NHSGGC Mental Health & Wellbeing Action Plan 2020-22

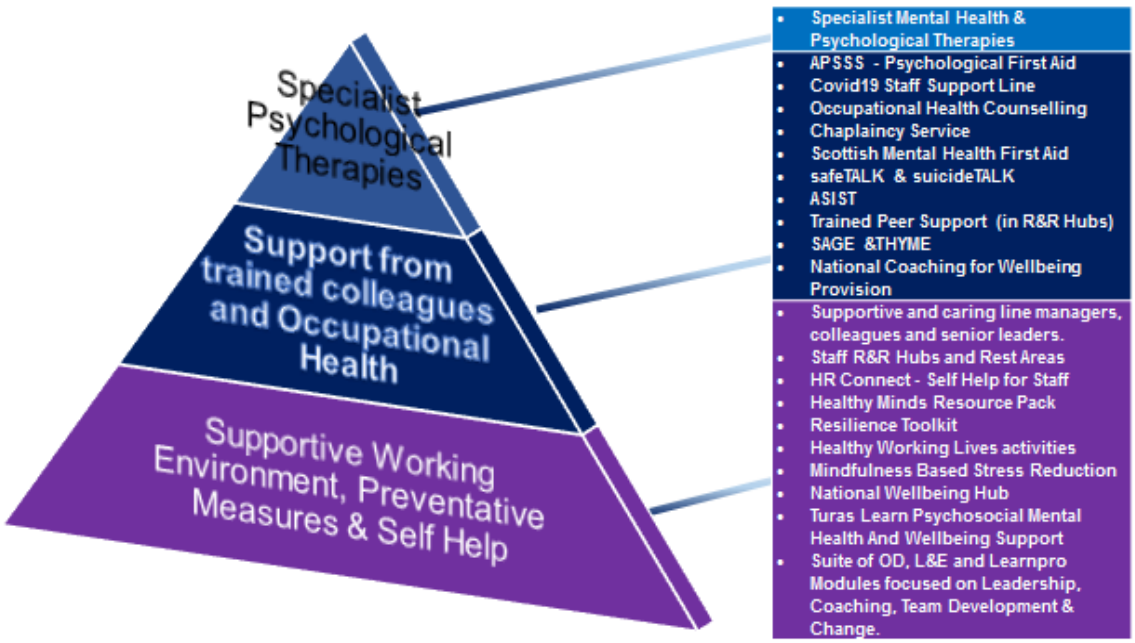
Introduction

This paper considers the longer term staff wellbeing and mental health impact of the Covid19 pandemic across Health and Social Care and examines the gap between the current support available and what will be required in future to support (intervene and treat)our staff using responses to the pandemic phases as a guide. The plan to address identified gaps is set out in the paper with all actions considered and agreed in partnership with Staff-side colleagues.

The plan has been developed with input from HSCPs and reflects their approaches to sustaining and improving staff wellbeing aligned to the principles of the NHSGGC – A great place to work framework.

In order to categorise the various types and levels of support it was felt helpful to have a model that places the activities into different tiers of support. The pyramid model proposed below also indicates that the bottom tier activities would be accessed more universally and the support becomes more specialised with lower demand as you move up the model.

Current provision



Gap Analysis Recommendations

A gap analysis was carried out using the Phased Model for Staff Wellbeing and Mental Health: COVID-19 (Appendix 1), particularly to prepare for the End Phase and Recovery Phase of the Covid19 crisis and to assess what support may be missing or needs to be further developed from current provision. The current (including recently developed) provision was found to be supporting the needs of staff well in the current stage of the crisis. This has included for instance the success of the R&R Hubs and the redirecting of the Psychology Service to support our own staff. In normal circumstances there is no Psychology support tailored for our staff and this gap will continue to be

addressed as we move forward. Further flexing during peak phase meant less psychology resource/sessions in the Hubs and more focused support for staff in the ICUs. Also the Psychology run Staff Support Line has been made available to all Care Home staff (including those in independent care homes), Scottish Ambulance Service, Golden Jubilee and NHS 24 Staff.

The gap analysis identified the following for consideration to address later phases of the crisis:

1. Sustain the Staff R&R Hubs and consider a staffing model (at least in the short term) that would enable peer to peer support conversations and also to use the Hubs to raise awareness of all the support provision available.

