants in the second dataset opted to receive four sessions.

Analyses

Analysis of data examined the differences in pre- and post-coaching and follow-up scores, to assess if scores had improved following coaching and if any differences were sustained. The post-coaching analysis of wellbeing and resilience included a sample of 574 individuals who completed both the T1 and T2 surveys (excluding responses with missing data; N=88). Further analysis assessed any differences in scores by delivery method, number of sessions, and gender. The analysis of sustained outcomes included a sample of 202 individuals who completed all three surveys (and excluding responses with missing data; N=14). The analysis of sustained outcomes only included responses from individuals who completed the T3 survey more than two months after their post-coaching survey.

Table 1. Number of Coaching Sessions, Total Sample

Number of sessions	Frequency	Valid per cent
1	113	19.69
2	135	23.52
3	123	21.43
4	203	35.37
Total	574	100.0

Source: Programme activity data.

Table 2. Number of Coaching Sessions (Subset of Sample Who Completed All Three Surveys)

Number of sessions	Frequency	Valid per cent
1	27	14.29
2	37	19.58
3	41	21.69
4	84	44.44
Total	189	100.0

Source: Programme activity data.

Multiple mixed-ANOVA tests were used to analyse if average wellbeing and resilience scores changed following coaching and over time, and if influenced by method, number of sessions, or gender. Partial eta squared (η^2) is reported for significant models.²

The impact of change in wellbeing and resilience on individual's intention to leave at post-coaching was explored using a multiple regression.

Qualitative Measures

Participants were invited to share their perceptions of the coaching using semi-structured interviews. Participants were asked to reflect on how working during the COVID-19 pandemic had affected their wellbeing, and to what extent the coaching had (or had not) affected their individual wellbeing, ways of working, or behaviours (individual level). The interview also asked them to reflect on any resulting impact on colleagues or their team (team level), and any impact on the provision of patient care (sector/system level) and any other comments they were prepared to make.

The interview also used a 'critical incident approach' where participants were asked to recall a time in the last week where they had used learning originating from their coaching, and to provide an example of how the coaching led to improved wellbeing and/or other outcomes.

It proved very difficult to arrange interviews, given participants' workload pressures. Of the 30 participants who volunteered,

²Partial $\eta^2 = 0.01$ indicates a small effect; partial $\eta^2 = 0.06$ indicates a medium effect; partial $\eta^2 = 0.14$ indicates a large effect.

Table 3. Model 1: Wellbeing and Resilience Between Pre- (Time 1) and Post-Coaching (Time 2)

Measure	N	Time 1 Outcome Mean ^{adj} (SE)	Time 2 outcome Mean ^{adj} (SE)	F	P value	Partial η^2
SWEMWBS	574	19.739 (.299)	23.721 (.384)	99.174	.000	.149
BRCS	574	12.243 (.260)	14.779 (.271)	87.931	.000	.134

Source: Survey analysis.

only 20 interviews could be arranged during the evaluation period.

Quantitative Results

Post-Coaching Wellbeing

Results of Model 1 showed the average wellbeing scores prior to participants receiving any coaching, was 19.74 (see Table 3). This is lower than the estimated average wellbeing score of 20.8 in the UK population during March 2020 (Smith *et al.*, 2020). Following coaching, the average wellbeing was 23.72. Analysis showed that wellbeing significantly increased between the pre- and post-coaching measures ($F(1,567)=99.174$, $p<.000$, partial $\eta^2=.149$).

Model 1 results showed a significant interaction between the number of sessions and time ($F(3,567)=3.381$, $p=.018$, partial $\eta^2=.018$). Post-hoc comparisons showed individuals who participated in three or four sessions during the evaluation period (24 April 2020 to 28 May 2021) demonstrated a greater improvement in wellbeing scores following the coaching, compared to those who participated in just one session.

There was no significant interaction between change in wellbeing over time and modality ($F(1,567)=.253$, $p=.615$), role ($F(1,567)=.191$, $p=.663$), or gender ($F(1,567)=.146$, $p=.703$) suggesting individuals' wellbeing improved to the same extent, regardless of the delivery method used or gender.

The main effect of modality ($F(1,567)=.470$, $p=.493$), and gender ($F(1,567)=.007$, $p=.934$) was not significant.

Post-coaching Resilience

The results of Model 1 demonstrated that prior to participants receiving any coaching the average individual resilience score was 12.24, reflecting low resilient coping (see Table 3). Following coaching, the average resilience was 14.78, reflecting medium resilient coping. Analysis showed that resilience significantly increased between the pre- and post-coaching measures ($F(1,567)=87.931$, $p<.000$, partial $\eta^2=.134$).

