



PCCS Mental Health Support Best Practice Framework

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Overview

NHS staff experience higher levels of stress than other workers, with 40% of staff reporting work-related stress (NHS Staff Survey 2020 - pre pandemic), due to a number of factors.

Frontline healthcare staff working in paediatric critical care services (PCCS) face a range of stressors including traumatic exposure, moral injury, workplace stress and home pressures. These stressors currently come at a time when NHS teams are already stretched, often understaffed and when organisational morale may be far from ideal within the NHS as a whole.

It is important to consider three core elements of working conditions as they relate to health and wellbeing of staff as described by the Stevenson/Farmer Review (2017):-

1. The conditions which allow all staff to thrive at work.
2. Helping staff to manage reactions to work-related stressors.
3. The needs of an important minority of staff who are experiencing mental health to mitigate the impact of work on their mental health.

This document written by the Paediatric Critical Care Society Wellbeing Special Interest Group outlines the psychosocial resources that PCCS might put in place to support staff, to help them manage their reactions to work related stressors, and to mitigate the impact of the work on pre-existing or new mental health problems. Recommendations in this document are intended as advisory only; implementation in PCCS may vary based on local needs and the resources available.

Core Conditions to Thrive at Work:

All NHS staff require core conditions of work in order to thrive and achieve a positive wellbeing. Evidence shows us that these core conditions are related to:

- a. Leadership: The relationship with managers and supervisors, and the right leadership approach, is the strongest predictor of workplace wellbeing.
- b. Staff engagement: Staff need to experience engagement and belonging in the workplace. This includes staying informed and keeping up lines of communication and involvement.
- c. Job design and job related resources including equitable access to education and career development, but especially the correct safe staffing levels.
- d. Environmental factors such as staff room, lighting, space, and access to food, hydration and rest facilities.
- e. Interpersonal relationships at work and workplace culture.

Please see the Intensive Care Society “Wellbeing Best Practice Framework” (endorsed by the Paediatric Critical Care Society) for further information:

https://www.ics.ac.uk/ICS/Pdfs/Workforce_Wellbeing_Best_Practice_Framework

Staff support needs to manage reactions to work-related stressors

We suggest that each unit develops a small cadre of experienced wellbeing staff from a range of backgrounds including frontline clinical roles. Members of this Wellbeing Support Team (WeST) should have had specific training to support staff, such as a Peer Support Model (see Peer Support section below). This team should be led by a nominated Wellbeing Lead, who should ideally be a psychologist but might be another senior leader in the PCCS (see ICS document) with a specific interest in staff wellbeing. Resources will vary between institutions but WeST staff might include senior members of the MDT, psychologists, family liaison nurses, chaplains or employee wellbeing counsellors already employed by the Trust/Health Board. PCCS teams should work closely with their affiliated Occupational Health (OH) services to oversee the delivery of the recommendations below.

Part One: Primary Prevention Measures

Primary prevention refers to interventions which aim to promote a positive experience of work and avert any possible psychological damage; secondary intervention focuses on those who are experiencing distress reactions to the workplace as they happen, and tertiary interventions are designed to help individuals restore to their baseline level of functioning, or manage the work-based exacerbation of mental health problems at work.

Induction and Education:

There is good evidence that frontline, trauma-exposed¹, staff are likely to gain some benefit from being made aware of the realities of the work they are being asked to do and the associated psychological challenges of their work. This requires those in

¹ Traumatic situations are ones involving death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence once or on multiple occasions. In their course of their duties, staff may be exposed to traumatic situations directly, as a witness or through indirect exposure to aversive details of the trauma in the course of their professional duties.

positions of responsibility to be upfront about what the likely occupational exposures might be and not to either over- or under- state the traumatic nature of a particular role. Briefings to new staff members should include discussion of the moral and ethical challenges of working in PCCS and the likely workplace pressures and traumatic exposures.