2. Continue to flex the face to face Psychology Service to the needs of various staff groups/teams who have been at the forefront of managing the pandemic.

3. Consider also the continuation of the All Staff Helpline run by Trauma Services and the resource implications of this.

4. Consider provision or access to provision by staff who are shielding or self-isolating and those feeling more isolated through working from home.

5. The model above lists many activities in the middle tier that are currently available but the gap analysis suggests more extensive usage of at least two of these would be of benefit:

    a. More training and use of Psychological First Aid by staff across Health & Social Care to enable more effective Peer Support conversations.

    b. Targeted use of Psychologist led team-based reflective practice models and also the roll out of end of shift 10minute Wellbeing Huddles as a routine for all patient facing care teams across Acute and in community settings such as Care Homes.

6. Define arrangements with the Psychology Service for carrying out a Staff Mental Health Check-in and Assessment Process at 3, 6 and 12 month timescale and mental health assessment and treatment/care pathway.

7. Consider what would be most effective support for Senior Leaders. This group is potentially high risk because they are not immune to stress caused by the crisis but are perhaps the least inclined group to access the available support mechanisms offered within the organisation.

Pandemic Phase	Mental Health & Wellbeing Related Actions	Lead	Resources	Timescale
Preparation /Pre Phase	Tier 1 Activities			
	1.1 Set up specific Covid19 Communications channels for staff, responsive, daily Briefs, FAQs	S.Bustillo	Corporate Comms Team	Complete
	1.2 Refresh Health & Wellbeing Web pages on Money advice, Mental Health & Wellbeing, Physical Activity at home.	L.Buck	Public Health Team	Complete
	1.3 Arrangements and discussions with staff for business as usual activity to cease and commence planning for reallocation of staff to Covid19 related/urgent activity and/or homeworking where possible. Accompanying support for managers.	All Senior Mgt Teams	Management capacity	Complete
	1.4 Change meeting types (e.g.MS Teams) and frequency across the organisation to ensure increased connection and support of staff by senior management.	All Senior Mgt Teams	IT and Management capacity	Complete
	1.5 Risk Assessments and HR guidance produced to prevent harm and to safeguard health& wellbeing eg homeworking RA & guidance.	A.MacPherson	HR & Health Improvement	Complete
	1.6 Programme of fit testing for FFP3 masks established across all sites.	R Wall	Health and Safety team	Complete
	Tiers 2&3 Activities			
	1.6 Psychology resources allocated to develop additional mental health and wellbeing support for staff.	R.Stocks	Reallocation of Psychology services	Complete

Mid Phase	Tier 1 Activities			
	2.1 Set up Staff R&R Hubs to allow staff to have a safe area separate from their wards or units to relax, reflect and recharge. Open to all staff across NHSGGC and HSCPs.	D.Mann	OD team set up with reallocated resources and donations	Complete
	2.2 Communications campaign, Core briefs, posters, leaflets detailing access to all wellbeing support arrangements.	S.Bustillo	Corporate Comms and printing costs	Complete
	2.3 Establish mini R&R areas next to Critical Care units to support staff unable to visit the R&R Hubs and organise support provisions.	D.Mann	OD Team	Complete
	2.4 Communications plan to include sharing of what different members of staff are doing to successfully cope.	S.Bustillo	Corporate Comms	Complete
	2.5 Development of a PPE modelling framework to ensure supplies of PPE available for clinical areas	C. Leese-Young	Procurement	Complete
	Tier 2 Activities			
	2.6 Organise reallocation of staff into the R&R Hubs, training in Peer Support and rostering onto 24/7 shift cover in each Hub. Incorporate Project Wingman Aircrew Volunteers onto shifts.	D.Mann	£5k training costs (OD)	Complete
	2.7 Implement models of Psychological First Aid via a variety of face to face, near me attend anywhere and staff helplines. APSSS and Health & Social Care Staff Support Line.	R.Stocks	Reallocation of Psychology Resources	Complete
	2.8 Establish 7 day Chaplaincy Service phone line for staff and patients cross system.	D.Allan	Chaplains	Complete
	2.9 Range of targeted staff support packages and services developed, grounded within Psychological First Aid.	R.Stocks	Psychology Resources	Complete