Model 1 results also showed there was a significant interaction between number of sessions and change in resilience between pre- and post-coaching ($F(3,567)=2.58$, $p=.05$, partial $\eta^2=.013$). However, post-hoc comparisons did not identify any statistically significant differences. Individuals who received more than one session demonstrated a greater change in resilience.

Table 4. Model 2 Post-Coaching Intention to Leave

	B	SE B	Std. B	t	P
Constant	3.362	.107		31.341	.000
T1-T2 Wellbeing difference	.062	.027	.202	2.284	.023
T1-T2 Resilience difference	-.006	.035	-.015	-.174	.862

Dependent variable: T2 Intention to Leave.

Source: Survey analysis.

There was no significant interaction between change in resilience over time and delivery method ($F(1,567)=.627$, $p=.429$) or gender ($F(1,567)=.911$, $p=.34$) suggesting changes in individuals' resilience from pre- to post-coaching were equal regardless of the method or gender.

The main effect of method ($F(1,567)=.005$, $p=.944$), number of sessions ($F(3,567)=.734$, $p=.532$), and gender ($F(1,567)=.096$, $p=.757$) was not significant.

Intention to Leave

The analysis also investigated if intention to leave was significantly predicted by change in wellbeing or resilience between pre- and post-coaching (see Table 4). The results showed that intention to leave at T2 was significantly, positively predicted by change in wellbeing scores. This indicates that as change in wellbeing between time points increased by one unit, intention to leave score increased by .06 of a unit. A higher score signifies a lower intention to leave the organization, thus increases in wellbeing led to less intentions to leave.

Intention to leave was not significantly predicted by change in resilience scores between pre- and post-coaching.

Wellbeing at Follow-Up

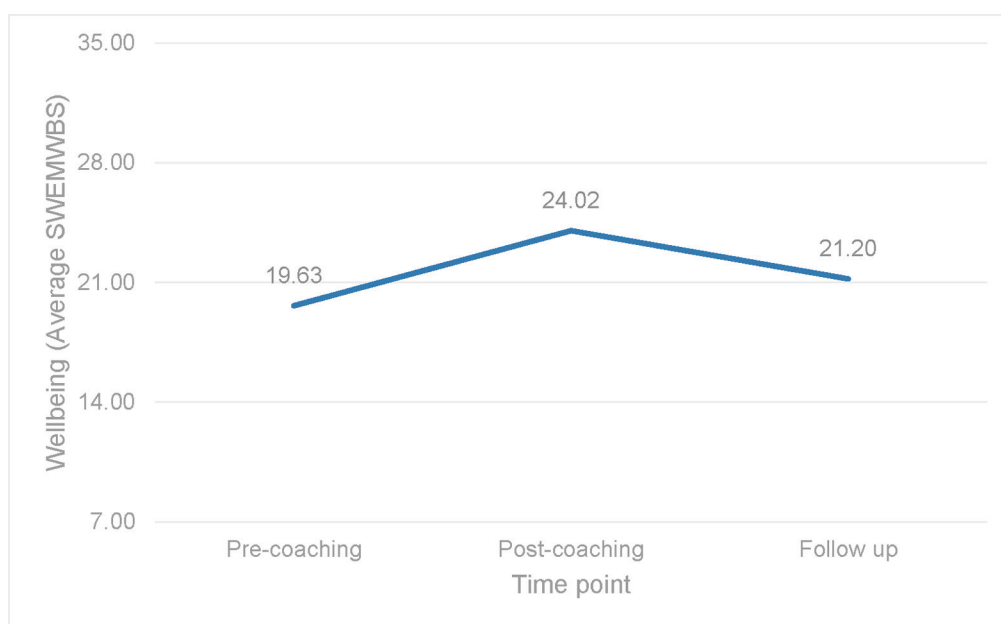
The results of Model 3 showed the average pre-coaching wellbeing of the individuals was 19.63. Following coaching the average adjusted wellbeing score³ increased to 24.02, and at follow-up the average wellbeing was 21.2 (see Table 5).

The results showed a significant difference in individual wellbeing scores over time ($F(2,398)=5.33$, $p=.005$, $\eta^2=.026$). Pairwise comparisons showed wellbeing scores were significantly different between each time point (see Figure 2). Wellbeing scores significantly improved between pre- and post-coaching and significantly declined between post-coaching and follow-up. However, wellbeing scores

³Means adjusted for number of days lapsed between T2 and T3 as a covariate.

