Wellbeing needs of medical trainees because of Covid-19

By Dr Chris Hewitt Associate Postgrad Dean

chris.hewitt@hee.nhs.uk

Executive Summary

- Mental health and educational wellbeing needs of medical trainees because of Covid-19 will include:
    - Anxiety
    - Depression
    - Burnout
    - Moral Injury
    - PTSD
    - Career Coaching
    - Support for impact on training and progression

- It is not possible to predict the volume of such needs. However, planning can be informed by research and experience from previous pandemics and major incidents.

- There has been a decrease in referrals to PSW during the Covid-19 pandemic; this may be due to trainees being immersed in clinical work or shielding and/or self-isolating. This could contribute to a backlog of PSW referrals when the first wave of the pandemic is over.

- HEE and the PSW are well placed to have a leadership role in informing and coordinating services for medical trainees.

- The resources and research articles considered for this briefing paper highlight that there is no reliable science or method to predict the extent of health and wellbeing needs of NHS medical trainees in response to the Covid-19 pandemic.

- There is likely to be a small number of trainees dealing with personal mental health reactions that will require rapid referral to experienced occupational health consultants and/or to senior psychiatrists and psychologists able to deal with issues triggered or exacerbated by Covid-19 related impacts on training and clinical work.

- Trainees and educators will need to be aware of the services available to them and to their own GP when they seek referrals.

- Occupational Health, psychiatric and psychology expertise need to be available to hospital, academic and primary care medical trainees. There needs to be a simple process for trainees in most urgent need to speedily access one-to-one assessment and support from professionals with experience and expertise dealing with PTSD.

- Trainees and educators and trainee's own GPs will need to be aware of the services and specialists available when they seek referrals for urgent mental health interventions for trainees.

Contents

Anticipating the volume and range of wellbeing needs of trainee doctors impacted by Covid-19

This briefing paper reviews the possible wellbeing support that may be needed for NHS medical trainees because of the Covid-19 pandemic. There is a review of research to identify the possible volume and depth of needs that may need to be addressed by the regional Health Education England team.

It is important that we anticipate and actively plan for an increase in the depth, breadth and volume of issues requiring the input of educational support and wellbeing services for medical trainees in healthcare caused by Covid-19. Planning proactive services that are able to intervene upstream to offer anticipatory interventions is preferable to reactive services, which may have limited capacity. Although it is impossible to predict the exact volume and nature of these needs, it is likely that there may be an increase in referrals to the PSW related to impacts of Covid-19 on individual trainees' mental health and on their educational training. Services led by Health Education England local Practitioner Support and Wellbeing (PSW) services will need capacity and strategies to stretch to meet the specific needs of trainee doctors related to impacts of Covid-19 both in relation to physical and mental personal wellbeing and educational support.

The Professional and Wellbeing Support Service (PSW)

The types of trainee issues that the PSW regional team in the East Midlands deal with include:

- **Performance and progression** (including communication, exam and management skills);
- **Behavioural issues** (confidence, leadership, motivation and team working);
- **Personal factors** (stress, bereavement, family concerns etc.);
- **Environmental issues** (workload, bullying, training programme issues etc.).

<u>Data from East Midlands PSW</u>

(Compiled by Thomas Hamilton 12th May 2020)

Total Referrals

1st April 2017 – 31st March 2018: 216 (Exams, Organisation, Communication, Confidence)

1st April 2018 – 31st March 2019: 258 (Exams, Anxiety, Dyslexia)

1st April 2019 – 31st March 2020: 264 (Exams, Anxiety, Stress)

Referrals in Covid-19 period (March, April and up to 12th May 2020)

2020: 37 (23 in March, 9 in April, 5 in May)

Same months in last 2 years:

2018: 45 (18 in March, 15 in April, 12 in May)

2019: 52 (26 in March, 25 in April, 1 in May)

There has been a decrease in referrals to PSW during the Covid-19 pandemic; this may be due to trainees being immersed in clinical work or shielding and/or self-isolating. This could contribute to a backlog of PSW referrals when the first wave of the pandemic is over.