	2.10 Development and launch of a social distancing guidance document with an embedded risk assessment process	K. Strannigan	Health and Safety Estates and Facilities	Complete
	Tier 3 Activities			
	2.11 Implement face to face Psychology Service Support provision in the R&R Hubs.	L.Reynolds / E.Murray	Reallocation of Psychology Staff	Complete
Peak Phase	Tier 2 Activities			
	3.1 Extend Health & Social Care Staff Support Line to all Care Home Staff (inc. independent care home staff).	L.Reynolds	Reallocation of Psychology Staff	Complete
	3.2 Web content developed for Care Home staff on Health & Wellbeing, Money Advice.	D.Schofield	Public Health Team	Complete
	3.3 Agree plan for additional provision or access to provision by staff who are shielding or self-isolating and also for those employees feeling more isolated through working from home to support them with the impact of this change to their normal working lives.	R.Wall / S.Reid	Occupational Health	End July
	Tier 3 Activities			
	3.4 Provide co-located face to face Psychology Support Service to Critical Care areas to support staff most impacted.	L.Reynolds / E.Murray	Psychology staffing reduced in main R&R Hubs to enable Critical Care support.	Complete
End &	Tier 1 Activities			

Recovery Phases	4.1 Establish overarching NHSGGC Mental Health & Wellbeing Group to oversee a joined up approach to planning and implementation of activity and connect to National Wellbeing Champions Group.	A.MacPherson	Group members	Complete
	4.2 Develop NHSGGC cross system Mental Health & Wellbeing Plan for Recovery Phase.	D.Mann / R.Wall	Group members	End July
	4.3 Set up Short Life Group for establishing permanent R&R Hubs inc. Estates, Capital Planning, Facilities, Staff-side. Also input from, for example, Art in Hospital and other arts initiatives that have already been using the arts to enhance wellbeing during Covid.	D.Mann	Group members	End July
	4.4. Using info/feedback from an evaluation survey, gain executive agreement in principle for the permanent operation of R&R Hubs and apply for Endowment funding for developing permanent spaces and operating. Revenue and Capital Funding Bids to be submitted.	A.MacPherson	Initial £45k of £150k Revenue granted from Endowments. Capital requirements still tbc.	End August
	4.5 Connect the Wellbeing plan to the NHSGGC Workforce Strategy including Leadership development for Staff Wellbeing, engagement and communications as part of *NHSGGC – A great place to work* and developing recovery and wellbeing plans within the HSCPs. Report to SEG and SG Committee.	D.Mann / R.Wall	OD and OH input.	End August
	4.6 Work with an identified group of Senior Leaders to define and develop mental health support provision for that group.	D.Mann / I.Hyslop	OD Planning/ Resource	End Sept
	4.7 Agree proposals and for a revised cross system Staff Mental Health Improvement programme including management training and capacity building, a communications campaign and further development of online resources.	L.Buck / T.Lakey	Health Improvement Teams	End Sept
	Tier 2 Activities			

	4.8 Peer Support Framework Action 1: Agree proposal and plan to develop team *20 Minute Care Space* for staff within care homes. Endowment application to fund backfill of staff qualified to facilitate.	R.Stocks / S.Conachan	Backfill staff funding: £141k	End July
	4.9 Peer Support Framework Action 2: Agree, plan and commence roll-out of 10minute end of shift *Wellbeing Huddles* as a minimum for all patient facing care teams in Acute and HSCPs (inc. Care Home Teams) facilitated by all local Team Leaders (Simple format and training)	R.Stocks / S.Conachan / B.Young	Included in above funding application plus use of existing L&E and local resources for training.	End Aug
	4.10 Peer Support Framework Action 3: Develop a proposal for provision of Psychological First Aid (PFA) training as an offering for members of staff or staff groups to enable better Peer Support / therapeutic conversations. Include HSCPs to link with their Local Authority to ensure their equivalent L&E teams are engaged.	R.Stocks	External training costs tbc. (To be covered by existing budgets).	End Aug
	4.11 Peer Support Framework Action 4: Agree resources/plan for Psychology to maintain face to face Psychology support for staff during Recovery Phase whilst also returning to normal business and dealing with backlog of referrals. In addition the development of peer support across Acute services including team specific group wellbeing sessions and reflective practice. Endowment application for 1.5 wte additional Clinical Psychology resource for 2 years submitted.	R.Stocks / S.Boyle	1.5 wte Clinical Psychologists for 2 years = £212k	End July
	4.12 Agree proposals and plan for additional provision of Mentally Healthy Line Manager Training.	L.Buck	Public Health Team	End August