Table 5. Model 3: Wellbeing and Resilience Between Pre-Coaching (Time 1), Post-Coaching (Time 2), and Follow Up (Time 3)

Measure	N	Time 1 Outcome Mean ^{adj} (SE)	Time 2 outcome Mean ^{adj} (SE)	Time 3 outcome Mean ^{adj} (SE)		F	P	η^2
SWEMWBS	202	19.632 (.318)	24.023 (.350)	21.201 (.376)	Time	5.325	.005	.026
					Time x Number of Days T2-T3	7.404	.001	.036
BRCS	202	12.725 (.239)	15.070 (.244)	12.880 (.288)	Time	2.204	.114	-
					Time x Number of Days T2-T3	12.844	.000	.061

**Figure 2.** Average Wellbeing Scores Over Time (T1-T2-T3).

at follow-up were significantly greater than at pre-coaching suggesting some of the improvements made were sustained over time, albeit to a lesser degree.

The results also showed a significant interaction between the change in wellbeing over time and the covariate number of days between T2 and T3 ($F(2,398)=7.404$, $p=.001$, partial $\eta^2=.036$). Further analysis identified that the decline in wellbeing between T2 and T3 was greater when the length of time between measures was longer ($r=-.337$, $p<.000$). The main effect of the number of days between post-coaching and follow-up was not significant ($F(1,199)=1.016$, $p=.315$).

Resilience at Follow-up

The findings of Model 3 showed that average pre-coaching resilience of the sample was 12.73, which reflects low resilient coping according to the measures' guidelines (see Table 5).

The average resilience score after coaching was 15.07, which suggests medium level of resilient coping, and at follow-up was 12.88, reflecting low resilient coping (see Figure 3).

There was a significant interaction between time and the number of days between post-coaching and follow-up ($F(1.912,380.568)=12.844$, $p<.000$, partial $\eta^2=.061$). As in Model 1, pairwise comparisons showed that resilience levels were higher at post-coaching compared to pre-coaching (see Figure 3) and were lower at follow-up compared to post-coaching. A significant negative correlation between change in resilience between post-coaching and follow-up and the number of days between the time points suggested that as the number of days between coaching and follow-up increased, resilience scores decreased ($r=-.356$, $p<.000$). There was no significant main effect of the number of days between post-coaching and follow-up ($F(1,199)=1.087$,

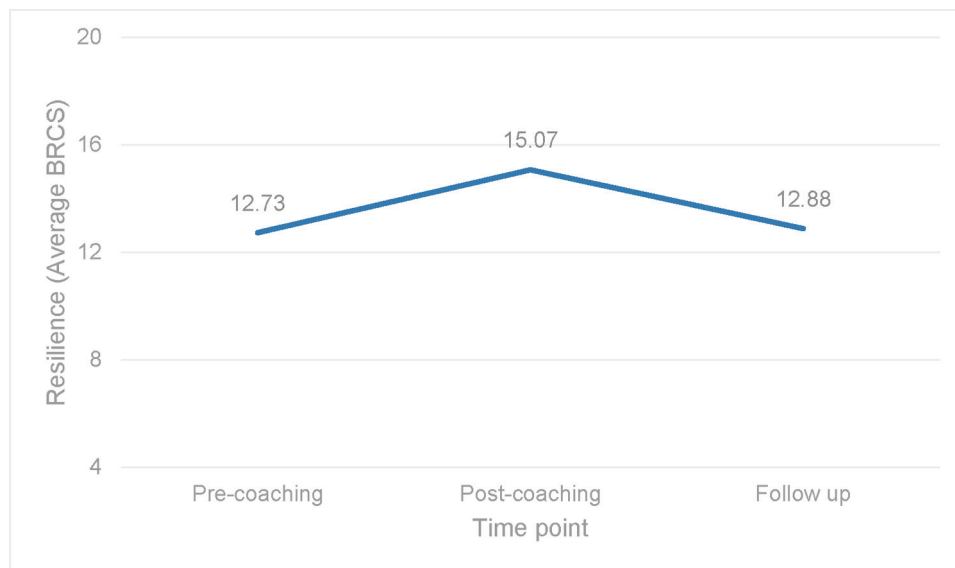


Figure 3. Average Resilience Scores Over Time (T1-T2-T3).