PLAN:

1. All staff prior to starting a job in a PCCU should be given a clear indication of the nature of the work and what is expected of them. This could include a member of staff being part of the interview panel and outlining some of the traumatic experiences at work or including this information in a pre-employment pack.
2. All new staff joining a PCCU should attend induction to make them aware of the challenging role they will be undertaking. 'Non sugar coated' information should be provided about the nature of the work mentioning specifically trauma exposure and the potential for moral distress and the support options available (see PCCS Website for links). In the current circumstances, the challenges of wearing PPE for extended periods and worries about COVID-19 should also be mentioned.
3. The induction briefing should ideally include a member of the WeST, who might advise on: the realities of the role, the challenges and associated psychological risks, self-help techniques including apps/information that might help (e.g. headspace, umind, sleepio, and daylight apps are currently free for NHS staff to access) and the other support options available to PCCS staff in both the NHS and charitable sectors. A key aim of this briefing is to ensure that all new staff understand that the unit they are joining take mental health of staff seriously and that seeking support and help when needed is part of normal practice within the team.

Screening:



The UK Paediatric Critical Care Society is aware that there is no role for formal pre-employment screening in predicting psychological vulnerability in trauma-prone roles. There is no evidence for undertaking employment screenings over and above the usual Trust OH processes.

PLAN:

4. Prior to joining the PCCS, the normal process of OH pre-employment screening should be undertaken. Any previous noted concerns about mental health should be flagged with the person's line manager, and ways to make any reasonable adjustments to support the person's mental health should be part of the manager's role.

[Peer Support and the Wellbeing Support Team \(WeST\):](#)

There is very good evidence that fostering cohesion between staff, both horizontally [camaraderie] and vertically [leadership] is consistently associated with good mental health. Essentially, much of the resilience of an organisation may lie in the social bonds between staff members rather than within individuals. It may also be helpful for frontline teams to adopt a buddy-buddy approach in which team members are paired up in order to check on each other's welfare as this can be an effective way of actively monitoring staff to identify early signs of distress. An active Peer Support system may also be of benefit.

PLAN:

5. If the buddy-buddy system is adopted, all staff should be told about it during their induction briefing. The induction briefing will encourage staff to take an active interest in each other's mental health and provide a brief outline of indicators that someone may be having trouble coping and instructed to not be

reticent in either speaking to the potentially distressed colleague or raising their concerns to a supervisor.

6. In units in which the buddy-buddy system is adopted, buddies will be asked to make active efforts to 'keep an eye on each other' for potential indicators of distress.
7. Units should consider a Wellbeing Support Team (WeST) model, where members of the team with an active interest are trained in wellbeing and mental health awareness, and are coordinated to offer peer-to-peer conversations. The WeST team members should be supported by ongoing supervision with a psychologist.
8. The WeST team should be empowered and encouraged to raise any concerns expressed by staff in relation to the "Core conditions to thrive at work" (see above) to the PCCS leadership team for action.

Supervisory leadership:

The best evidence for wellbeing at work is the relationship between staff and their leaders. There is evidence that emotionally intelligent supervisors and managers play a critical role in supporting the mental health of team members. Studies have shown that teams operating even the most arduous of environments are more likely to function well, and avoid the onset of serious mental health difficulties, if their supervisors create the right team ethos. Good supervisors have a range of important skills and attributes including looking out for team members' safety, communicating with team members regularly, not taking on extra work to make themselves look good at the expense of their team members and not criticising team members in front of others.

PLAN:

9. All team supervisors (e.g. nursing shift leaders and consultants) should be provided with training on topics such as active listening skills as well as a basic understanding of the likely impact of psychological trauma and exposure to significant moral/ethical dilemmas. This training should ideally be carried out by OH or by the PCCU psychologist to help supervisors develop the confidence to have a supportive conversation with staff about their mental health and to be aware of what to do if they identify a problem. The clinical team should regularly be offered such training; the nature of this can vary with need and circumstances, for example from face to face, through telephone or digital contact, to helping identify existing resources.
10. When appropriate (e.g. after a difficult shift), team leaders should carry out a post-shift review meeting with all members of staff which will include specific consideration of how staff are coping. This should not take the form of a formal psychological debrief. Staff should be enabled, but not forced, to share their experiences and care should be taken not to allow negative perceptions of one team member to distress others. It is important that these review meetings are seen as supportive rather than trying to identify whether someone is at fault or an attempt to apportion blame. Where someone appears to have been affected by the shift, team leaders should offer to speak with the individual on a 1:1 basis or to have another supervisor, or member of the WeST, call the person to speak at a more convenient time.

