Original Article

Translating the guidance on promoting frontline healthcare worker psychological wellbeing during COVID-19 pandemic: Psychological Needs Assessment Tool

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Abstract

Frontline health and social care workers are at high risk of experiencing mild to severe psychological difficulties from their role supporting patients and the public in response to COVID-19. A number of guidance documents were written to help organisations support the psychological wellbeing of their staff. A collaborative of practice-based health psychology professionals offered to support organisations to develop their staff support plans. Based on British Psychological Society guidance, the group developed a needs assessment tool to assist consultants in identifying gaps in psychological support for staff during the pandemic, enabling leaders to develop action plans to address identified gaps. The Psychological Needs Assessment Tool (PNAT) has subsequently evolved through practice and reflection. The group evaluated the tool using domains of the Theoretical Framework of Acceptability and found it to be acceptable and effective in guiding strategic discussions with client organisations. The tool has been successfully used to guide initial conversations with national charities, NHS trusts, social care partnerships and academic organisations. In future, the group will continue to evaluate the tool in other settings, contexts, and countries, and by consultants with varied career experience.

Key words: COVID-19; Health Psychology Consultant; psychological wellbeing; tool development

Introduction

Across Europe, frontline health and social care workers have been the vanguard of countries' responses to the COVID-19 pandemic. As the virus spread globally, national experts began to identify their frontline healthcare workers as citizens at particular risk of psychological injury, given the

many stressors involved in providing direct care in a crisis situation (Geoffroy et al. 2020; Greenberg et al., 2020; Lai et al., 2020). Lai and colleagues (2020) were amongst the first to report that a considerable proportion of frontline Chinese healthcare workers were experiencing symptoms of depression, anxiety, insomnia and distress. These symptoms were in direct response to the extreme pressures they faced providing care to those with the newly emerging virus (Lai et al., 2020). Others suggested that health and social care professionals often put the needs of patients first, sometimes at the expense of their own psychological and physical health, leading to psychological injury and burnout (Chen et al., 2020). As a result, numerous resources and guidance for providing psychological support to health workers to mitigate this risk were published on websites, via social media and in peer-reviewed journals (WHO, 2020a, 2020b).

The pandemic in the UK began to escalate in March (British Psychological Society, 2020): COVID-19 cases began to rise exponentially and, in response to national and international pressure, the UK government finally announced a national lockdown on 23rd March 2020. Although authorities emphasised the importance of sharing COVID-19 learnings internationally and readying a coronavirus response, two thirds of UK healthcare professionals felt unsupported by their hospital trust and shortages in Personal Protective Equipment (PPE) were widely reported (Bedford et al., 2020; Iqbal & Chaudhuri, 2020). This highlighted the urgent need for healthcare managers to proactively protect physical health and psychological wellbeing of staff, through regular monitoring and support (Greenberg et al., 2020).

Drawing from numerous other sources, the British Psychological Society (BPS) published evidence-based guidance on psychological support for health workers during the coronavirus pandemic (BPS, 2020). This provides healthcare leaders and managers with a set of principles for responding to the psychological needs of healthcare staff. The document suggested we could expect three phases of psychological responses over the course of the pandemic: Preparatory Phase, Active Phase, Recovery Phase. Each stage involved unique psychological challenges and thus different support needs for staff. Recommendations for leaders and others involved in staff support included ensuring access to physical safety including PPE (given the vital importance of a sense of physical safety for psychological wellbeing), having a clear communication strategy, providing visible leadership, normalising psychological responses and using a stepped care approach to psychological support (Figure 1). In 2011, WHO published guidance on how to implement, Psychological First Aid (PFA) in crisis situations (WHO, 2011). The relevance of the guidance for those experiencing distress was highlighted during the psychological response to COVID-19 (Lai et al., 2020).

