Pandemic Stage	Technical Capacity	Staff Challenges	Staff Own Actions	Interventions for Staff	Corporate Actions Senior Execs/Managers
Preparation for Covid-19	• Planning and anticipating • Gaining insights and information • Practical Preparation ie PPE and fit testing • Encourage simulation ("dry runs") of safety protocols and procedures, to facilitate embedding knowledge to increase safety **PPE** • Verified information re supply, when to use, what for and donning/doffing protocols • Need staff rotas that allow PPE to be worn in the way it is designed for whilst allowing for safe staff breaks	• Anticipatory anxiety vs. possible denial - potential for conflict • If PPE/fit testing delayed > more stress • Potential for stress if insufficient staff testing • May feel overwhelmed at prospect • Physical/emotional signs of tension • Information overload vs. lack information • Realisation reduced/absence agreed leave • Reasonable identification of limits to practice • Potential fear of reprisal relating difficult decisions May already be struggling due to work or unrelated issue (e balance	• Optimise 'Personal batteries' • Make *Personal Wellbeing Plan**See http://learn.4mentalhealth.com/ • Home contingency planning • Self-isolation planning • Work within own competencies but learn new skills to help others • Focus on what can be reasonably undertaken • Try to anticipate likely individual challenges both professional and personal. • Make a *Safety Plan** - See StayingSafe.net	• Encourage self-care • Good advice regarding COVID-19 safety protocols • Start regular supportive meetings with colleagues • Commence *End of Shift huddles** and regular supportive *Team Review Meetings** • (see full details below) • Optional 1:1 Coaching for senior staff • Ensure staff are aware of range of support options available including occupational health. • May need counselling support – by telephone/videolink (avoid over-medicalisation) • "Marathon not a sprint": maximise regular rostered short periods	• Develop regular communication channels e.g. daily emails at same time: use same wording format • FAQs updated daily with option to feed into process • Develop Media Plan: focus on certainty, transparent, honest • Remove non-urgent business-as-usual tasks ASAP and extend deadlines (e.g. non-essential mandatory training, job planning, appraisals, KPI) • Ensure active monitoring of staff wellbeing and PPE availability are standing agenda items in COVID-19 Management Meetings • Managers need support and coaching to avoid inadvertent overbearing approach. Avoid 'micro-management' and

		competing demands between work/personal/ family life • Be aware of the *Stress Response Curve** • Concern of serious risks to own health / fear of dying & leaving dependants • Concern over transmission to vulnerable relatives		of leave and annual leave whenever possible • Clear communication channels with clear escalation if needed	unnecessary changes, which are likely to demotivate staff and create workplace stress & anxiety. • No assumptions about which staff deemed 'at risk' – ie some staff may have undisclosed illnesses. Encourage staff share issues in confidence if RA needed for staff well-being / safety. • Harness/accept pro-bono offers of coaching • 'Open door' policy in person/remotely • Senior staff highly 'visible' and approachable. Need to 'walk the walk', not just 'talk the talk', • Involve chaplaincy services
Early phase	• Single/small number of cases • Potential for fast shifting caseloads (empty ITU suddenly filling) • Full technical capacity	• Anticipatory anxiety heightened • Potential severe anxiety if inadequate PPE • Increased psychosomatic symptoms	• Build new teams • Learn new self-care strategies • Actively use *Personal Wellbeing Plan** • Work within own competencies, but learning new skills to help others	• Informal peer-support • Create 'buddy' support • Pair up experienced with inexperienced staff • Start support forums (in-person and on-line) • Consider real time & regular weekly support	• Regular communication channels and consistent Media Plan as above • Encourage home-based tasks when staff well and self-isolating, to support sense of being useful