	4.13 Agree proposal for additional resources within Occupational Health to support the workforce. Identified as 3 WTE Cognitive Behavioural Therapists for 2 years. This will be implemented on a phased basis	R.Wall	£260K	End August
	Tier 3 Activities			
	4.14 Develop SBAR with proposals for Staff Mental Health Check-in and Assessment Process at 3, 6 and 12 months. Survey, data collection and scoring using (if possible) existing NHSGGC platforms (Webropol/iMatter team data) for the Online Check-in tool. 3 month check in to start in August. SBAR proposal to include additional Psychology resource to undertake specialist assessments from the Check-in Process and referral on to relevant local mental health service for provision of formal psychological therapies or other treatments for those who need them. Reciprocal cross-Board arrangements for 'highly visible' staff who require anonymity. Involvement of staff-side in Social Care will be also be required.	L.Reynolds	Recommend 2 wte Clinical Psychologists for 2 years = £283k	End July

Appendix 1

Phased Model for Staff Wellbeing and Mental Health: COVID-19

Introduction

Predicting the psychological and mental health impact of COVID-19 on staff and on the public is extremely difficult due to its ongoing and unprecedented nature. Literature, evidence and guidelines drawn from military, major incident/ mass casualties, disasters or other public health events struggle to generalise to this current, worldwide pandemic.

What we can predict with reasonable certainty is that most staff and the majority of the public will cope and recover naturally from COVID-19 without developing mental health /psychological difficulties and without requiring any formal psychological intervention. Some staff will develop post traumatic growth following this experience (positive transformations following traumatic experiences) and unfortunately some staff will develop longer term mental health difficulties which will require evidence based, often high intensity treatments/interventions from appropriate services.

At time of writing we are within the Mid Phase of this pandemic and this paper aims to start planning staff support responses based on projected demands from mid, through potential peak, into end and finally the longer term /recovery phase.

Phases of the Pandemic

The research and literature into this pandemic often refers to different phases of the pandemic. Although there is often a difference in the number of phases described and in the terms/words used to describe the phases the constant message is that, for the majority of staff, their wellbeing and mental health experiences will be stable throughout and after this pandemic. However, some staff may notice changes to their wellbeing or mental health during or after the pandemic. These changes may be experienced by staff at all levels of the organisation. The staff support response should be targeted and reactive to these changes

Wellbeing and Mental Health of staff

Although it is accepted that staff mental health, occupational health and wellbeing are intrinsically linked and will continue to influence each other throughout and after this pandemic it is useful to separate them to enable us to ensure we have appropriate responses to a wide range of staff needs which may or may not change over time. Some staff wellbeing supports which have been put in place in response to COVID-19 should continue long after COVID-19 e.g. visible management and R and R centres. Mental health responses should be appropriate to the mental health needs of staff at the various phases of the pandemic and should consider the evidence base and intensity of interventions. This response is predicted to change over time with the prospect of a

significant increase in demand for services such as Occupational Health and Psychological therapy services as well as specific clinicians such as Clinical Psychologists and psychological therapists.

Preparation/Pre COVID-19 Phase: A full breakdown of staff challenges, recommendations and management /corporate responses can be found in Table 1 of this document. This paper will focus from current phase forwards.

This is a planning and preparing phase prior to COVID-19. This phase is now over.

Mid Phase

This stage is when we start to experience many new cases of COVID -19, many new admissions into hospital with COVID-19 and unfortunately many new deaths related to COVID-19. There is an increase in the demand for PPE, healthcare services and partner services. The core business of all services has been altered and staff are getting used to new roles, remit and new 'norms.' We aim to avoid overwhelming this capacity and hence the Peak phase.