A steady stream of national resources to support healthcare staff have been published since the early stages of the coronavirus pandemic. Amongst these resources are those from Support the Workers, a group of experts in disaster response, crisis psychology and high-pressure decision-making, who offered crisis-relevant advice on sleep hygiene, communication, interdependence and dehydration amongst others (Smith, 2020). Recommendations from other sources include facilitation of reflective practice, online support, and suggested helpline communications (Chen et al., 2020; Cheng et al., 2020; Geoffroy et al. 2020; Rimmer & Chatfield, 2020). National government and local authorities have also issued generic information and guidance for social care staff on supporting patients and the public (Care Inspectorate, 2020; Local Government Association, 2020; National Institute for Health and Care Excellence, 2020; Scottish Social Services Council, 2020).

There was a large body of guidance and evidence

appearing in relation to supporting the psychological needs of health workers in the NHS with a corresponding paucity of specific advice in the social and community care sectors early on in the pandemic response (Hanratty et al., 2020). The authors, a group of health psychology professionals working with healthcare staff in practice and academic settings, received anecdotal evidence that frontline colleagues were overwhelmed with the volume and frequency of communications. Following the reconfiguring of healthcare services, and redeployment of workers (Rimmer, 2020), one healthcare leader said that keeping track of incoming guidance was "like sipping water from a hosepipe" (personal communication March, 2020). In addition to the vast amount of information, providing psychological support to health workers was hampered by geographical variations in availability of expert psychology input into strategy, planning and implementation of psychological support (Care Quality Commission, 2017). For those in social and community care, published guidance early in the pandemic lacked specificity with regard to mental health and learning disability services, a further source of distress for social care managers (Care Inspectorate, 2020; SSSC, 2020). The lack of data and adequate guidance in this sector highlighted an evident gap in 'pandemic planning' and prioritisation of staff and resident's needs (Hanratty et al., 2020). Clearly then, there was a need to provide expert advice and support to some health and social care leaders to help translate the plethora of reports and guidance and to implement workable plans to provide psychological support for their workforce.

Health Psychology and COVID-19

During the early days of the pandemic in the UK, a collective of 145 health psychology professionals (including researchers, practitioners and trainee health psychologists), the Health Psychology Exchange (HPX), was formed to volunteer their services to health, social care, and public health organisations throughout the UK and Ireland (HPX, 2020). In the UK, since 2001, professional training of health psychologists includes consultancy as a core competence (Michie & Abraham, 2008). The British Psychological Society define consultancy in health psychology as "the use of specialist health psychology skills and knowledge to provide a service to an external business client" (BPS, 2018). In practice, this involves translation of health psychology theory and behavioural science evidence to working with a wide range of organisations (clients) involved in healthcare, e.g. public health, NHS, social care, and private healthcare organisations. Consultancy can include working with clients to explore problems and potential solutions, providing expert advice, and sometimes involves implementing solutions (Earll &Bath, 2008). Several consultancy requests received by HPX related to information and guidance on providing psychological support for staff.

Responding to the need

The HPX group collectively provided expert consultancy, support and guidance to several organisations in response to COVID-19. After understanding the current and emerging evidence-based guidance in relation to providing psychological support for healthcare workers (BPS, 2020, Smith, 2020, WHO, 2011) and discussion with clients, the group learnt that current guidance was either sparse or overwhelming sector-specific. In response to the requests for support for frontline staff, members of HPX with experience in psychological interventions and practice developed a translational tool for health psychology consultants to hold strategic, supportive conversations with senior managers.

This paper reports on our findings and

reflections on rapidly developing a consultancy tool in times of crisis and shares initial indications of acceptability for other health psychology professionals to explore its use.

The Psychological Needs Assessment Tool (PNAT) Aims and Principles

The aim of the tool was threefold: 1) to map existing provision against the guidance 2) to conduct gap analysis to identify risks of psychological injury, and 3) to be adaptable to different health and social care settings. We developed the Psychological Needs Assessment Tool (PNAT) to guide health psychology undertaking consultancy to facilitate a needs assessment for organisation-level psychological support for health and social care staff during the coronavirus pandemic. The PNAT does not attempt to plan how to address psychological intervention gaps. It is, in essence, a needs assessment tool. However, it enables consultants to help leaders and managers to respond quickly to develop a strategic plan grounded in evidence and expert published guidance, without the need to review all sources of evidence themselves. The PNAT includes six main topics: physical safety, physical health requirements, space to decompress, psychological needs, decision making, and leadership. These six topics were adapted from the BPS (2020) guidance on this topic as depicted in the figure below (figure 1).

