NHS frontline staff experiences of an in-house psychological support service during the COVID-19 pandemic

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ABSTRACT

The COVID-19 pandemic has led to enormous practical and emotional challenges for healthcare workers globally, including NHS staff. Psychological support provisions have been established by an NHS healthcare trust in the North of England, including 1:1 psychological support provided by the in-house psychology team. This study sought to understand how staff experienced the service, what worked well and what could be improved. Five participants who had accessed the staff support service took part in semi-structured interviews. Data were analysed using Interpretative Phenomenological Analysis (IPA). Three main themes emerged from the data: ‘The need for a flexible, responsive approach’, ‘Individual and group benefits’ and ‘The future of staff support: “we need to invest in staff mentally”’. Accessing the service was seen as personally and professionally rewarding for the NHS staff interviewed. These findings are discussed in relation to the relevant literature. Clinical implications, methodological limitations and directions for future research are discussed.

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Introduction

The coronavirus disease 2019 (COVID-19) pandemic has placed enormous pressure on National Health Service (NHS) provision, leading to staff shortages, (re)deployment and rapid service restructuring (Billings et al., 2020b; Greenberg et al., 2020). Rising to the challenge of supporting COVID-19 patients has come at a significant personal cost for many NHS staff (Billings et al., 2020a). For some healthcare workers, the impact of working during the COVID-19 pandemic may increase the likelihood of ‘moral injury’ (Litz et al., 2009) and psychological difficulties (Lai et al., 2020).

The British Medical Journal (BMJ) declared that during this ‘period of increased stress and uncertainty, it is more important than ever for NHS staff to look after themselves’, affirming that to deliver the best possible care during the pandemic, ‘we must support our staff from the very beginning’ (BMJ, 2020; Unadkat & Farquhar, 2020). The British Psychological Society (BPS) has issued guidance to support NHS staff across the duration of the pandemic.

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Support for NHS frontline workers has occurred within a context of longstanding, mounting challenges faced by the health service, including limited budgets and overstretched resources (Murray et al., 2014). Declining staff morale has been captured in NHS annual staff surveys, which echo the harmful impact of working under these conditions on staff’s physical and emotional wellbeing (NHS Employers, 2019).

A healthcare trust in the North of England providing acute hospital services developed a comprehensive package of psychological support services, including access to an in-house psychology team of 14 psychologists. The service aims to support ‘frontline workers’ (Cabinet Office, 2020) to address psychological distress in the current context, for example, by reflecting on their strengths and coping strategies. Staff are able to self-refer, and managers are able to request additional support for their teams from this service. Between 1st April and 30 June 2020, 84 people requested one-to-one appointments with psychologists in the service.

This study explores staff’s experiences of using this service in the hope of informing further service planning and provision. Approval was granted for the study by the NHS trust research and development team.

**Methods**

**Theoretical approach**

An interpretative phenomenological approach was used as it is concerned with the ‘lived experience’ of individuals and how they make personal sense of these subjective experiences (Smith et al., 2008). It is particularly suitable when exploring a novel experience, such as the experience of using this new service, as it tries to mitigate ‘top down’ assumptions.

**Procedure**

Participants were NHS staff accessing the 1:1 psychology support service. They were made aware of the study through an advertisement by the Trust’s Organisational Development (OD) department. The recommendation of 4–10 participants, to ensure ‘data richness’, was followed (Smith et al., 2009). Volunteers were invited to a semi-structured remote interview by video conference call or telephone. All identifying data were changed to ensure anonymity.

Participants were asked a series of demographic questions, as well as their experience of accessing the staff support service. Questions were used in a flexible, open-ended and non-directive way, in order to facilitate the participants telling their story in their own words and to enable exploration of topic areas not anticipated by the researcher.

**Analysis**

Data were analysed using Interpretative Phenomenological Analysis (IPA), guided by Smith and Osborn (2008). Multiple readings of each transcript identified emergent themes which were clustered to form main themes for each participant. Themes were
then compared across the whole sample. Themes were chosen on the basis that they represented a balance between salience and representativeness of participants.

