

“Going for Growth”

An outline NHS staff recovery plan post-COVID19 (outbreak 1)

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Introduction

There is good evidence from scientifically conducted reviews^{1,2} that the most predictive risk factors for the onset of post traumatic mental ill-health are those which operate after the traumatic incident is over. These main post-incident factors are: a. access to effective social support [including colleagues, supervisors, family and friends] and b. the pressure that people experience as they try to recover. Such pressures may include direct effects of the traumatic experience [e.g. moral injury, ill-health, bereavement] or secondary stressors [e.g. financial difficulties, relationship problems, altered working conditions etc.].

As such, whilst efforts to prepare and sustain staff ‘fighting’ COVID-19 are important, dealing effectively with the period after the most intense COVID-19 work is likely to be more critical in terms of reducing the likelihood that staff will become unwell whilst increasing the likelihood that staff will experience post traumatic growth³. During this ‘post’ period staff may reflect on what has gone on and develop a narrative that makes sense to them which may in turn reduce the chance they will suffer with moral injuries which have been highlighted as a particular risk during the current crisis⁴.

A poorly implemented post-COVID-19 plan, leading to seemingly false promises of support or of time to readjust to the new normal or managers making high work demands on staff who have been working ‘flat out’ has the potential to derail staff support efforts to date and to cause serious psychologically harm. Put another way, the unwritten psychological contract between NHS staff, their managers, and the public, has been that staff members will give their all to save lives and in return the nation will give them the support, and time they need, to be able to recover.

Alongside the specific points within this plan, there will be a need for staff members who have been working long hours in arduous circumstances to be allowed sufficient time to reconnect with family and friends and to ‘reset’ before they embark on their usual work. Such an approach, called post operational stress management (POSM)⁵ is used within the UK military. It consists of a staged return to duty after a deployment consisting of time informally mixing with colleagues, leave and then gradual reintegration into normal duties. The principles of a staged return to usual duties is likely to have merit in the current situation.

Recovery plans for staff will be needed on a group basis for hospitals or teams and on an individual basis for people who are not part of formed recovering teams. The latter also encompasses those who were not in the NHS prior to their COVID-19 work, and will not be afterwards; such as those who had returned

¹ Brewin CR(1), Andrews B, Valentine JD. Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *J Consult Clin Psychol.* 2000 Oct;68(5):748-66.

² Ozer EJ, Best SR, Lipsey TL, Weiss DS. Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. *Psychol Bull.* 2003 Jan;129(1):52-73.

³ Brooks S, Amlôt R, Rubin GJ & Greenberg N. Psychological resilience and post-traumatic growth in disaster-exposed organisations: overview of the literature *Journal of the Royal Army Medical Corps* *BMJ Military* 2020;166:52–56.

⁴ Greenberg N, Docherty M, Gnanapragasam S, Wessely S. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ.* 2020 Mar 26.

⁵ LAND POST-OPERATIONAL STRESS MANAGEMENT (POSM), April 2014. <https://bit.ly/2KLStms>

to the NHS and those in independent practice. It is important that NHS management and clinical leaders should also 'model' making use of the support processes to help build on the 'all in this together' message as well as to protect their own mental health.

The overall aim of the Going for Growth plan is the rebuilding of healthier organisations and teams. This aim is particularly important given that staff may be asked to deal with subsequent outbreaks of COVID-19 in the months ahead and need to be as psychologically ready to do so as possible. Recovery plans should include the following elements:

a. Any staff member who unexpectedly does not turn up for work should be proactively contacted

There is good evidence that people who are distressed by traumatic/challenging experiences can be avoidant either because of the triggers experienced by being back in a challenging environment or because their family express concerns about them going back to work and being upset. As such, all non-attendees should be contacted to by someone able to have a psychologically savvy conversation with the intent of identifying whether mental health difficulties are a possible cause of non-attendance. Those identified as possibly suffering from such difficulties should be either advised of the various welfare offerings (e.g. local and national offers) or if the apparent risk is high, then a mental health professional should be asked to call the individual back and carry out an assessment of need and risk. Whatever the nature of the conversation, all non-attendees should be resent information about the various welfare offerings.