The PNAT content is based upon the stepped care model which highlights the importance of addressing basic needs and physical resources as a foundation for delivering formal psychological care as well as addressing information and peer support, and psychological first aid as first line supports. The PNAT content is depicted in the below flowchart (Figure 2).

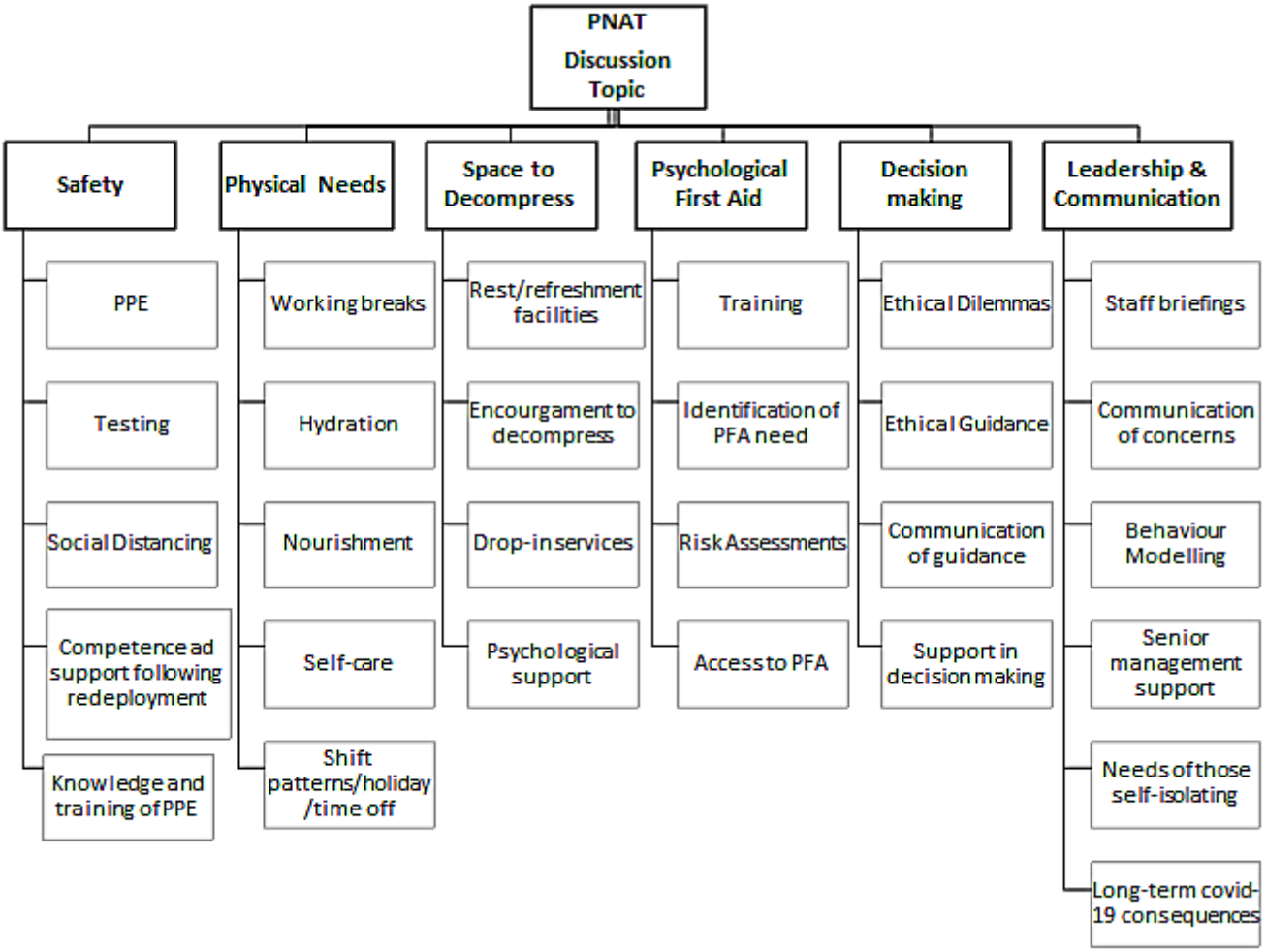
Figure 1. Stepped care model taken from BPS guidance on the psychological needs of healthcare staff as a result of the Coronavirus pandemic (BPS, 2020).