Quality and validity were ensured by sharing transcripts, reflections and individual perspectives with the study’s supervisors. The primary author engaged in a process of reflexivity throughout, noting ideas, reflections and questions in a reflective journal, as well as through discussions with the study’s supervisors to ensure that personal experiences and evoked feelings were logged and acknowledged and not imposed on interpretations. A sample of the analysis was also shared with the primary researcher’s supervisor, who provided support for the analysis.

**Findings**

Five participants gave interviews, three by video conference call and two by telephone, lasting approximately 30–45 minutes. All participants identified as White-British women, aged between 25 and 54 years. Four participants worked as nurses and one as an allied health professional. The range of time spent in each respective speciality for participants was between 6 and 14 years. Two participants accessed the individual support four times each; another participant accessed individual support approximately twenty times, as well as two group support sessions; and one participant continued to access the service at the time of her participation in the study.

**The need for a flexible, responsive approach**

**Riding an emotional rollercoaster**

Participants articulated a sense of unpredictability and the rapid pace of developments in the context of COVID-19. Participant 3 captured the emotional impact of the speed at which things changed:

‘I had to self-isolate and I think being at home not being in work, everything like just like hit me at that point and I just felt like I was on a big rollercoaster and that’s when I emailed [psychologist]² to organise a phone call erm and that was literally a rollercoaster I can’t even remember those two weeks I was like up and down’ (Participant 3).

Participant 2 explained that the emotional impact of her work followed her home, where ‘at the peak of it I was just constantly crying, you know I’d come home from work and I’d cry for like an hour erm and I couldn’t control it’.

**Guided by staff needs**

All participants reflected that the flexibility of the psychologists with regards to timing and number of sessions meant that they were able to access support in a way which was sensitive to the demands of their work and their specific emotional needs. Participant 2 described, ‘I believed that if I’d asked to speak to her for 10 sessions, then she would have done that. It was kind of guided by how I was feeling at the time’.

Participant 1 explained that the flexibility in the support she received contributed to her experience of the service as person-centered, as she described, ‘in that moment it was just
like all about me, like if this is what you need and this is what will help, we will be there and we will get there'. She continued to reflect that if the service was more rigid in its approach, she would have experienced the support as a less meaningful arrangement from the Trust:

‘I think having that strict barrier would have really hindered me because I definitely would have felt it was just a tick box exercise, this is for HR, this to show they’re giving me support, whereas I absolutely didn’t feel like that’.

**Individual and group benefits**

**Supported to remain in work**

Participants spoke about the impact of the increased pressure they faced as frontline staff and the importance of being supported by the psychology service to both stay in work and to return to work. Participant 1 explained that ‘at the time that I accessed the service, it was very much a I was trying to get some help or I was going to sign off sick’. For Participant 4, the service played an important role in supporting helping her to return to work: ‘I was off sick for a few weeks and as I say without the input from the psychologist I don’t think I would have been back in work yet’.

For Participant 3, the return to work was challenging and became a focus for support: ‘we tried to do like coping mechanisms and tried to put like plans into place for when I’m in work’.

Investing in support at this stage led to additional benefits for the staff interviewed. Participant 2 experienced that her ‘long standing anxiety’ had alleviated and she felt ‘kind of prepared that if obviously when things get busier at work (...) I just feel better equipped for it’.

**A ripple effect of support**

A sense of community spirit or solidarity was spoken about by the participants, who felt ‘more aware of other people now so I feel like I can help other people as well’ (Participant 1).

‘I think I’m just more aware of how others are feeling so you can I think you can observe people a little bit more and see whether they’re struggling erm and just like asking them if they’re ok as well ... if they need a chat’ (Participant 3).

Participant 5 also felt confident in recommending psychological support to her peers following her involvement with the service: ‘You don’t realise until you’ve had that input ... I can’t recommend that kind of service enough’.