Some staff enter this phase with a sense of rising to the challenge and we will see an increase in teams crossing boundaries and coming together with a new camaraderie. As this phase continues and staff are faced with increasing workload, less breaks, new scenarios and new roles they may start to neglect their physical and psychological self-care. Fear of infection, implications for family and tensions from home and wider family may overrun work life and as staff move to different areas of the organisation they may experience a temporary loss of supportive, established colleague relationships, which may lead to an increased vulnerability to stress and risk of developing difficulties with mood, anxiety and sleep.

A full package of support should be made available for staff extending from, low intensity/wellbeing supports such as R and R centres where staff can relax and recover within a safe environment, have the opportunity to restore basic human needs such as exercise and food and engage in peer to peer supportive conversations, to the use of higher intensity staff supports such as staff support helplines and remote one to one psychological sessions. Psychological First Aid principles should be utilised to develop a confidential staff support helpline and remote face to face sessions. Having trained Clinical Psychology staff to respond to a wide range of needs and who can, through their core training, also identify the early presentation of mental health difficulties and risk is helpful. Easily accessible resources, advice, psychoeducation and coping skills is also recommended. Whilst continuing to monitor PPE provision and staff support senior managers /execs should also be identifying any gaps in staff support. Regular communication /staff briefings is recommended ensuring senior staff are visible and approachable.

Peak Phase

This is when demand on our equipment, staff and services outweighs capacity due to number of cases. Staff can become overwhelmed and the risk of psychological harm to staff is high. Moral distress and injury are a risk as healthcare becomes limited and people are unable to act and respond within their own moral and ethical code, death and dying may not be handled in the way it is usually (with family etc). Staff may begin to feel emotionally disconnected from the work, experience compassion fatigue and may engage in avoidant and unhelpful coping including alcohol and substance misuse. The personal and familial impact of COVID-19 may also be impacting staff wellbeing and mental health. The full range of staff supports should be available during this time with the option of increasing or decreasing the intensity of the intervention in a matched care model of delivery.

End Phase

As we gradually experience a decrease in new cases, hospital admissions and deaths due to COVID -19 staff who have been working throughout this crisis may be close to exhaustion and burn out. Again managers, team, leaders, supervisors and peers should be checking in with each other and exploring how the other person is coping. The full range of staff support measures should continue with the early identification of staff members who require a more formal psychological intervention being matched to an available evidence based service/intervention.

Long Term/ Recovery Phase

All staff should continue to benefit from some of the staff wellbeing inputs and developments that were developed following COVID-19. Visible, compassionate management and valuing staff through regular thanking or improvements to the staff working environment are essential to long lasting staff wellbeing.

Most staff and the public will recover naturally from COVID-19 without requiring any formal psychological intervention, some staff will develop post traumatic growth following this experience and, unfortunately, some staff will develop longer term mental health difficulties which will require evidence based, often high intensity treatment/intervention from appropriate services.

It is impossible to predict the number of staff who will develop psychological difficulties requiring intervention and treatment due to the fact that this is an unprecedented event and we are only learning about the longer term staff psychological impact from countries that have also recently went through this pandemic. Major incident, mass casualties, disaster and military literature and data are limited in their generalisation to this event however predict that there could be as many as 20% (figures from this literature range between 10-20%) staff and members of the public who will require psychological and psychiatric treatments following COVID-19. It has also been suggested that due to the ongoing nature of COVID-19, the already high number of deaths relating to COVID-19, the interpersonal and familial impact of COVID-19, the financial consequences for many of COVID-19 and the fact that normal bereavement, religious and community supports/ mechanisms have been unavailable due to COVID-19 that this figure could be higher.

The scope of mental health difficulties that could develop should also be considered when proposing longer term service demands. Whilst again, I will note that most staff will recover well following COVID-19 the literature and evidence would suggest that people may present with a variety of mental health

needs including but not exhaustive: depression, anxiety disorders, traumatic grief, moral injury , adjustment disorder, post-traumatic stress disorder, alcohol and substance misuse difficulties and /or marital/familial breakdown difficulties.

Guidelines and recommendations do inform us however, that early intervention and matched care to evidence based approaches are essential to reduce the severity and impact of these mental health difficulties. Literature also advises us that some of those staff members most at risk of developing mental health difficulties are the last people to ask for help. To counteract the impact of this 'hidden demand' screening procedures have been implemented at 3 , 6 and 12 months following these events to 'catch' those who have not voluntarily came forward for support but to also identify and monitor staff members symptoms to enable early intervention.