b. Once someone completes their COVID-19 work they should be thanked, be provided with opportunities to informally mix with their colleagues and given relevant mental health and welfare information

It is appropriate for a senior manager to express sincere gratitude for the work that has been done during the current pandemic. This should be in verbal and written form. The letter of gratitude should acknowledge the challenge of the work the employee has done and the possible impact on the person and their families. It should also include information about possible indicators of psychological difficulties and information about the local and national offers of support. The letter should also address the use of the word 'hero' which some people find difficult to relate to and also alert staff that feelings of deflation, or indeed loss, may affect some staff after ceasing the intense work carried out during the crisis.

In addition, NHS organisations should ensure that all suitable opportunities are taken to hold one or more celebratory functions for staff and their families. The nature of these will be likely to vary between hospitals, clinics and medical centres and the functions will need to take account of physical (social) distancing measures that may be in place at the time. However, some (reasonable) element of these functions should be funded in a way that the NHS staff member is not required to contribute financially. The(se) function(s) will be a demonstration of gratitude from NHS managers to their staff and also provide opportunities for staff to informally speak to each other about the challenges they have faced which has been shown to be linked to better mental health⁶. Opportunities for informal interactions between staff should be encouraged in order to (re)build team cohesion which has also been shown to be protective of staff mental health⁷. Especially during the earlier stages of the recovery, managers should ensure that opportunities for informal interactions between staff members are encouraged. Such interactions may provide an opportunity to speak about the practical and emotional challenges which many have had to contend with since the crisis began.

⁶ Greenberg N, Thomas S, Iversen A, Unwin C, Hull L, Wessely S. Who do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military peacekeepers on return from deployment. *J Ment Health* 2003;12:565-73. doi: 10.1080/09638230310001627928

⁷ Jones N, Seddon R, Fear NT, McAllister P, Wessely S, Greenberg N. Leadership, Cohesion, Morale, and the Mental Health of UK Armed Forces in Afghanistan. *Psychiatry* 2012; 75 (1): 49-59

If the NHS is able to secure additional offers of gratitude from the community (e.g. discounts) which extend beyond the time that COVID-19 is affecting the country this too would be ideal. However, the NHS should also ensure that organisations/entities which wish to thank NHS staff are sincere and that NHS staff are not misled into buying items/services which are not fit for purposes [e.g. services seemingly sold as a discount but which in fact cost more] or which may inadvertently harm them [e.g. well intentioned psychological treatment services based on non-evidence based approaches].

c. Workplace supervisors should carry out a structured return to post-COVID-19 work interview

There is good evidence that having a supportive supervisor is good for one's mental health⁸ and a staff members' supervisor should have a discussion with them to get a clear view of the staff member's experience of working during COVID-19 and their recent state of mental health.

In some cases the supervisor will have been part of the same team as the staff member, but it is wholly possible that the staff member may have been redeployed, or had to work remotely, and their supervisor may have little or no knowledge of what the staff member has done. Supervisors should be provided with a structured template for the post-COVID-19 interview but should not make it a tick box exercise. All interviewed staff who appear to be distressed should be collaboratively helped to make an individualised recovery plan. This may include workplace adjustments, flexible working or indeed referral to mental health services, occupational health or elsewhere. Managers should refrain from making offers of support which they cannot deliver as this will likely cause, rather than alleviate, harm. In order to conduct these interviews, the NHS should ensure that supervisors are confident about speaking with staff about their psychological wellbeing; this may require further training for some. Managers should also provide information about the self-check process described below which can be accessed by NHS staff at any time. It is important that Managers actively support the various elements of the recovery plan and do not intentionally, or otherwise, undermine staff's belief in the likely benefits of the plan or the intentions behind it.

d. Staff should be written to again three and 12 months [and possibly later] post completing their COVID-19 work and be given information about how they can check their own mental health