'Team training':

As well as developing individuals and team skills (e.g. resuscitation, infection control etc.) group staff training presents an important opportunity of fostering strong links between team members and helping staff develop a sense of being in control over otherwise unpredictable, and anxiety provoking, situations. Depending on local resources, the WeST or OH team should engage with the clinical and education teams to ascertain how they might usefully contribute to these: both directly through

developing mental health awareness, and indirectly through their expertise in interpersonal and team dynamics more generally.

PLAN:

11. Team training events should be used as opportunities to improve awareness of the psychological impact of working in PCCS and to foster camaraderie.

Wellbeing interventions:

There are a range of positive wellbeing techniques available to train in which include mindfulness, yoga and meditation and many other such interventions which have come into and out of vogue from time to time. Whilst the evidence supporting these approaches protecting staff mental health is relatively weak, it is likely that some individuals will find them enjoyable and it is unlikely that they will cause harm. However it is important not to consider these as sufficient interventions to support the mental health of staff.

PLAN:

12. As a positive addition, if possible, wellbeing training (such as mindfulness, yoga, meditation or similar initiatives) should be made available for PCCU staff and the free app-versions of these approaches should be advertised to staff who wish to make use of them. However, it is recognised that there is insufficient evidence to support such wellbeing interventions being strongly recommended or made mandatory.

Part TWO: Secondary prevention measures

Active monitoring:



It is anticipated that some staff may experience mental health problems including anxiety, depression, and post-traumatic stress disorder (PTSD). It is also possible that various other conditions such as psychosis and substance misuse will be seen.

The National Institute for Health and Care Excellence's (NICE) guidance on the management of PTSD recommends active monitoring of people who have been exposed to traumatic events in order to identify whether any early symptoms resolve [which is to be expected in most cases]. These acute stress symptoms can be part of a normal response to a traumatic event and may include anxiety, low mood, irritability, poor sleep, poor concentration and recurrent dreams or flashbacks. Where early symptoms do not resolve within a few weeks, individuals should be assisted to access sources of professional assessment and support.

Staff with any known pre-existing mental health problems should have a plan with their manager to actively support and monitor their mental health, just as they would a physical health problem.

PLAN:

13. If available, the WeST might consider systematically checking in with staff who appear to have struggled on shift; or who do not turn up to a rostered shift; and signpost as appropriate. The WeST should check on the staff member's psychological wellbeing in order to decide if: a. no further action is indicated: b. the team member is considerably distressed but is not content to make contact with their own GP and/or use nationally provided resources, in which case the WeST should continue follow up to nudge the staff member towards help and to encourage active coping or c. the team member is very distressed, speaks about a red-flag risk² or appears reticent to access support in which case a referral to the local OH team might be considered (if consent is given).

² i.e. significant risk to themselves or others including safeguarding risks.

Psychological debriefing.

The Paediatric Critical Care Society is aware that psychological debriefing, or post incident counselling, has been shown to be more detrimental to the psychological wellbeing of traumatised individuals than not being provided with any psychologically focused intervention at all. NICE specifically recommends against the use of psychological debriefing for the prevention of PTSD. However, it is important to distinguish psychological debriefing from leader-led operational review/clinical debriefing [i.e. identifying the reasons for specific outcomes and identifying ways of improving practice] which is likely to be a facet of good leadership and should thus be encouraged [see above].

14. Brief, operationally focussed post-event team reviews soon after an event (e.g. end of shift) may be useful as a “check in” after an incident. Formal psychologically focussed debriefing is not to be offered.
15. Staff benefit from the opportunity to reflect on the nature of their work, and so opportunities to attend Restorative Supervision and reflective case discussion (such as Reflective Rounds or Schwartz Rounds) where possible should be offered, but not mandated.

Screening:

Post incident psychological health screening aims to identify personnel who have developed early signs of, or have established, mental health difficulties in order to help them access professional care. Whilst this is well intentioned, there is no evidence that this approach works in organisational settings. It is likely that concerns about what employers will do with screening results, concerns about reputation and confidentiality and screening only being a ‘snapshot’ in time, which does not take account of the usual fluctuating course of mental health disorders, are some of the varied reasons why screening within organisational settings is not effective. Post incident screening, may also do harm by falsely reassuring employers that staff members are



psychologically healthy when this is not true. The Paediatric Critical Care Society is aware that post incident screening initiatives, or ongoing psychological health monitoring, is not an effective tool in workplace settings.