A screening process would involve all staff members covering all HSCPs within GG and C area being sent a screening tool which they would be asked to complete and return. This tool will measure general mental health difficulties and psychological functioning. If this tool identifies high levels of symptoms and /or low levels of psychological functioning the staff member would be asked to attend a mental health assessment and matched to appropriate support /service. This tool would be repeated at 3, 6 and 12 months allowing reluctant staff multiple opportunities to self-identify as well as the identification of late onset/ exacerbating symptoms.

The longer term staff mental health impact of COVID-19 will place resource and service demands on a variety of NHS GG and C services and clinicians. It is essential that we have the resource, staff, skill mix and systems to support staff through this final phase of COVID-19. Prior to COVID-19 services supporting staff wellbeing and mental health including Occupational Health teams, mental health services and psychological therapists were already stretched and had capacity difficulties. Moving forward we envisage these stretched services to be further stretched in terms of capacity due to staff sickness, capacity reduction due to longer term social distancing and in the increased demand from existing service users, new demand from the public relating to COVID-19 and new staff support demand. As the Scottish and UK Governments pledge resource to mitigate the financial and physical costs of COVID-19, the mental health costs should not be minimised or ignored for all but especially for the health and social care staff who have worked tirelessly throughout this pandemic and without whom the death and illness costs would have been so much worse.

Options/Resources

Board-wide covid-19 specific, staff group interventions e.g. staff covid-19 anxiety group
Psychology Bank Staff

Table 1: Staff Wellbeing Mental Health Challenges and recommendations by Pandemic Phase

Pandemic Phase	Technical Capacity	Staff Challenges	Needs/Recommendations	Corporate Actions/ Senior Managers/Execs
Preparation/Pre Phase	No known cases in UK/Scotland **Focus**: Planning, anticipating and preparing **Actions**: Simulation("dry runs") of safety protocols and procedures e.g. PPE provision and fitting	Anticipatory anxiety Increased Stress: e.g. If PPE/fit testing delayed Feel overwhelmed at prospect Physical/emotional signs of tension Information overload vs. lack information Communication and concentration difficulties "Readiness Burnout" Reasonable identification of limits to practice Potential fear of reprisal relating difficult decisions May already be struggling due to work or pre-existing mental health difficulty Concern over	Encourage self-care Good advice regarding COVID-19 safety protocols Start regular supportive meetings with colleagues Commence End of Shift briefings, huddles and regular supportive team meetings Ensure staff are aware of range of support options available including Occupational Health. "Marathon not a sprint": maximise regular rostered short periods of leave and annual leave whenever possible Clear communication channels with clear escalation if needed	Develop regular communication channels FAQs updated daily with option to feed into process Develop Media Plan: focus on certainty, transparent, honest Remove non-urgent business as-usual tasks 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. 'Open door' policy in person/remotely Senior staff highly 'visible' and approachable

		transmission to vulnerable relatives		
Mid Phase	Many new cases Daily Strain in technical capacity due to insufficient equipment and staff sickness, covering for colleagues and redeployment **Focus**: Ensuring frontline services are not overwhelmed **Actions**: Support staff wellbeing and mental health Ensuring staff safety through PPE provision and social distancing work environments.	Staff being faced with new scenarios/ roles Staff lose usual hours and breaks and start to overwork Staff neglect physical and psychological self-care as they feel it is not a priority. Tensions at home and within wider family may over run work life. Stress has a cumulative effect and smaller things trigger reactions. Pre-existing mental health difficulties and vulnerabilities are at higher risk of crisis and suicidality Running on empty and starting to burn Out Fear of infection and implications for family.	Range of targeted staff support packages and services grounded within Psychological First Aid. Set up R and R centres and hubs to allow acute staff to have a safe area to relax and reflect within. Focus on supportive teamwork Encouragement of peer to peer support. Implement models of Psychological First Aid via a variety of face to face, near me attend anywhere and staff helplines. Ensure staff have access to a range of psychoeducational and coping resources which normalise psychological reactions and matches need with support. A wide range of supports around financial advice, housing, domestic abuse, legal and emotional coping. Management and Team leads are visible and offer regular communication briefings, supervision and support. Clinical/ Management/ Professional	Active monitoring of staff wellbeing and PPE availability standing agenda item COVID- Active identification of gaps in staff support package and adapt/ extend staff support to all care groups of staff. Management Meetings Regular communication channels and consistent Media Plan as above Ensure successes are shared, no matter how small Vigilant to monitoring resources adequate Awareness of own wellbeing and mental health and accessing own support