	• Vigilance regarding sufficient resources • Potential for PPE shortages and changing or conflicting advice re PPE • Some ethical dilemmas	• Increased awareness of own symptoms • May feel overwhelmed by responsibilities • Possible denial/some on overdrive • Most will be coping with the 'new normal' • Potential fear of reprisal relating to difficult decisions • Potential guilt and negative impact on wellbeing for staff self- isolating or shielding		• *End of shift huddles**, • Regular supportive *Team Review Meetings** • May be able to access Liaison/psychology • Home-based tasks when staff well and self-isolating/shielding to support sense of being useful • Redeployment of home-based staff including, supporting 'frontline' staff, giving results, supporting patient relatives,	• Encourage use of technology (e.g. Skype) for home-based staff so that they can join team meetings and feel connected with colleagues. • Provide increased levels of supervision and ensure no one is pressured into a role that provokes overwhelming anxiety and stress • Active monitoring of staff wellbeing and PPE availability standing agenda item COVID-19 Management Meetings • Managers need support and coaching to avoid inadvertent overbearing approach • Remember 'marathon not a sprint' • Managers need to avoid scapegoating of staff • Compassionate and supportive management, listen and hear and act on concerns. Avoid becoming frustrated if staff concerns persist.

					• Ensure staff are allowed confidentiality of any medical issues •
Mid-phase	• Many new cases daily • Potential for PPE shortages and changing or conflicting advice re PPE • Strain in technical capacity due to insufficient equipment and staff sickness, covering for colleagues, redeployment anxiety • Challenging ethical decisions will need support process from regulatory organisations, professional bodies and senior staff	• Potential severe anxiety if inadequate PPE • Distress and worry increase • Some staff not coping and already overwhelmed • Many habituated to 'new normal' • Some on 'overdrive' • Starting to deplete personal reserves: 'Running on empty' and starting to burnout • 'Staying strong' for patients • Potential fear of reprisal relating difficult to decisions • Potential for reduced workforce and stress if insufficient staff COVID19 testing • Potential for stress and anxiety due to increased exposure	• Focus on 'circle of influence' • Focus on supportive teamwork • Practice developing psychological and cognitive strategies • Conscious attempts to establish a routine for relaxation/sleep hygiene • Avoid excess caffeine/alcohol	• Prioritise drinks/food/rest/sleep • Strategic comfort breaks and rest periods (and avoid caffeinated drinks prior to shift) to optimise comfort whilst conserving stocks of PPE • Consolidate supportive meetings • Ensure regular 'offload' • Formal 'buddy' each shift • May need intensive support • Access support and guidance from specialist services • Clear communication channels with clear escalation if needed	• Active monitoring of staff wellbeing and PPE availability standing agenda item COVID-19 Management Meetings • Regular communication channels and consistent Media Plan as above • Ensure successes are shared, no matter how small • Vigilant to monitoring resources adequate • Consider additional practical support for staff to allow to stay at work • Redeploy some staff to support staff caring for COVID-19 patients • • Managers need support and coaching to avoid inadvertent overbearing approach. • Remember 'marathon not a sprint'

		to caring for dying patients that may staff not feel equipped to deal with. • May experience bereavement / emotional distress if working in long term care settings and lose patients they have cared for over a long period of time. • Distress at impact of restricted visiting for patients and families at end of life. Potential for moral injury			
Peak-phase	• Case overload ++++ • Potential for PPE shortages and/or changing or conflicting advice re PPE • Insufficient Capacity due to patient numbers • May need national review of boundaries of individual scope of practice	• Potential severe anxiety if inadequate PPE • Distressed due personal impact • Likely to have affected family/friends • 'Altruistic Distress' • Feeling overwhelmed +++ • May feel unable to cope ++	• Focus on 'circle of influence' • Focus on supportive teamwork • Use psychological, cognitive and self-compassion strategies constantly • Conscious attempts relax/sleep hygiene • Avoid 'overdrive'	• Prioritise drinks/food/rest/sleep • Strategic comfort breaks and rest periods (and avoid caffeinated drinks prior to shift) to optimise comfort whilst conserving stocks of PPE • Compassionate management • 'Buddy system' every shift • Opportunistic support	• Active monitoring of staff wellbeing and PPE availability standing agenda item COVID-19 Management Meetings • Regular communication channels and consistent Media Plan as above • Ensure successes are shared, no matter how small • Consider additional practical support for