Recent surveys of Mental Health and Wellbeing of Clinicians

BMA – British Medical Association

In a survey of members published on 14th May 2020, the BMA reported that 45% of doctors are suffering from depression, anxiety, stress, burnout or other mental health conditions relating to, or made worse by, the COVID-19 crisis[1]. This was followed on 20th May 2020 with the publication of:

The mental health and wellbeing of the medical workforce – now and beyond COVID-19[2]

This paper makes 10 key recommendations:

1. Supporting the mental and physical health of doctors and staff must be a top priority
2. There should be equal provision of wellbeing support services for all doctors
3. Health and wellbeing issues need to be monitored to ensure interventions are effective
4. Wellbeing support must be inclusive, accessible, and meet the needs of users
5. Occupational health services should be accessible to all and have a capacity to provide timely support
6. Staff presenting with significant mental health conditions must be able to access appropriate treatment 7. Workplaces should actively encourage peer support and mentoring to ensure doctors have a safe space for reflection
8. The process for taking sickness absence and returning to work should be as smooth as possible to reduce additional stress
9. Staff who need to take time off or would like to work flexibly should be supported
10. The NHS should be proactive in preventing suicide of NHS staff and supporting those who are bereaved

RCN - Royal College of Nursing

Over 4000 qualified and trainee nurses, midwives and health care assistants are actively participating in a three surveys contributing to research led by the University of Warwick and the RCN Research Society Steering Group. The *Impact of Covid-19 on the Nursing and Midwifery Workforce (ICON) study* is undertaking surveys that focus on conditions:

- before the peak of the pandemic;
- during the peak of the pandemic; and
- after the first wave of the pandemic.

According to a Nursing Times report of the preliminary survey findings[3] the first survey highlighted the impacts of reports of lack of training by nurses and midwives to deal with Covid with many reporting being under major psychological strain. In the second survey (28 April to 12th May 2020) 88% of respondents reported worry about risks to their families because of their clinical role; significant numbers reported depression, anxiety, stress and emerging signs of Post-traumatic Stress Disorder. In this mid-pandemic survey:

- 12% reported using NHS wellbeing Apps (including ~ *Unmind*, *Headspace* and *Sleepio*);
- 17% had accessed 'time out' rooms;
- 1% had used *Silvercloud - a digital mental health platform with behavioural therapy for anxiety and depression;*

In the Nursing Standard report on the RCN portal[4] a further report on this research concluded with a quote from one of the lead researchers, Daniel Kelly, RCN chair of nursing research and professor at Cardiff University's school of healthcare sciences. Kelly said that *"… the three-survey approach is important as it will examine what nurses might need when the crisis is over. We need evidence of the impact of COVID-19 on the nursing workforce otherwise we risk dealing with anecdote and media impressions. 'We need evidence to base reactions on.'*

The Challenges for HEE - the building blocks of a national response

Trainees in medical and dental specialty training will need additional support for their well-being as a result of the Covid-19 pandemic. The key messages were summarised in a BMJ analysis paper by Greenberg et al[5]:

- Healthcare staff are at increased risk of moral injury and mental health problems when dealing with challenges of the Covid-19 pandemic
- Healthcare managers need to proactively take steps to protect the mental wellbeing of staff
- Managers should be frank about the situations staff are likely to face
- Staff can be supported by reinforcing teams, and providing regular contact, to discuss decisions and check on wellbeing
- Once the crisis begins to recede, staff must be actively monitored, supported, and, where necessary, provided with evidence-based treatments

NHS Staff and Learners' Mental Wellbeing Commission[6]

In February 2019, twelve months prior to the Covid-19 pandemic, HEE published a major review of mental health provision for the NHS workforce led by Keith Pearson and Simon Gregory. The report produced 33 recommendations based around twelve key themes and issues as follows:

1. Preparing for transitions.
2. Diverse needs.
3. Need for self-care.

4. Being human beings.
5. Caring for the carers.
6. Moral distress.
7. Bereavement by exposure.
8. Bereavement by suicide.
9. Looking after loved ones.
10. Take a break.
11. The simple things.
12. Role of technology.

The Manchester Arena Bomb May 2017

A suicide bomber detonated a shrapnel bomb as people were leaving the US singer Ariana Grande's concert at the Manchester Arena on 22nd May 2017. This killed 22 people. The incident caused considerable psychological impacts on first responders including staff working with the fire, police and ambulance services. News reports have highlighted that some police officers have suffered with complex PTSD as a result of the incident and are still off work and receiving treatment 12 months later[7].

