NHS Briefing paper for NHSEI and NHS staff wellbeing offer during COVID19 response

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Summary:
This paper describes the latest review of the evidence base and our informed approach we are taking to ensure the wellbeing, collective psychological resilience and decision-making capacity of our NHS people working in response to the COVID-19. It outlines the three-stages, preparation, active and recovery (PAR) that we are expecting to see, and the support offers that will need to be in place to support our NHS people to thrive beyond these events.

What we know from the review

1. This is an unprecedented event the support we will need to provide will need to be informed by evidence and best practice but also responsive to testing and evaluating so we can adapt and change where we need to

2. We want to deliver the right support in a timely way, we need to focus on caring for physical and safety needs now, building a sense of belonging as the psychological impact and response is likely to be needed later after the active or eye of the storm phase

3. We need to respond in line with the three phase PAR approach and adapt our interventions as we learn more about what is required

1. Background
1.1 This paper focuses on two sources of information, firstly discussions with clinical experts who have led large scale responses to major incidents (Manchester bomb, London Bomb, Ebola outbreak in Sierra Leone, 911 fire fighter and emergency service response and Boston Marathon bombing; response to Gulf War Syndrome etc.) and a review of associated literature. It is not intended to be full scale literature review, but action focused to:

   - Translate the findings into evidence-based action and monitoring our interventions as we know our current context differs from the incidents reviewed

2. Evidence precis
2.1 There are three phases we need to pay attention to when dealing with wellbeing and psychological responses to major incidents which are likely to predict positive outcomes. (Appendix Fig 1)

2.2 Prepare stage:

A low-level approach will be needed to begin with, helping people cope for themselves and building in line-management and team support to enable the usual coping systems to function well. The more efforts we put into prevention, briefing and preparation the more positive outcomes will be. We need to pay attention to physical, safety and belonging needs. Messages need to be collective rather than individualistic to promote the sense of being in this together.

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2.3 We will increase the frequency and enhance the content of our system briefings about health and wellbeing based on the following:

- **Reducing anticipatory anxiety** - What will this look and feel like? Ensure that the elements of surprise about what I may see, hear etc. are reduced (the military use live footage of battle theatres to do this). This is especially important given those returning to service who are likely to be unprepared for what they will experience.

- **Preparing people for side skilling** – existing models of training which encourage people to stay within their absolute speciality puts people at risk of feeling de-skilled and not ready to participate in this 'new' role.

- **Enhanced line management knowledge and support** - Being honest and open about what is happening and why – if there are equipment shortages, be honest – people need to feel that they and their families are safe. Demonstrating good leadership is a key future indicator of well health as people need to have confidence in the decisions being made and the leader making them with the team.

- **Reduce the risk of moral injury/distress** - originated in the military and is defined as the psychological distress which results from actions, or lack of them, which violate someone’s moral or ethical code. Those who experience this as more likely to experience negative thoughts about themselves, as well as intense feelings of shame, guilt and disgust which contribute to depression, PTSD and even suicidal ideation. Understanding what this is and strategies for preparing for this have been shown to be effective in reducing the impact e.g. there will be complex decisions that need to be made and this is how we will do that and making time and space to reflect on difficult decisions e.g. through compassion circles or Schwarz rounds.

- **Normalisation** of the feelings that people are having and preparing for the potential distress that people may experience. Offering self-help and the importance of distraction, coping and resilience strategies e.g. distraction, talking to colleagues, sleep, hydration and exercise and diet. *This is especially important in the preparatory phase where some hospitals are in ‘active’ stages and at capacity with others having empty beds and, in the waiting /prepare mode, anticipatory distress is likely to be higher.*

- **Leadership and Teamwork** – A focus on fostering team cohesion will be critical – the functioning of the team under crisis and ensuring that team members can rely on each other to notice if one of the team needs help or additional support. The natural leaders for this role may not be the most senior or usual leader in the team, enabling the right people to lead in the crisis team is critical.

2.4 **Active phase**

- During the **active phase** which is the ‘eye of the storm’ in terms of demand, there is little ‘head space’ for staff to attend to their own wellbeing as well as the care needed for patients and their families.

- The situation is considered urgent, there are expectations of patients, families and colleagues and not to be thinking largely about oneself. This may again differ for our response as we will have many of our staff who are impacted personally and may feel conflicted by this stage and being immersed, potentially at the detriment of their own families.

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• This is likely to be the most significant area of differentiation for us as evidence and experience have relied upon limited active periods. Our phase is likely to be longer and less predictable and so we will need to monitor activity well here.

• Messages that focus on individual wellbeing or ones considered largely focused on psychological health are not received as well as collective - ‘we need you to stay well’ to make sure you can return tomorrow for our patients. An example of this is in the firefighter’s response to 911 where they continued to work and expose themselves despite the detrimental impact on their own health.

• We need to move away from the ‘NHS workers are heroes’ narrative that is developing as this is likely to increase the perceived pressure on our staff to work beyond what would be safe and good practice for them.

• As staff are unlikely to be paying attention to their own needs, we will need to be physically managing breaks and rest periods, providing food and physical care.

• It is also worth noting that given what we know about the concerns of our staff around their own families, alleviating the burden by paying attention to individuals welfare needs is important.