Table 6. Qualitative Thematic Coding by Level and Theme with Illustrative Quotes

Level	Theme	Illustrative quotes
Individual	Ability to cope	<i>I could have gone down the track of things getting worse, but I took the positive [track], and I can now cope with the stress of work. It helped me to stop dwelling and reframe on what is happening. Challenged me to think about actions that I could do to relieve my anxieties about my role. Using the coaching I was able to get my points across without getting emotional which was incredibly helpful.</i>
	Working pattern	<i>I came to realize either I stayed and reduced my workload or did not stay at all ... gave me confidence to negotiate reduced [hours]. Changing my working arrangements which has left me with slightly better wellbeing.</i>
	Purpose	<i>Stepping back and remembering why you are doing what you are doing.</i>
Team	Relationships	<i>It's helped address stressful situations with a different perspective. I ask the team what we can do to address the situations, leading people to think towards positive outcomes. Talking about your vulnerabilities to other people ... helped the practice [meetings] run well. Because of the coaching I now feel really supported by my team.</i>
	Collaboration	<i>The coaching gave me the confidence and structure I needed in team settings, to move issues forward to work towards getting the common goals done. Renewed confidence enabled me to try and view the situation from different team members viewpoints and using the information gained I encouraged the team to work towards common goals.</i>
Sector	Managing Demand	<i>Finding alternative ways of managing patient expectations ... before I felt the situation became too stressful. Helped with productivity. It has made a real difference to me and my wellbeing, and in turn, how they (the GP Partners) are able to run their business.</i>
	Service quality	<i>It's certainly improved relationships, which is then helping us to deliver a better service.</i>

Source: LAYT Interviews.

$p=.298$). The main effect of time was also not significant ($F(1.912,380.568)=2.204^4$, $p=.114$).

Qualitative Results

Table 6 summarises thematic coding, by level, with illustrative quotes.

⁴Greenhouse-Geisser correction.

Individual Level Learning

Three themes emerged in individual learning learning: Improved wellbeing especially own ability to cope; Implemented changes to their own working pattern; and Reconnected with their purpose. All twenty interviewees identified wellbeing benefits to themselves from the coaching in terms of improving their ability to cope with stress, anxiety, or general sense of wellbeing. Most often this was explained in terms of the coaching having reframed how they responded to overwhelming or challenging situations e.g. *"It flipped my mindset from what I can't do to what I can"*.

Six interviewees stated that they had subsequently changed their working arrangements in some way through having the time and space to reflect on strategies to improve, or prevent a worsening of, their own wellbeing. Changes included reducing their number of clinical sessions (less hours worked), delegating non-clinical responsibilities (focus on fewer types of task), and moving into different roles (job change).

Three interviewees identified a renewed sense of purpose and meaning through work as a major personal benefit. The coaching helped them reconnect with their original purpose in entering their profession or working within the NHS which gave them renewed energy and motivation to stay in their roles.

Team Level Learning

Half of interviewees also identified team outcomes from their coaching. Two team level learning themes emerged from participants in relation to others and the team as a whole: Better working relationships with co-workers; and More effective teamworking towards common goals. Several interviewees indicated that the coaching helped increase their awareness of the viewpoints of others' needs and feelings, especially in a challenging work context, and that this had benefits beyond themselves. Four interviewees reported that they were team leaders and, of these, two suggested that they had a heightened awareness of how to help team members with their wellbeing, which they perceived helped the team "*feel safer*".

Organizational Level Learning

Six interviewees stated that the coaching resulted in benefits to their sector or patients. Two sector level themes emerged: Higher productivity and ability to manage demand (due to higher wellbeing); and Ability to deliver a better quality service (due to improved teamworking). Interviewees credited the coaching in full, or in part, with these resulting organizational/sector level benefits, with one interviewee describing a chain of impact beginning with what coaching prompted them to do:

I was able to approach subjects using language that was less challenging, less threatening and more supportive, professional and courteous which led to more opportunities for reflection in meetings. It is these types of conversations that ... help the practice run well and more efficiently, improve patient care and the organization. (General Practitioner).

Discussion

The present study adds to the coaching literature by finding that a virtual coaching intervention improved employee

wellbeing and resilience at a time of crisis. Impact was generated at individual, team, and organizational levels. Since work pressure may create conditions for disengagement and absence from work, this is an important addition to an evidence base for HRD interventions that work at the individual level. This study supports the results of Lungu et al., (2021) in terms of positive wellbeing outcomes from coaching delivered virtually and also supports suggestions by Di Trani et al., (2021) that the use of emotional strategies allow individuals to stay in a critical situation without the need to control it. In sectors that present situations of high intensity and stress, virtual coaching therefore holds potential as a protective measure against poor employee wellbeing.