			Supervision is prioritised Team specific interventions to increase resilience and improve team building such as reflective practice Managers, supervisors are '' available'.	
Peak Phase	Case overload ++++ Insufficient Capacity due to patient numbers Challenging ethical decisions required Focus Compassionate management and continued staff support Actions: Support Senior/ Execs staff to enable strong leadership and staff support through peak phase. Support staff wellbeing and mental health to prevent the development of longer term psychological difficulties Continue to support staff	Highest risk of psychological damage Moral distress and injury are a risk as healthcare becomes limited and people are unable to act and respond within their own moral and ethical code and death and dying may not be handled in the way it is usually (with family etc.) Staff may begin to feel emotionally disconnected from the work, experience compassion fatigue and may engage in avoidant and unhelpful coping. High levels of adrenaline and on "automatic pilot" they may experience sudden exhaustion.	Range of targeted staff support packages and services grounded within Psychological First Aid. R and R centres and hubs to allow acute staff to have a safe area to relax and reflect within. Focus on supportive teamwork Encouragement of peer to peer support. Offer Psychological First Aid via a variety of face to face, near me attend anywhere and staff helplines. Occupational Health and Human Resource help and advice lines available. Ensure staff have access to a range of psychoeducational and coping resources which normalise psychological reactions and matches need with 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 staff to allow to stay at work Redeploy some staff to support staff caring for COVID-19 patients Liaise with external bodies

	safety and staff family health through PPE and safe working environment.	Distressed due personal impact Feeling overwhelmed May feel unable to cope Staff 'running on empty' & burnout Potential work conflict due to excess stress Potential fear of reprisal relating difficult decisions	Management and Team leads are visible and offer regular communication briefings, supervision and support. Managers, supervisors are available. Supports are in place to Identify and refer any staff members with mental health difficulties e.g. new or exacerbated pre-existing difficulties for treatment.	as required. Awareness of own wellbeing and mental health and accessing own support
End Phase	Technical capacity OK • Minor ethical dilemmas	Most staff will recover following a normal recovery trajectory Some staff will develop post traumatic growth Some staff may feel exhausted and have burnout Some staff will have retrospective guilt Potential fear of reprisal relating difficult decisions Some staff requiring	Continue to offer staff wellbeing interventions such as R and R centres, access to mental health information, resources and support. Ongoing Occupational Health Service Ongoing helpline , remote face to face support Compassionate Management Watch and wait and refer to formal mental health /psychological therapies if and when required. Services are in place for staff developing	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 'Open door' policy in

		psychological and psychiatric interventions for new /exacerbation of pre-existing mental health difficulties	mental health difficulties	person/remotely Awareness of own wellbeing and mental health and accessing own support
Long Term/ Recovery Phase	Full technical Capacity Still reduced staff functioning/reduced numbers Increase in demand from public and staff on reduced capacity (social distancing environments, longer term lockdown restrictions) services. Actions Resource services to respond to both staff and public mental health consequences of COVID-19. Actively identify and intervene early with staff members who require	Expect a delayed response both post traumatic growth and post trauma mental health difficulties. Most staff will recover following a normal recovery trajectory Potential for the development of a wide range of mental health difficulties which will place demand on many services e.g. Occupational Health/Psychological therapy services Requires access to evidence based psychological therapies.	Focus on supporting self and others utilising Psychological First Aid supports, interventions and resources. Compassionate Management Screening process at 3 , 6 and 12 months Increase and / or develop capacity within services to deliver this mental health response. Refer to appropriate services for evidence based psychological Intervention if and when appropriate	Managers need support and coaching to avoid inadvertent overbearing approach. Open door on offer as needed Continuation of staff wellbeing interventions which staff benefited from.

	mental health intervention/ support through screening process. Ensure clear pathways, systems and service provision for staff who require this.			