• During an active phase of combat, the military works with those people showing signs of intense stress using the PIES³ approach (Table 1) – the approach assures that the psychological welfare is primarily the responsibility of the direct leader, applied to our setting this would be our line managers. It is intended to maintain the individual team members psychological health whilst ensuring those experiencing stress could return to operational efficiency as soon as possible.

• We know from current reports of the contexts our teams are working in that acute stress episodes are likely. Evidence from a 20-year longitudinal study in the Israeli Army shows that the more of the principles applied where army personnel were deployed (our active phase), the better the longer-term outcome for the individual.³

• Whilst we are not the military, the response that we will need to undertake will be more akin to a military deployment that our usual ways of working. The principles are closely aligned to compassionate workplace and would seem a good way of keeping providing support even in hard pressed acute wards.

<table>
<thead>
<tr>
<th>Proximity</th>
<th>Treating the individual by redeploying them into an operationally significant role but one that matters to the team, utilising roles of the line manager/team leader as a listening ear and confirm that ‘we are in this together’ – ‘this is normal’, ‘how can I help’</th>
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</thead>
<tbody>
<tr>
<td>Immediacy</td>
<td>Timely intervention of the above negates prolonged stress symptoms which could be enough to eventually overwhelm the ability to cope</td>
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<tr>
<td>Expectancy</td>
<td>Make sure that people know what is coming – ‘virtual’ tours of what the ward looks like now – prepare for the work ahead – ‘no surprises’</td>
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<td>Simplicity</td>
<td>Focus on meeting basic needs – ‘3 hots and a cot’ – are people rested, eating and being looked after physically – focus on a good night’s sleep (See Maslow’s hierarchy)</td>
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</tbody>
</table>
2.4. Recovery

- We know least about this area today but will use a data driven approach to model what we think is happening against clinical expertise in this area.
- We know that this phase usually takes place once the immediate threat or the active phase is over. This is based on short lived active phases and therefore we may see more of a presentation of psychological difficulties during the active phase.
- This phase is typified by the idea of survival, we got through, my patients and families no longer need my whole attention and self and therefore I can begin to think and reflect on what I have been through.
- After events we want to encourage teams to be actively monitoring their reactions and continue with our support offer for up to 18 months given what we know about the timescales of other serious incident demands.
- We will want to support understanding of normal stress responses to abnormal events and this this is something you can recover from without intervention. Even where individuals experience acute stress reactions to the events, this does not mean they will go onto develop PTSD.
- After the initial distress, approximately 50% of individuals will adapt (return to usual functioning) over a period of 3-6 months without any formal therapeutic input.
- The prevalence of PTSD following single incidents of trauma in the population would be between 9% for males and 16% for females.
- Stress and trauma responses vary within the population and are also based around previous levels of vulnerability which we will not be able to account for or guard against right now.
- Given the high levels of exposure to traumatic events, especially where staff are not used to this type of work, we anticipate higher levels than average.
- It is worth noting that some people who have encountered significant challenges, moral or traumatic will experience a degree of post-traumatic growth (Fig 2).
- Any work carried out to support traumatic stress response should link back into the line management to enable successful re-entry into work or redeployment as appropriate.

Fig 2: Spectrum of trauma responses
Appendix:

Fig 1: Three phases of support for responding to major incident

<table>
<thead>
<tr>
<th>What will be happening?</th>
<th>What support we will need to offer</th>
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<tbody>
<tr>
<td>• Worrying about own and family safety</td>
<td>1. Collective messaging is key – we are here, together and behind you</td>
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<tr>
<td>• Fear about the demand to come</td>
<td>2. Enhanced line management support – we will make collective decisions – I have your back</td>
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<tr>
<td>• Worry about what I/we will be asked to do</td>
<td>3. Safety provision, honest, open and transparent messaging about how we will keep frontline workers safe</td>
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<td>• Will I be enough? Will I be OK?</td>
<td>4. Expectation – preparing people for what is to come and how we will support them</td>
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<td>• Who has my back?</td>
<td>5. Line managers trained and ready to have psychologically informed conversations</td>
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<td></td>
<td>6. Teams who understand what is expected of them and how to work together well</td>
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<tr>
<td>• Intense and consuming periods of work</td>
<td>1. Physical provisions, prompts and messaging to support care of basic needs</td>
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<td>• Limited attention to own self and needs</td>
<td>2. Places to decompress – even if not frequently used – serves to emotionally contain and demonstrate ‘we are here together’</td>
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<td>• Guilt, remorse, worry about own performance and expectations of others e.g. families, colleagues, media</td>
<td>3. Clear protocols for normalising stress response opportunities for debrief and networks of support within the workplace</td>
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<td>• Thrive and growth – I got through this – every moment counts</td>
<td>4. Anonymous opportunities for discussions</td>
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<td>• Morale injury – I have had to make tough decisions had negative impacts and were beyond my control</td>
<td>5. Line managers trained in signs of stress and trauma – specialist psychological services equipped to respond</td>
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<td>• Survivor guilt – I made it through – why me and not them</td>
<td>6. Return to work strategies which may require short term redeployment</td>
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References


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