The present intervention allowed staff to choose up to four sessions with total contact time of 45 to 135 minutes and found that receiving more sessions had an increased impact. It was not possible to know if this effect would plateau at some point. Coaching time may be worthy of further research. However, we can say that improvements in individual level wellbeing and resilience were achieved from one (45 minute) coaching session. This provides further support to Theeboom et al., (2013) who found that a small number of coaching sessions could be effective.

The interview data highlighted how improved individual wellbeing aided team level relationships despite a stressful context. When individuals took action to aid their wellbeing, and change their behavioural responses to situations, this was reported to aid team communication, team cohesion, and improved management towards common goals.

An intervention that may help retain staff as well as support them, has organizational level importance to employers beyond healthcare. Intentions to leave are concerning from an HRD perspective in sectors with high costs of turnover, especially among highly trained staff. Poor psychological wellbeing is often couched by employers in financial terms based on absence, presenteeism, and turnover costs. Intention to leave post-coaching in our study was significantly, positively predicted by an increase in wellbeing. It is important to find that, in one sector, wellbeing is a key mediating factor in intention to leave. Previous research has found that low resilience leads to intention to leave (Sinsky et al., 2017) but our findings do not support this. A different healthcare setting and/or one's personal experience of a crisis, may have led to different results. It would be interesting for further studies to explore whether perceptions of one's own wellbeing are a greater predictor of intention to leave than resilience.

Our study adds to the literature on whether wellbeing improvements from coaching are sustained. Sustaining benefits depends on an individual's ability to keep implementing what they have learned. Although both wellbeing and resilience scores significantly declined between post-

coaching and follow-up in the present study, these findings are hard to draw firm conclusions from. The findings might suggest that some positive effects are short-lived, but we do not know if additional coaching time may have resulted in more sustained effects or whether perhaps the results were adversely affected by working in a prolonged crisis. Further research is needed to inform HRD practitioners on whether coaching for wellbeing is best selected as short-term interventions to support staff. Or whether other interventions might be better choices if longer term benefits are sought. However, it could be argued that wellbeing was sustained, since wellbeing scores at follow-up remained higher than at pre-coaching. The inclusion of a control group in future research would be helpful.

Limitations

There are several limitations present in the existing study. Staff self-selected themselves for coaching and the data used excluded those not completing the time two survey. The sample included had relatively high levels of wellbeing prior to the intervention, compared to those not completing a post-coaching survey. All these factors could have influenced how staff responded to coaching and subsequent outcomes. The sample were also more likely to have had more sessions than those not completing post-coaching surveys, suggesting higher engagement which could positively impact outcomes. Future evaluations of coaching interventions would benefit from receiving time two data from all individuals contacted at time one.

This analysis did not include a control group. This means the effects reported cannot be exclusively attributed to the coaching intervention. Limitations such as selection bias remain, and causal inference is unable to be determined. A randomized controlled trial would be necessary to make confident conclusions of causality.

The intervention evaluated was not derived from a solid theory-base and evidence-base for the wellbeing of healthcare workers during a crisis: it was a welcome response to the pandemic. Organizations may suddenly face a different crisis so analysing data collected during the COVID-19 pandemic has utility today. However, there remains a need for this theory-practice gap to be addressed.

Future research should seek to better understand whether coaching is effective for psychological outcomes other than wellbeing and resilience, and whether it reduces other negative by-products of working in difficult circumstances such as burnout, absence, and turnover.

Practical Implications for HRD Practitioners

This study contributes to our understanding of the effectiveness of an externally led coaching intervention,

utilizing both directive and non-directive styles of coaching. HRD practitioners may consider including coaching among their suite of employee wellbeing offers, as well as among their development offers.

Our study found that receiving just one session of 45 minutes yielded wellbeing and resilience improvements. Where lack of time is otherwise a barrier to staff accessing coaching (e.g., amid a crisis), HRD practitioners may consider offering one session or short sessions.

Our findings also suggest that the positive effects of coaching may be short-lived. Finding ways to maintain the effects of coaching over time is crucial. HRD practitioners may wish to add regular top-ups or other sustained support or encourage employees to continue engaging in reflective practice between or beyond coaching sessions.

HRD practitioners, especially those in organizations employing critical workers, may like to reflect on what they could put in place, and how quickly, should a new crisis present. The challenges of quickly scaling up workplace counselling or psychological resilience training can be considerable, especially when staff cannot be released for training due to high workload. Scaling up challenges are not unique to the COVID-19 context but the learning from that context is applicable in planning for any as yet unknown future crisis. The ability to repurpose existing HRD assets (e.g. access to IT booking platform, coaching supervision, relationships with coaching providers, and programme management capability) made selecting a coaching intervention a pragmatic choice in our study context.

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