There was considerable public fundraising for victims and survivors, which resulted in a Resilience Hub being made available to professional workers and members of the public. The Social Influences on Recovery Enquiry (SIRE) is a program of independent research and evaluation into this hub and those affected by the Arena bomb. The study started in October 2019 to explore the experiences and opinions of people who used the Manchester Resilience Hub. It is coordinated by clinicians and researchers within Greater Manchester to try to gain an understanding of what has helped people cope, adjust and recover following the Manchester Arena Attack. By April 2020, online information on SIRE/site??? reported that

- 18 telephone interviews have been conducted.
- All the interviews have been transcribed and anonymised to remove any personal identifying particulars or details.
- The transcripts are currently being subject to detailed analysis.
- Theses interviews have produced very rich and detailed descriptions of people's experiences of helpful and unhelpful social support and how this has influenced their coping, adaptation and recovery.

Unfortunately, publication of this report has been delayed by the Covid-19 pandemic.

International and national briefings

Several organisations have produced activity and guidance in general terms in relation to health workers' wellbeing and health during the Covid-19 pandemic:

- **WHO** - the World Health Organisation produced a briefing paper in March 2020: RIGHTS, ROLES AND RESPONSIBILITIES OF HEALTHWORKERS, INCLUDING KEY CONSIDERATIONS FOR OCCUPATIONAL SAFETY AND HEALTH[8] – There was no specific guidance or examples from WHO in regards to good practice in provision of mental health and counselling resources for health workers and health trainees.

- **UN** - the United Nations Inter-Agency Standing Committee produced a paper on 17th March 2020 - Interim Briefing Note ADDRESSING MENTAL HEALTH AND PSYCHOSOCIAL ASPECTS OF COVID-19 OUTBREAK[9.] This paper gives an overview of the impact of Covid-19 on frontline health workers and particularly focuses on how nurses, doctors, ambulance drivers, case identifiers, and others may experience additional stressors during the COVID-19 outbreak. There is, however, no specific reference to trainees in healthcare.

- ***MindEd*** - this is a collaboration between the Royal College of Psychiatrists, Health Education England and others. MindEd has produced online resources and guidance for front line health workers, managers and team leaders. This includes specific resources for managers in health organisations[10], building on the work of Williams, Murray, Neal & Kemp in their discussion document '***Top Ten messages for supporting healthcare staff during the Covid-19 pandemic'*** [11]

- **Covid Trauma Response Working Group** - this group was established by the University College of London and the Traumatic Stress Clinic at Camden and Islington NHS Trust. The group's aim was to help co-ordinate trauma-informed responses to the Covid outbreak. This resulted in the early publication (27th March 2020) of two well considered and timely publications:

1. ***Guidance for planners of the psychological response to stress experienced by hospital staff associated with COVID*** [12, 13]. (see table on page 10)
2. ***Rapid Guidance - Moral Injury in Healthcare Workers Associated with COVID*** [14]

Proceed to table on page 14

Table 1: An Outline Plan for Staff Care to Mitigate Against the Psychosocial Impacts of COVID-19