	• Challenging ethical decisions will need support process by senior staff • Potential shortage of essential drugs •	• Staff 'running on empty' & burnout ++ • Potential work conflict due to excess stress • Potential fear of reprisal relating difficult decisions		• Regular supportive *Team Review Meetings** • Support 'off load' time built into shift • May need 1:1 or small group support • Clear communication channels with clear escalation if needed	staff to allow to stay at work • Redeploy some staff to support staff caring for COVID-19 patients • Liaise with external bodies as required • Managers need support and coaching to avoid inadvertent overbearing approach.
Tail off phase/ Recovery Phase **NB timeline is not yet unknown with potential for a second wave so process re-starts**	• Technical capacity OK • Minor ethical dilemmas • Introduction of 'business as usual 'with phased introduction of non-COVID19 related activity • Normal 'pre-pandemic' workload increases / potential backlog to deal with • Service re-design secondary to COVID ie use of Video /tele consultations	• Staff 'running on empty' • Many with burnout • Potential retrospective guilt • Potential fear of reprisal relating difficult decisions • Staff now in period of limbo, awaiting return to normal place of work • Team dynamics across organisation changed	• Focus on supporting self and others • Use psychological and cognitive strategies when required • Focus on compassion self and others • Ensure annual leave taken • Focus on learning new skills	• Compassionate management • Regular supportive *Team Review Meetings** • Watch and wait and refer/Occupational Health • More formal psychological help when required	• Active monitoring of staff wellbeing and PPE availability standing agenda item COVID-19 Management Meetings • Regular communication channels and consistent Media Plan as above • Ensure share successes, no matter how small • Liaise with external bodies as required • 'Open door' policy in person/remotely • Re-establish Departmental meetings • Engage staff in 'recovery plan' • Acknowledge that potential for service

					redesign and seek staff ideas. •
Post COVID-19 **The New Norm – with potential for further spikes of COVID** **NB timeline is not yet unknown**	• Full technical capacity • Reduced staff functioning/reduced numbers • **Staged return to normal duty** ✓ Informal mixing with colleagues ✓ Period of leave ✓ Gradual reintegration into normal duties • New Teams established with capacity to flex Follow advice in Greenberg paper '**NHS staff recovery plan post COVID19 (outbreak 1) Version** **Staged return to normal duty based on** post operational stress management (POSM)	• Expect a delayed response • Mitigate staff distress and/or burnout • Fear reprisal for difficult decisions • Potential for guilt, negative feelings or anxiety in HCP who perceive they have not contributed • Risk of blame being attributed	• Focus on supporting self and others • Use psychological and cognitive strategies if required • Focus on compassion self and others	• Compassionate management • Prioritise annual/study leave • Watch and wait and refer/Occ Health • More formal psychological help if and when required • Schwartz rounds • Potential for sabbaticals • Reintroduction of PDR/appraisal with a new coaching approach	• A poorly implemented post-COVID-19 plan, (false promises support or time to readjust to new normal/managers making high work demands on staff prev. 'flat out' has potential derail prev. good staff support and cause serious psychological harm. • Managers need support and coaching to avoid inadvertent overbearing approach. • Vital managers compassionate and psychologically savvy • Open door on offer as needed • Plan team building activities • Support a coaching culture in the organisation

IMPORTANT

- This is an unprecedented situation that none of us have previously had to contend with.
- We must remember that all of us, however junior or senior, may be feeling out of our depth, which is an entirely normal and reasonable response.
- However, with planning and preparation and working as a collective we can support each other to do our very best.
- We will need to be creative, pool resources and also consider harnessing non-NHS people for support tasks and tasks to optimise our performance.
- "The available evidence strongly suggests that how staff are supported as the crisis begins to recede is of critical importance in determining whether staff members will experience psychological growth, develop a mental health disorder or neither" Prof Neil Greenberg

IMPLEMENTATION

• Introduce practices that promote psychological safety and do not risk causing further harm to staff.

- ▸ "De-briefings" that encouraging discussion of distressing feelings experienced during traumatic events must be avoided.
- ▸ Staff need time to recover and "reset" before returning to normal duties after a period of exceptionally high demand working.