Method

Developing the tool

The tool was developed iteratively and collaboratively. Initially, to prepare for a meeting with an NHS hospital trust, one author (RB), an experienced Health Psychologist consultant, wrote a topic guide with prompts based on the official guidance (BPS, 2020; WHO, 2011). These topic prompts included physical safety, nourishment, time and space for reflection, open communication and ongoing psychological support (personal communication, 2020). This early version of the PNAT had the topic headings as in figure 1, but less detail than in the final version. Following the meeting she reflected with the HPX intervention subgroup colleagues on the topic guide's use: feasibility, comprehensiveness, and effectiveness in

Figure 2. Overview of PNAT tool discussion topics



facilitating open conversation about the psychological needs of the hospital workforce. This topic guide led to the development of a first draft PNAT tool.

These reflections led to improvements in the clarity of terms, options for self-care resources, transparency of staff communication styles and staff involvement in decision making. Two months of discussion within the HPX Psychological Interventions subgroup led to four further iterations which culminated in the addition of discussion prompts surrounding access to PPE, sleep hygiene and long-terms consequences of working on the frontline. The subgroup members then began to use the final PNAT version in conversations with client organisations.

A further four group members used the tool in conversations with local government and third sector organisations. Finally, the tool was reviewed by an independent health psychologist consultant (LBD) who compared PNAT with the previously published COVID-19 wellbeing support guidance (BPS, 2020; Smith, 2020; WHO, 2011) to add elements that did not appear.

Evaluating acceptability, monitoring tool use and initial indicators of impact

To more formally capture our group's ongoing experiences, acceptability and potential impact of using a PNAT tool in health psychology during COVID, we developed an evaluation questionnaire based on the Theoretical Framework of Acceptability (Sekhon, Cartwright, & Francis, 2017) which includes seven component constructs relating to acceptability of healthcare innovations: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. The questionnaire contained 25 items, 15 requiring Likert scale (8 items, 5- point scale) and 10 free text responses on users' acceptability of the tool, the areas of use, potential improvements and post-use reflections (see appendix 1). Group members also collected their own more detailed field notes about the topics discussed with clients from health and social care organisations. The group also collected qualitative client feedback where provided from organisations, but we did feel it was feasible to ask clients to complete further evaluation activities such as questionnaires when under intense workload pressures during the pandemic's first wave.

Findings

Use of the PNAT with clients

In its first month, eight of our group's health psychology consultants used the tool in nine HPX consultancy meetings, either alone or with a co-facilitator. During meetings with HPX clients including public health, NHS, and health charity leaders, health psychology consultants validated the good work already implemented by leaders in the health and social care sectors to provide psychological support. This was helpful particularly for those leaders without access to psychology expertise. During most of the conversations, the tool also helped the client reflect on gaps in staff support provision (e.g. lack of access to facilities for staff breaks within COVID zones in one hospital), further outlined in Armstrong and colleagues (2020). This naturally led to solution-focussed working: clients took the opportunity to discuss ideas on how these might realistically be addressed with the health psychology consultant. Consultancy strategies included ideas for restructuring environments to allow better access to rest facilities, providing information on how best to introduce PFA in organisations, how to encourage staff to build regular hydration habits into their busy work days, pathways in organisations to raise open and honest communication of concerns, holistic return to work plans, implementation of reflective practice groups in organisations and evidence-led health messaging (Armstrong et al., 2020). In addition, consultancy work using the PNAT allowed the more experienced members of the HPX psychological interventions subgroup to offer opportunities to trainee health psychologists to develop consultancy skills through shadowing and co-leading consultancy meetings with clients (Byrne et al., 2020). Client feedback from interactions with both trainee and experienced consultants was positive. One social care manager commented "I have found them both to be very supportive and given valuable feedback and examples and ideas of their own experience to problem solve". Other feedback from public health and NHS trusts reported that "The HPX have been incredibly responsive and have gone above and beyond expectations to help cascade their expertise for the benefit of key workers" and "Their prime skill is in taking complex concepts and distilling them into ideas that you can understand and