Potential Timeline	Primary & Secondary stressors faced by staff	Suggested plan to mitigate identified stressors / demands	Actions needed to support the plan
Throughout the Crisis	Physical fatigue and exhaustion Hunger Dehydration Personal hygiene Moral distress	At all times throughout this crisis, organisations should ensure that staff have regular breaks, can rest, eat, and are hydrated – especially those who habitually wear PPE. Rotas, annual leave and pre-existing physical health needs of each member of staff must be carefully considered by managers.	Workforce to support managers in identifying and addressing these ongoing needs.
Build-up Phase	1. Anxiety (worry about not knowing what is to come & increased work demands) 2. Anxiety (worry about risk to self and others) 3. Stress related to preparation & planning 4. Distress linked to exposure to social media and public anxiety	In addition to existing support offered to staff by their employers all members of staff require good and effective communications, a flow of timely and accurate information that is hosted on a trusted intranet site and unique to COVID-19 – with its own icon. This site should host: • Basic 1-page advice on wellbeing that is based on WHO advice • Weekly short videos offering specific advice • A wellbeing-related FAQ section. • Direct consultation with managers / clinical leads to help their preparation & assist them in managing their anxiety (Critical Care Focus initially). • Promote specific ways in which employers can support staff during the crisis. • Continue to offer staff one-to-one support, when possible, by using telephones / virtual means e.g. Skype if possible. • Offer staff access to an Employee Assistance Programme for phone-based su	This requires: a. Identified support to manage the Intranet site. b. Additional mobile phones. c. Lockable cases for storing clinical notes for staff who are working from home.
Acute Phase	All the above and also: 1. Increased exposure to the distress of other people. 2. Increased exposure to public & peer hostility. 3. Increased exposure to experiences that create moral / ethical distress (threats to purpose or over identification with patients). 4. Stress related to concerns about personal safety & safety of loved ones.	In addition to the above: • Coordinate an Action Group to identify and monitor the developing physical & psychosocial needs of frontline and supporting staff. • Provide support for managers with OD colleagues. • Offer staff drop in sessions (the aim is to offer support and a space to decompress and feel heard). • Promote peer support networks. • Facilitate access to a wider network of support from colleagues in mental healthcare.	a. Create an Action Group involving representatives from HR and occupational health services. b. Link with HR services and facilities. c. Link with medical and clinical directors to coordinate referrals and hospital-based support.
Post-Acute - Cool Off Phase	All the above and also: 1. Exhaustion and exposure to feeling overwhelmed. 2. Teams may fragment as the pressure eases. 3. Increased friction between members of staff.	In addition to the above: Use a Schwartz Rounds framework to facilitate recognising COVID-19-related themes in all hospitals and for community-based staff and enable a plan to meet the needs of staff who are likely to be exhausted and over-stretched	Link with organisers of Schwartz Rounds to plan & populate.
Return to Business as Usual Phase	Unknown	In addition to the above Create an Action Group to evaluate the needs of staff.	

- **Dr Alys Cole-King and Dr Linda Dykes**[15] - reported work from a combination of UK and international subject matter experts in the psychology of staff wellbeing (psychiatrist, psychologists, counsellors) plus medical managers and everyday clinicians from clinical areas likely to get hit hard by Covid-19. The collaborative produced the following:

Optimising staff preparedness, wellbeing, and functioning during the Covid-19 pandemic response [16]

This a powerful document with excellent practical advice on support healthworkers. Cole-King's work also provides an excellent focus on the mental health of frontline health workers during different phases - a good example is this section dealing with the tail off and post Covid-19 phases:

(from Alys King-Cole[16])

Optimising staff preparedness, wellbeing, and functioning during the COVID-19 pandemic response

				• Clear communication channels with clear escalation if needed	
Tail off phase **NB timeline is not yet unknown**	• Technical capacity OK • Minor ethical dilemmas	• Staff 'running on empty' • Many with burnout • Potential retrospective guilt • Potential fear of reprisal relating difficult decisions	• Focus on supporting self and others • Use psychological and cognitive strategies when required • Focus on compassion self and others	• Compassionate management • Regular supportive *Team Review Meetings** • Watch and wait and refer/Occupational Health • More formal psychological help if and when required	• Active monitoring of staff wellbeing and PPE availability standing agenda item COVID-19 Management Meetings • Regular communication channels and consistent Media Plan as above • Ensure share successes, no matter how small • Liaise with external bodies as required • 'Open door' policy in person/remotely
Post COVID-19 **NB timeline is not yet unknown**	• Full technical capacity • Still reduced staff functioning/reduced numbers	• Expect a delayed response • Potential retrospective guilt • Mitigate staff distress and/or burnout • Fear reprisal for difficult decisions	• Focus on supporting self and others • Use psychological and cognitive strategies if required • Focus on compassion self and others	• Compassionate management • Prioritise annual/study leave • Watch and wait and refer/Occ Health • More formal psychological help if and when required	• Managers need support and coaching to avoid inadvertent overbearing approach. • Open door on offer as needed • Plan team building activities

Trajectory of Mental Health Needs by Professionals after major disasters

Four typical trajectory patterns of mental health and wellbeing needs of professionals and recovery workers after major incidents and pandemics have been described[17]:

- Resilience;
- Recovery;
- Chronicity; and
- Delayed onset.