Training for the Wellbeing Support Team:

There are a number of protocols for training peers to actively monitor and support colleagues within the workplace. Examples of these are Trauma Risk Management (TRiM) which focusses on trauma assessment and the UK Intensive Care Society model¹ which offers a broader system of Peer Support. These programmes may have some utility in encouraging staff who are reticent to speak to their managers, or use more formal support mental health processes such as an Employee Assistance Programme (EAP), to speak about their difficulties. Members of the WeST may find it helpful to have training in one or more of these methodologies.

PLAN:

16. Members of the WeST should have completed a peer support training package and be 'in date'. A structure for supervision for the WeST team should be considered in each unit, to ensure that they do not become vicariously traumatised when carrying out their work, helping them to implement practical measures with staff members they are supporting and being available to discuss difficult cases with them in a supervisory relationship. Ideally, this should be with the local OH or PICU psychologist.

Overcoming barriers to seeking care:

There is considerable evidence that stigma, perceived fears about one's reputation and perceived vulnerability, and the potential impact on career can act as barriers to seeking help and support. A reluctance to seek help may be particularly evident in staff who work in routinely high-risk roles, as such staff may believe there is a need to be



psychologically 'strong' in order to maintain their reputation and indeed their employment.

PLAN:

17. Senior managers within the PCCS should, along with the WeST, implement a communications campaign aimed at reducing stigma, reminding staff to be alert for each other's welfare and of the various avenue of support available in order to encourage a culture of "It is okay not to be okay" and supporting each other. This campaign should be ongoing and use different forms of communication to achieve the desired effect and ideally done with local OH support.

Early Intervention:

Often simple support measures such as advising distressed staff to get a good night's sleep, communicate with a loved one, take some exercise or have a shower can have a substantial impact on someone's wellbeing and ability to continue functioning. It may also be possible to reassure staff with mild issues that these are normal, to be expected and not indicative of a serious mental health problem.

PLAN:

18. Where frontline workers have a significant exacerbation of mental health, likely to impact on their ability to carry out their role safely, they should be referred to the local OH department to assess these risks, which should be actively managed with care rapidly arranged. Should someone require a period of respite, or care, the aim should be for that to be as brief as possible. The PCCU management team should actively liaise with OH colleagues about fitness for duty options for staff members who have been referred.



PART THREE: Tertiary prevention (treatment)

Treatment:

The local OH team should follow evidenced guidelines for the assessment and initial treatment of any problems. In general, OH departments do not offer routine follow-up care (other than a limited number of counselling sessions in some institutions), and will rather be signposting and/or referring relevant individuals to appropriate NHS Mental Health pathways if required.

PLAN:

19. The local OH service should advise staff with significant psychological difficulties about how to access evidence based treatment locally or through the NHS primary care services.

Conclusions

In summary, PCCS should adopt a 'nip it in the bud' approach, avoid medicalising 'normal' distress, fostering and maintaining effective social bonds between team members and supervisors. Provision of psychological education is important as it is important to validate the normal response to stress. The WeST will act locally and expert advice and early assessment in order to support these aims should be available from the local OH team when needed. Where staff are unable to have their immediate mental health needs met by the WeST or OH team, follow on care should be arranged outside the Trust/Board. Additionally, it is imperative that research opportunities are considered and that staff are offered the opportunity to opt in to take part in research activities which will allow for better mental health support plans to be developed in future.



Annex A. WeST advice and support

Requests for support may come from team managers or by self-referral, although individuals considering self-referral will be encouraged to do so by managers or other trusted senior colleagues. Working to the 'nip in the bud' principle, it is anticipated that many requests for support will be managed by brief advice or reassurance.

On occasion, face-to-face conversations will be required, and suitable confidential space should be identified for this in or near to the PCCS. It is recognised that the nature of the shift-work means that staff might have short periods to see the team before being required to return to duty. The WeST will actively try work with this limitation to provide optimal flexible, rapid advice and support, potentially with follow-up at later more convenient times.

These conversations will not be recorded in detail by the WeST. The WeST should, however, keep records of the numbers and types of referrals, the basic demographics of those referred, and pathway outcomes. Data will be stored in accordance with information governance practice of the local Trust.

ⁱ www.ics.ac.uk/wellbeing