**The future of staff support: ‘we need to invest in staff mentally’**

This staff support service was established on an emergency basis and whilst participants were grateful about this, they reflected that they could have benefitted from this support at other times too.
‘I am quite passionate about staff mental health massively you know, I just think we need to invest in staff mentally, their mental wellbeing is just as important as we know, its publicised quite openly now isn’t it, but this service I personally feel it should be there as a service that we offer our staff and colleagues because it’s not just COVID, it’s also the after effects of COVID now and potentially going to be COVID again shortly’. (Participant 5)

This was supported by other participants; Participant 2 reflected that ‘even if I’d have been able to access it 6 months ago it would have helped me personally without a pandemic’. Participant 3 linked this to her role in the critical care department specifically:

‘I think in critical care I think it’d be useful to have it and have some kind of service there (…) I just think we just accept we just we’re just expected to just you know that’s your job that’s what you should see so I think like there should be like a service in place’.

Some participants spoke about the proximity of the staff providing the support and the benefits of speaking to somebody ‘within the system’ (Participant 2) who was familiar with the pressures in which both parties worked and who ‘had an understanding of the Trust’ (Participant 4).

Discussion

In times of local or national crisis, individuals are more likely to experience psychological distress (Makwana, 2019). The most salient experiences within participants’ accounts were the descriptions of the rapid development of events, which left some feeling overwhelmed and underprepared, as well as the deep personal impact of grief and bereavement due to COVID-19. Many staff are experiencing the distress and impact of losing loved ones under difficult circumstances, which may also impact on their work. Individual considerations should also be made for those who have recently been bereaved due to COVID-19 (BPS, 2020b).

Participant’s accounts reflected that support had an impact on staff not only at the time, but also for enduring difficulties and preparedness for work in the future. Workforce shortages, staff burnout and increased workload are expected to continue throughout the duration of the pandemic (Ford, 2020). Protecting the wellbeing of staff during the COVID-19 response will directly impact their capacity to fulfil their roles (WHO, 2020). The literature suggests that psychological support should be offered as part of a wider embedded framework of support for NHS staff, addressing practical support such as appropriate access to PPE, adequate funding and social care investment (Billings et al., 2020b; Ford, 2020).

Peer support has been described as beneficial and important to healthcare staff (Gerada, 2019; Jackson, 2018) and may be preferred by some people who may not want to burden those around them, such as their family (BPS, 2020; Billings et al., 2020b). Participant’s here described feeling connected with and more willing to support others after accessing the service. Hope-filled community interventions have been recognised for their potential to support coping and eventual recovery over the coming months (Tinlin et al., 2021). Participants felt that the in-house team were well placed to empathise with the pressure on systems, whilst being removed enough to feel comfortable sharing their experiences. The support infrastructure which was created in
response to COVID-19 could be incorporated and gaps in provision should be addressed to relieve pressure on staff within the context of the NHS (Wilkinson, 2015). Given that various stages of psychological response are likely to be experienced by NHS staff over phases of the COVID-19 outbreak, it is important that varied feedback mechanisms are established to ascertain staff’s views on support; consistent with guidance published by the COVID Trauma Response Group (Billings et al., 2020c).

Due to the small, self-selected sample, and the choice of IPA, generalisations to a wider population should be considered with caution. Healthcare staff with various ‘protected characteristics’ (Legislation.gov.uk, 2010) may have unique and intersecting vulnerabilities that may have intensified difficulties during the current climate (DCP, 2020), in particular people from Black, Asian and ‘minority ethnic’ (‘BAME’) groups have been disproportionately affected (Intensive Care National Audit and Research Centre (ICNARC), 2020; Kursumovic et al., 2020). IPA designs with more purposive sampling could be used to explore the experiences of more frontline workers and those from a wide range of demographic backgrounds.

Dissonance with a ‘heroes’ narrative may make it harder for some NHS staff to disclose problems, exacerbating distress (BPS, 2020); it is hoped that this study gave participants an opportunity to discuss their experiences of navigating extremely difficult circumstances.

Supported by the accounts presented in this study, a long-term strategy for protecting the physical, psychological, and emotional wellbeing of the workforce must be a priority for the NHS throughout the COVID-19 pandemic and beyond. Longitudinal studies assessing the offer of support for frontline staff as the pandemic develops may be beneficial, as well as further exploration of the benefits of peer and community support to better understand how these can be developed to support the wellbeing of people affected by COVID-19.

Notes

1. [text in square brackets] indicates additional information.
2. (...) indicates removed text.

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