recognise as interventions that would work in your organisation. They have helped shape our thinking and I quote them regularly to colleagues!".

PNAT acceptability as a consultancy tool

The team's evaluation informed PNAT reiterations and the development of the 'how to' guide (appendix 2). The acceptability questionnaire recorded nine occasions where our group of volunteer health psychology consultants used the PNAT and data suggested that the PNAT had high acceptability, as defined by the TFA. Indeed, in five of nine consultations, health psychology consultants reported that the tool was 'completely' acceptable, suitable, and enjoyable to use. In eight of nine consultations, users reported that the tool took some effort to use supporting the group's view that the tool is best used by health psychology consultants in conversations with clients, rather than by clients themselves. Further qualitative feedback from all of the five consultants including early career and trainee health psychologists, revealed high self-efficacy using the tool, especially after the development of a 'how to guide' (appendix 2). The evaluation also captured potential future tool developments. Practitioners suggested adding safeguarding, COVID-19 testing, and employment of psychological staff, which were not specifically captured by the consultancy tool. Our group also found that although all sections of the PNAT were relevant for psychological wellbeing, the time needed to explore all areas of the PNAT required more than one or two meetings with organisation leaders. Further development of the PNAT could include guidance on how to prioritise areas.

As well as being acceptable, our evaluation questionnaire suggested that consultants found PNAT effective in identifying gaps and enabling organisations to address them. More importantly, consultant field notes included examples of clients' comments, for example "The tool allowed me to raise issues that the staff nor I would have thought of or discussed without the tool". All organisations went on to implement at least one recommendation as a result of the PNAT conversations. The implemented recommendations are discussed in full elsewhere (Armstrong et al., 2020). Relationships with clients have been overwhelmingly positive and, as a result, individual health psychologists have been contracted to work with healthcare organisations on implementation projects.

Further developments: a 'How To' use the PNAT guide

As a result of consultant feedback from the evaluation the brief 'how to' guide was written (Appendix 2). The guide contains prompts to use evidence-based communication skills during the meetings. It includes guidance on agenda setting, boundaries, and how to prioritise topic areas. Both trainee and experienced consultant feedback indicated that the how to guide helped to increase consultant confidence and reduced the time taken to cover the topics in the PNAT.

Discussion

The PNAT has allowed consultants to support clients in identifying gaps in provision of psychological support for healthcare staff, and to share their ideas about how to address those gaps with psychologists. In addition, it has enabled consultants to encourage organisations to identify and to reflect positively on their achievements in supporting the psychological needs of their staff (Rodgers, 2002). These include, developing and piloting a model for online group reflective practice (Brady et al., 2020), designing evidence-based

public health messages, and translation and synthesis of government guidance (Armstrong et al., 2020). To date, the PNAT, a consultancy tool based on evidence-based guidance, has been applied to successfully support leaders in cancer support services, NHS hospital trusts, local government, public health, social care and educational institutions.

Health psychology as a discipline has informed the COVID-19 response by advising independent scientific committees (Scientific Advisory Group for Emergencies, 2020), conducting rapid reviews (Ghio et al., 2020) and research studies, by continuing to practice clinically and, through consultancy, a key competency of the discipline. The BPS health psychology guidance provided an opportunity to develop a consultancy tool to improve the confidence and effectiveness of consultants in health psychology. We believe that by developing the PNAT, we can scale up and structure the support provided by health psychologists in translating international, national and local guidance into practice for client organisations.