Organisational/managerial failure to recognise and facilitate this has the potential to de-rail all preceding efforts at staff support and can cause serious psychological harm.

• As well as ensuring resources are provided for staff experiencing higher levels of distress, organisations should encourage introduction of simple self-and-team support strategies.

• Consider utilising small-group structured interventions, such as Trauma Risk Management (TRiM) or Critical Incident Stress Management (CISM) at appropriate point(s) within the pandemic response and then as available/ appropriate after critical incidents.

▸ TRiM or CISM peer-practitioners also need support and access to (psychological) supervision.

• Optimise access to Psychological First Aid: these skills will be present in most NHS organisations, but routes of access may need to be improved or clarified.

• Responsive and appropriately timely Occupational Health support (via both self- and manager-referral) is, as always, vital. This should include to same-day support when this is indicated.

• Staff must be able to access help on a confidential basis, with confidentiality breached only either with permission, or if a risk of harm to the individual or others is identified.

▸ There are many possible models, but based on the available evidence-base within medical contexts (which is limited) plus the extensive experience of military services, we recommend the following:

1. **Nominated buddy**
2. **Post-shift huddles**
3. **Weekly Supportive Team Reviews Meetings**

Nominated buddy

• Encourage staff to pick a "buddy" they trust: *"someone you know, someone you trust, and someone you feel comfortable confiding in"*
• This person need not be a shop-floor colleague, but it is helpful if they have some insight into their buddy's work environment and role.

Post-shift huddle

• A quick meeting (rarely more than 5 minutes) after a shift to which the whole team
are invited (but attendance is not mandated). Can be done standing.
• Alternatively, embed wellbeing questions and considerations into other daily team interactions, such as the safety huddle.

How does it work?

• Semi-structured, checklist-driven:
‣ What went well?
‣ Have we learned anything to implement next time?
‣ Have we identified any needs to escalate (i.e. practicalities?)
‣ Ask everyone the One Positive Thing question: "what's one positive thing you are looking forward to after your shift?"
- This is a screening question: if unable to answer, take seriously and ask further questions. The colleague may be in need of a higher level of support.
‣ Do you have someone to chat to at home/on phone after your shift?
‣ Remind colleagues about available support & encourage them to talk to their choice of "buddy"

Supportive Team Review Meeting

- For the purpose of this document, a *Team Review Meeting* refers to a semi-formal structured, regular and facilitated meeting where teams are given the opportunity to come together to reflect on the experience of working together, build a shared understanding of what has happened, foster connection, give mutual support and think about their self-care needs. If regular meetings are not possible a one-off Team Review Meeting is to be encouraged.
- Ideally, they should be facilitated by at least one suitably qualified professional (i.e. psychologist, psychiatrist, trained mental health nurse or other) although COVID-19 may mean flexibility is required across all aspects of provision.
- The primary process is for compassionate support and not as a treatment intervention. However, it is important that at least one facilitator has a background in psychiatry or psychology and is able to recognise signs of PTSD should they emerge, so they can signpost on and ensure the team review is delivered safely.
- Where possible there should be two facilitators, with one being already known to the team (e.g. senior clinician, , team psychologist).
- Team reviews must always be optional, and no staff member should be compelled to attend.

Guide to delivering a Team Review Meeting

• Short (approx. 15 minutes), semi-structured
• Led by a senior team member

• This kind of meeting is standard practice after particularly distressing cases in ED and ICM, such as maternal or paediatric deaths, where they are sometimes called "de-briefs"

‣ We recommend avoiding the term "de-brief" to avoid potential confusion with *emotional* debriefing, which is believed to be harmful.

- *This structure least likely to exacerbate PTSD, whilst still being supportive and helpful if run correctly*
- *Recommend this structure and not 'one off' or 'debrief' style meetings*
- *Aim is to minimize likelihood of PTSD, whilst still being supportive and helpful*

• Psychologist is not required but would be included if they are already part of the team. However, but this type of meeting is *not to talk about feelings*.

• All team members are invited, but attendance is optional and off-duty staff are not expected to attend unless they want to

• Non-minuted, but action plans/requests might be generated

• Where, when, and how requires thought, as social distancing is required

How does it work?