It may be that although a member of staff manages to deal with the psychological impact of a crisis well whilst it is ongoing, subsequently they may either begin to suffer with mental health difficulties as they reflect on their experiences or they may become affected by secondary stressors which they had previously ignored. However, it is not always easy for people to recognise that they have a mental health difficulty and even when they do recognise themselves as having problems they may not wish to acknowledge that they have difficulties to their employer. Work carried out after the London Bombings⁹, and after more recent terror attacks in Tunisia, Paris, and Brussels¹⁰, suggests that a 'case finding' (often known as screen and treat) approach is an effective method of identifying those in need of professional support and helping them to access it. The National Institute for Health and Care Excellence (NICE) also specifically recommend active monitoring of individuals who have been exposed to potentially traumatic events¹¹.

⁸ Jones N, Seddon R, Fear NT, McAllister P, Wessely S, Greenberg N. Leadership, cohesion, morale, and the mental health of UK armed forces in Afghanistan. *Psychiatry* 2012;75:49-59. doi: 10.1521/psyc.2012.75.1.49 pmid: 22397541

⁹ Brewin CR, Fuchkan N, Huntley Z, Robertson M, Thompson M, Scragg P, d'Ardenne P, Ehlers A. Outreach and screening following the 2005 London bombings: usage and outcomes. *Psychol Med.* 2010 Dec;40(12):2049-57.

¹⁰ Gobin M, Rubin GJ, Albert I, Beck A, Danese A, Greenberg N, Grey N, Smith P, Oliver I. Outcomes of Mental Health Screening for United Kingdom Nationals Affected by the 2015-2016 Terrorist Attacks in Tunisia, Paris, and Brussels. *J Trauma Stress.* 2018 Aug;31(4):471-479.

¹¹ National Institute for Health and Care Excellence. Post-traumatic stress disorder. NG116. 2018. <https://www.nice.org.uk/guidance/ng116>

Given the large numbers of NHS staff involved in the COVID-19 response, there is likely to be benefit of a case findings approach using an anonymous confidential online screening tool which would be able to provide those using it with automated, tailored, feedback. The nature of the feedback would vary depending on the scores on the various psychometric tests within the screening tool. Making sure that the screening tool is hosted by a trusted party and is completely confidential could encourage those who might benefit from it to use it and to act on the tailored feedback. In order to this to be effective, feedback options would need to include a range of information and self-help materials, low level supportive interventions (e.g. Apps) and access to formal mental health assessment and treatment in a timely fashion if required. The NHS national offers would be appropriate to use as signposting options with local options (which may change) being available through a website which could be updated as required. Staff should be written to and strongly encouraged to check on their mental health after 3 months and 12 months and possibly longer depending on how the COVID-19 work progresses. However, the tool would be available for them to use at any time should they wish to until the service is deemed ready to be closed.

e. Taking account of staff who are in higher risk groups

Certain groups of staff may be more at risk of developing psychological difficulties than others. Work to identify higher risk groups has been carried out by NHS England and such groups include: a. Staff members bereaved by COVID 19; b. those in an already disadvantage groups e.g. BAME; c. those who lack social support/who are away from usual forms of support e.g. isolating or shielding away from family or apart from family for work; d. those who have returned to practice; e. the youngest and least experienced staff members taking account of any mismatch between their usual experience and the role they performed; f. those who have a pre-existing mental health condition; g. proximity to the delivery of care on COVID-19 wards especially where this is not someone's usual place of work; h. staff members who have been interacting with distressed or challenging members of the public; i. those individuals who experienced difficult or challenging relationships within their team during the crisis or as they return to more usual practice; j. staff who belong to the more hidden functions within an organisation e.g. porter services, mortuary attendants, reception/telephony staff and k. staff who have been unable to provide the support/care they would have liked to because of them being shielded or living with someone who was being shielded or in a higher risk group.