The main strength of the tool is that it has been developed by health psychology consultants for health psychology consultants, who are familiar with the evidence for providing psychological support for staff during crises, who work within professional boundaries and who are sensitive to ethical implications when supporting clients. The tool was developed rapidly in response to the pandemic and was implemented and evaluated across a range of UK client organisations. As the tool is still in early use, there is as yet little data on transferability to different contexts.

We encourage health psychology consultants to continue to use the tool to guide needs assessment with organisations. We would be glad of a wider range of evaluation responses to our acceptability questionnaire, including from 'consultancy clients'. Further application of the PNAT will enable health psychology consultants to support client organisations to tailor psychological support according to the needs of their staff, and to organisation priorities and resources. We envisage that it may also be possible to pool feedback from different organisations to advise government and policy makers on the challenges faced.

Conclusion

PNAT is a translational instrument used to support health psychology consultants in initial consultancy conversations with client organisations about frontline staff psychological and physical wellbeing. It is a supportive and structured tool facilitating a needs analysis leading to clients developing action plans for their organisation. The tool is in its infancy and needs further use and evaluation, and we encourage health psychology consultants nationally and internationally to trial the tool and share their findings.

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Ethics

This work is classified as service improvement so ethical approval not required. Researchers followed guidelines for ethical conduct established by the Declaration of Helsinki, the Research Governance Framework for Health and Social Care, and the

British Psychological Society's Code of Ethics and Conduct (2018).

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Authors' contributions

AC, LBD & JH formed and lead the Health Psychology Exchange (HPX) and EB formed and led the HPX Psychological Intervention sub-group. AC, LBD & JH received requests for voluntary health psychology expertise from organisations seeking psychological support and passed requests onto HPX volunteers, including those in the HPX psychological intervention sub-group (RB, JB, LMH, AC, EB SA, DW and others). RB initiated the development the Psychological Needs Assessment Tool that supported HPX volunteers to facilitate meetings with organisations. SA and DW produced the first draft manuscript; all authors provided input towards the final manuscript.

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Appendix 1. PNAT Acceptability questionnaire

Acceptability of the psychological needs assessment consultancy tool

The psychological needs assessment consultancy tool is an agenda setting tool. It aims to help health psychologists to have consultancy conversations where they would like to identify the psychological needs of staff within an organisation during the COVID-19 pandemic.

This brief questionnaire below is designed to collect your valuable feedback and reflections on how useful and acceptable the tool is in doing this. Acceptability questions are based on the Theoretical Framework of Acceptability (Sekhon et al. 2017).

Questionnaire

1. Health psychology team member name:
2. Date of conversation:
3 .How many professionals did you speak with in this conversation?
4. What type of professional(s) was your conversation with? (Frontline practitioner, Local manager, HR/wellbeing personnel, Senior Leader in the organisation, Other)
5. What is their role in relation to COVID-19 issues?
6. What was the reason for the conversation today?
7. How acceptable did you find using the tool today? (Likert Scale)
8. How much did you like using the tool today? (Likert Scale)
9. How much effort did it take to use the tool today? (Likert Scale)
10. How fair or moral did it feel to use the tool

today? (Likert Scale)

11. Using the tool helped me identify the psychological needs of staff during the COVID-19 pandemic (Likert Scale)

12. It makes sense to me how the tool will result in organisations better supporting their workers' psychological needs during COVID-19 (Likert Scale)

13. How confident would you feel about using the tool again in future? (Likert Scale)

14. How did you find using the tool today? Please expand on the points above in sharing your reflections.

15. Do you think anything important is missing from the tool? (yes/no)

16. Do you think all sections are relevant to include in the tool? (yes/no)

17. Is there anything within the tool that you don't understand? (yes/no)

18. Finally, do you have any other suggestions for improving the usefulness and acceptability of the tool

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