Research after the Great East Japan Earthquake focused on trajectories for Post-traumatic Stress Disorder Symptoms among local recovery workers.[18] This work revealed diversity in the courses of PTSD symptoms experienced by the workers who were first responders to the major disaster. The majority of workers were found to be resistant to PTSD or described as “subsyndromal” throughout the study period. A small number of workers had chronic symptoms though some did show recovery over time. The trajectory pattern in this study differed from the four typical trajectory described by Galatzer-Levy et al. (above).

Although there has been research on trajectories of mental health and wellbeing needs for professionals exposed to disasters, the patterns of trajectories have varied and so cannot be used to accurately predict needs and to plan provision of support services. The research after the Great East Japan Earthquake showed that both workplace and personal factors affected longitudinal PTSD symptoms. The study identified that continuation of increased workload immediately after a disaster may prevent maintenance of

workers' mental/physical health or prevent recovery from personal losses. The research highlighted the importance of both improving overall working conditions and of providing individual support for workers with higher exposure to risk factors related to disaster.

Summary

The resources and research articles considered for this briefing paper highlight that there is no reliable science or method to predict the extent of health and wellbeing needs of NHS medical trainees in response to the Covid-19 pandemic. It my view that clinicians work in a culture where presenteeism is more common than absenteeism and where there is a tendency to work when unwell and to hide physical and mental health problems from colleagues and supervisors.

Identifying trainees who need support

In hospital trusts and GP training practices, there will need to be a culture of encouraging trainees to self-identify as having wellbeing needs related to Covid-19. Delayed reactions will be common – they could happen within 6 months or they could happen at any stage in an individual's career. In training posts, medics will need to be encouraged that concerns will be handled sympathetically and that there will be suitable specialist services available.

Several trainees are likely to respond positively to offers of facilitated peer support groups and/or online webinars dealing with psychological reactions to distress, uncertainty or fear.

Other trainees may be grappling with mental health reactions that will require rapid referral to experienced occupational health consultants and/or to senior psychiatrists and psychologists able to deal with issues triggered or exacerbated by Covid-19 related impacts

on training and clinical work. Trainees and educators will need to be aware of the services available to them and to their own GP when they seek referrals.

Training the Educators

Many HEE Educators (Heads of School and Educational and Clinical Supervisors) are likely to seek training in awareness of symptoms and signs of simple and complex PTSD, burnout and moral injury following the first wave of the Covid-19 outbreak. These educators are also likely to need updates in the range of services available to trainees and how they can signpost trainees to these services for rapid access via a referral from the trainees own GP.

HEE Professional Support and Wellbeing Service (PSW)

HEE and the PSW are well placed to have a leadership role in informing and coordinating services for medical trainees. PSW training courses and updates for educators and regular communications and website updates available to both educators and trainees will potentially result in an increase in self-referrals by trainees to the PSW. The PSW case manager system may struggle capacity-wise with surges in demand. The case manager system is well placed to assess individual trainees and to refer or signpost them to expert services such as experienced psychologists and occupational health consultants.

Occupational Health Services needs to be available to hospital, academic and primary care medical trainees – this needs to be individual, timely and with an appropriate level of expertise.

Appendix - Summary of key findings from BMA Survey "Mental and Health and Wellbeing of the Medical profession' (October 2019)[19]

- **Mental Health Symptoms and diagnoses**

These included anxiety, stress, depression, obsessive behaviours and burnout. Other respondents reported that they were able to maintain good mental health and attributed this to supportive families and supportive colleagues and workplaces.

- **Barriers to seeking help**

Practical barriers identified to seeking help for mental health issues included lack of time, lack of awareness of services and fears over confidentiality combined with concerns about referrals to the regulator e.g. GMC, accessibility issues and line management issues.

Perceptual barriers included stigma, guilt, so-called "superhero syndrome" and pride.