People in higher risk groups should of course have access to all the usual support options available to other members of staff but extra effort should be made to ensure that support plans are tailored towards their particular needs. Such tailoring may be done at individual or group levels. The structured return to work interview (discussed above) with a supervisor offers the opportunity to ensure that those in higher risk groups have their needs carefully considered and provided for. For instance, someone who had been bereaved could be specifically informed of the bereavement support line which forms part of the Our NHS people national offer (<https://people.nhs.uk/help/>) or someone who was distressed because of work they did which they felt ill-prepared for could be specifically signposted to the NHS virtual common rooms which provide a space for people to talk about the challenges of their work or supported to attend a locally run schwarz round which they may not feel able to attend without support.

f. Secondary stressors

Many staff are likely to have experienced a range of secondary stressors¹² such as problems with relationships, financial problems, educational difficulties experienced by their children, health problems related to COVID-19 directly or indirectly because of limited healthcare availability. Whilst employers may not readily be aware of who is experiencing such difficulties, once again the structured return to work interview provides an opportunity to ask about the presence of secondary stressors and support staff members who potentially may be affected by them. Helping individuals to problem solve to mitigate the impact of these stressors may be beneficial and supervisors who are cognisant of such difficulties

¹²Lock S, Rubin GJ, Murray V, Rogers MB, Amlôt R, Williams R. Secondary Stressors and Extreme Events and Disasters: A Systematic Review of Primary Research from 2010-2011. PLOS Currents Disasters. 2012 Oct 29 . Edition 1

can take account of them when organising rotas and the pace of someone's return to work. It is important to note that not uncommonly the onset of trauma-related mental health problems can be precipitated by secondary stressors¹³ and thus active management of them may have a considerably beneficial impact on a staff members mental health.

g. Time for reflection

Many staff will have found that the type and pace of the work they have done during the crisis has been such that they have not had many opportunities to reflect on the realities of the work they have been doing. There is very good evidence that people who can develop a meaningful narrative of their experiences are less likely to develop mental health difficulties such as moral injuries or associated mental health problems such as depression or Post Traumatic Stress Disorder¹⁴. In order to help staff members derive a positive meaning from their COVID-19 work, NHS employers should offer group discussions based on Schwarz rounds,¹⁵ which provide a forum for healthcare staff from all backgrounds to safely discuss the emotional and social challenges of caring for patients. These discussions should be led by senior staff members who can help both demonstrate that all healthcare staff may struggle with the work they do at times but also that when all is said and done when working in challenging conditions there may be no perfect or indeed ideal way to behave. Where possible such periods of reflection should focus on the 'unprecedented' situation as being 'to blame' rather than blaming oneself, a colleague, a manager or the NHS.

Conclusion

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. Putting in place a robust plan which communicates clearly to staff members that their employers, and the nation, are truly grateful alongside allowing them sufficient time to reset before embarking on more usual duties is likely to be highly beneficial. By letting staff know that 'it's ok not to be ok' and that the NHS 'has their back' may also help encourage those who need to access professional care to do so.

¹³ Tempest EL; English National Study on Flooding and Health Study Group, Carter B, Beck CR, Rubin GJ. Secondary stressors are associated with probable psychological morbidity after flooding: a cross-sectional analysis. *Eur J Public Health*. 2017;27(6):1042-1047. doi:10.1093/eurpub/ckx182

¹⁴ Williamson V, Murphy D, Stevelink SAM, Allen S, Jones E, Greenberg N. The impact of trauma exposure and moral injury on UK military veterans: a qualitative study. *Eur J Psychotraumatol* [Internet]. 2020 Dec 31 [;11(1):1704554. Available from: <https://www.tandfonline.com/doi/full/10.1080/20008198.2019.1704554>

¹⁵ Flanagan E, Chadwick R, Goodrich J, Ford C, Wickens R. Reflection for all healthcare staff: a national evaluation of Schwartz rounds. *J Interprof Care* 2020;34:140-2. doi: 10.1080/13561820.2019.1636008 pmid: 31390225