• Semi-structured, checklist-driven:

‣ What is going well?

‣ Any good news from anywhere?

‣ What have we learned this week?

‣ Is there anything we need to implement, or do differently, next week?

‣ Is there anything we need to escalate (e.g. regarding support, staffing or kit)

‣ How are we looking after ourselves?

‣ Remind about need for self-care, and available support.

*Safety Plan

- The mental health equivalent of putting on a car seat belt: a set of strategies, emotional and social support in the event of emotional distress. See StayingSafe.net

*Personal Wellbeing Plan

- The mental health equivalent of an MOT, designed to maximise wellbeing and build emotional resourcefulness to help mitigate tough times.
- See http://learn.4mentalhealth.com/

GENERAL PRINCIPLES

•Foster own HCP resources

•Avoid medicalising distress

•Ensure at correct 'level'

•Ensure choice of support

•Don't mandate support

•Ensure clear governance

•Ensure confidentiality
•Confidentiality breached with permission OR only if risk of harm self/others identified
•Ensure ALL staff aware support
•Allow HCP access support work time
•Offer support at a range of times to match shifts
•Match support to HCP preference increase acceptability and take-up

Important Additional Principles

•Consider 'hub and spoke' model/ bespoke COVID19 *Staff Wellbeing Support Service (SWSS in BCUHB)
•Consider use Psychological First Aid and/or referral for Occupational Health support as indicated
•Consider role small group structured interventions, such as TRiM or and CISM.
•Use with appropriately trained people, at the correct time within this pandemic and as available and as appropriate after critical incidents.
•Those delivering TRiM or and CISM need additional support/supervision
• TRiM trained managers should also ideally have access to supervision from experienced psychologists

***Circle of Influence (based on Covey's work)**

- This can potentially be adapted to clinical settings to reduce cognitive load when working in a high pressure or crisis situation.
- Encourage staff to think about the things that they can control, those they can influence and those they can neither control nor influence.
    - If staff start to become overwhelmed encourage them to focus on what is directly under their control at that very moment, and to encourage breaking down units of time or tasks into manageable chunks.
    - This can be applied to focussing on individual patient tasks if they start to become overwhelmed by unmanageable clinical workload or emotional distress

***Stress Response Curve:**

- Terms such as 'stretch and strain' can be useful to consider in understanding of the dynamics of the state people are in, and what has become widely known as the Nixon Curve [P. Nixon 1979] has also been called the *Stress Response Curve*.
- The term "stretch" is often used when someone is working and functioning at a high level whilst generally coping and efficient. At this time a person may be experiencing what might be termed "good stress".
- However, as the stress increases, accumulates or develops multiple layers, this good stress can become distress (bad stress).
    - At this point people may be seen as strained, and though initially they may appear to be functioning and coping, the truth is they may rapidly descend into someone developing psychological, emotional and physical signs and symptoms which may lead to them becoming unwell, experiencing crises and burnout with even the smallest additional stresses.

NOTES FOR EXECUTIVE TEAMS & SENIOR MANAGERS

- Senior leaders to include active monitoring of staff wellbeing and in COVID-19 Management meetings through engagement with stakeholders in Organisational Development/Occupational Health, Psychology, Liaison Psychiatry and faith leaders.
- Consider canvassing and harnessing pro-bono offers of coaching.

Communication is KEY

- Focus on certainty with transparent, honest and consistent style with same wording format.
- Whenever possible write concise, clear and focused communication

IF YOU HAVE BEEN EMAILED THIS DOCUMENT…

- This guidance is an evolving project: there will be expansions and additions soon.
- The latest version will always be downloadable from https://www.lindadykes.org/covid19 and announced from our Twitter account @HCW_Welfare

COMMENTS OR SUGGESTIONS?

- Message Dr Alys Cole-King on Twitter - @AlysColeKing or to our Twitter account, @HCW_Welfare, which will continue until the pandemic is over.

APPENDIX – Contributors

As this is an interim document: multiple drafts have been flying around the contributing team, and this list will be updated as new contributors participate (or if we have accidentally missed anybody out!)

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