- **Impact on attendance and career choices**

Doctors in the study reported frequently starting to manage their mental health with requests for more flexibility to try to self-manage their situation. Where these requests had been denied, the doctors were left feeling that their proactive attempts to help themselves were futile. During this window of time, any number of incidents linked to the five risk factor groupings may have led to mental health problems becoming more complex and difficult to cope with. At this point, the doctors experiencing mental health challenges tended to embark on a journey towards more reactive measures, commencing with seeking help from a GP, and resulting in extended periods of absence, or even resignation or retirement. Doctors in the study with mental health challenges typically took extended periods of time off work and many had re-considered their career options during this time. Those doctors returning to work were not systematically offered formal modifications to aid the transition such as phased returns, reduced hours, workplace adjustments etc., particularly more

senior doctors and those in primary care (e.g. GP Partners as they were the ones who were responsible for providing these services in their workplace and there was no-one more senior to take this responsibility when they were ill). Those who did have access to these services, typically found them to be beneficial but too short-lived.

- **Interventions**

Experiences of interventions such as talking therapies, including counselling, psychotherapy, and CBT, were scarce in this research. Amongst the minority where this kind of support was offered in their workplace, there was the feeling that the quality was not always adequate. There was some disparity between primary and secondary care in terms of occupational health provision. Many of the doctors in secondary care, who returned to work following a period of absence due to mental ill-health, had an occupational health visit but most found the experience disappointing due to poor communications.

- **Medical Students**

Compared with qualified doctors, the medical students in this study generally felt well-supported by their medical school/university in terms of preventative measures and initiatives, and as such felt they may enter the workforce with fewer perceptual barriers to seeking support if they needed it at some stage in their career. Peer-to-peer networks were often set-up during the student induction process and most students had been offered wellbeing services including mandatory wellbeing conferences, workshops on stress reduction, as well as free on-campus meditation and yoga classes to promote individual wellbeing. Students in the study also felt that more formal services such as counselling and CBT were well sign-posted and available when needed. Although students identified that wellbeing and mental health was high on the agenda of their place of study, some expressed concerns around whether these services would cease when they progressed into the role of junior doctor.Taken together with junior doctors 'less positive experiences, assumptions of sustained improvements to both access and attitude to support cannot be taken for granted, as students enter the workforce.

- **Support and services doctors would like to see:**

1) Systemic changes

Doctors from this study believed that the most significant improvements would result from substantial systemic, structural changes to working practices and priorities, that would give doctors more time to spend on their ‘main role ’of patient care. Identified examples from this research included increasing GP appointment times, reduction of administration burden and increased staffing levels. More flexibility in working hours and patterns were also considered to be beneficial to improve doctors ’feelings of self-control over their work/life balance.

2) Support to deal with endemic challenges

Doctors and students in the study stated that the most effective way to help them throughout some of the more difficult moments of their career in medicine, was through peer support, both formal and informal. Participants mentioned talking groups for doctors after traumatic events to help them deconstruct in a professional environment. Junior doctors requested more formal peer support structures whilst on rotations, along with junior doctors being paired with a named doctor when on rotations.

3) Promotion of camaraderie

Many medics in the research wanted to see better coverage of mental health issues within university lectures, as well as within inductions and workplace workshops, to help to reduce stigma within the profession. To prevent further erosion of peer relationships, the provision of peer-to-peer support groups was considered highly beneficial for doctors at all levels, including Schwartz rounds and Balint groups, to help reduce the risk of isolation, and also provide doctors with more opportunities for socialising. Doctors also requested the introduction of mental health ‘buddies ’to whom they could turn in times of need.

4) Environmental improvements

Doctors in the study highlighted a range of environmental factors that could be improved to help the promotion of happy, healthy workplaces. Examples included protected lunchtimes and coffee breaks to help to reduce professional isolation and to raise morale. Other

practical environmental changes were considered helpful in allowing doctors to feel more valued by their place of work including the provision of showers and dedicated socialising space.

5) Responding to sociocultural change

These were identified as macro environmental factors, such as rising patient expectations, the increase of patient self-diagnosis and negative perceptions of the medical profession.

Summary and Recommendations - areas that need addressing

Systemic changes - to allow for more time and better peer relationships to promote good mental health amongst doctors and ultimately, improved patient care and outcomes.

Environmental factors - to providing healthy, happy workplaces (these can be simple measures such as staff lockers, doctors 'mess, parking for night shifts, rest rooms, canteens, kitchens)

Awareness-raising and signposting - for wellbeing and mental health support

Access to local and high-quality support services

References

1. https://www.bma.org.uk/media/2419/bma-covid-tracker-survey-scotland-results.pdf (accessed 16th June 2020)
2. https://www.bma.org.uk/media/2475/bma-covid-19-and-nhs-staff-mental-health-wellbeing-report-may-2020.pdf (accessed 27th May 2020)
3. https://www.nursingtimes.net/news/workforce/nurses-report-emerging-signs-of-mental-health-strain-during-covid-19-peak-21-05-2020/ (accessed 27th May 2020)
4. https://rcni.com/nursing-standard/newsroom/news/covid-19-survey-rcn-calls-nurses-feedback-crisis-159796 (accessed 27th May 2020)
5. https://doi.org/10.1136/bmj.m1211 (Published and accessed 26 March 2020)
6. https://www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf (Accessed on 8th May 2020)
7. https://www.independent.co.uk/news/uk/home-news/manchester-arena-attack-anniversary-police-ptsd-stadium-arianna-grande-a8362316.html (accessed on 27th May 2020)
8. https://www.who.int/docs/default-source/coronaviruse/who-rights-roles-respon-hw-covid-19.pdf?sfvrsn=bcabd401_0 (Accessed on 8th May 2020)
9. https://interagencystandingcommittee.org/system/files/2020-03/IASC%20Interim%20Briefing%20Note%20on%20COVID-19%20Outbreak%20Readiness%20and%20Response%20Operations%20-%20MHPSS_0.pdf (Accessed on 8th May 2020)
10. https://covid.minded.org.uk/further-resources-for-managers/ (Accessed on 8th May 2020)

11. https://www.rcpsych.ac.uk/docs/default-source/about-us/covid-19/top-ten-messages-williams-et-al.pdf?sfvrsn=990e3861_0&dm_i=3S89,146AV,2H3JLO,3X5OG,1 (Accessed on 8th May 2020)
12. https://www.traumagroup.org/ (Accessed on 8th May 2020)
13. https://232fe0d6-f8f4-43eb-bc5d-6aa50ee47dc5.filesusr.com/ugd/6b474f_daca72f1919b4c1eaddb8cfcbb102034.pdf (Accessed on 8th May 2020)
14. https://232fe0d6-f8f4-43eb-bc5d-6aa50ee47dc5.filesusr.com/ugd/95d7e1_70fe0bc417df4e6cbcb77385ec4db87a.pdf (Accessed on 8th May 2020)
15. https://www.lindadykes.org/covid19 (Accessed on 8th May 2020)
16. https://d29e30c9-ac68-433c-8256-f6f9c1d4a9ec.filesusr.com/ugd/bbd630_48e96c3b5f394de89609c170ad4ec698.pdf (Accessed on 8th May 2020)
17. Trajectories of Resilience and Dysfunction Following Potential Trauma: A Review and Statistical Evaluation. Galatzer-Levy et al. Clin Psychol Rev 2018
18. Trajectories for Post-traumatic Stress Disorder Symptoms among local disaster recovery workers following the Great East Japan Earthquake: Group based Trajectory modeling. A. Sakuma et al. Journal of Affective Disorders (2020) vol 274 pp742-75
19. https://www.bma.org.uk/media/1361/bma-mental-health-and-wellbeing-medical-profession-research-summary-oct-2019.pdf (accessed 27th May 2020)

Resources

Literature Search on wellbeing needs of medical trainees because of the Covid-19 pandemic


257. Search strategy.docx


257. Health workforce wellbeing

National HEE Powerpoint and Resource bank (in relation to Post-Covid wellbeing)


HEE COVID19 Wellbeing Slides up


Pandemic recovery resource bank 17 04

HEE East Midlands PSW - Pro-counselling resource


Pro-Counselling - Communication plat

Publications on PTSD


Cucciare US Women 2020.pdf


Rona PTSD 2012.pdf


Rubin Ebola qual 2016.pdf


Greenberg Ebola consequences 2015.


Peacekeepers 2008.


Lamb Ebola qual 2018.pdf


Sundin IA UKAF 2012.pdf