Summary of NHS Staff Discussion, 20th October 2020

Challenges	Ideas and Suggestions from Participants
Service Users: • Continuing to see presentations, including psychosis, from those who not previously known to services • Health anxiety more common in those seeking support • Increases in negative coping mechanisms such as drug and alcohol use, and self-harm, among both young people and adults • Some young people struggling due to return to school and stresses at home, including their parents' mental health suffering • Some GPs not able to offer as much support to those with mental health issues, some community mental health teams not seeing people face to face, so service users are losing their trusted support and increasing the pressure on home-based treatment teams and crisis teams	• There was a noticeable demand for those aged 65 and over at the start of lockdown; some trusts have put in place specific services to support this group • NHS 111, option 2 is working well in, with appropriate and helpful signposting leading to positive outcomes
Staff Wellbeing: • Staff are feeling pressured and overwhelmed with the demand being placed upon them and the presentations they are dealing with • Some staff are now only working with high risk groups, which is emotionally demanding • Guidance on Covid restrictions can feel vague and changes often, making it difficult for staff to advise patients and understand what they can offer • With staff members having to isolate there is an increased demand on those working on wards	• Amica provide support for those working in the NHS, and some Trusts are seeing staff using and valuing it • Peer support has proved to be an effective way for staff to offload and feel supported, creating space for people to vent and not feel judged • Staff need to be encouraged to take annual leave/days off to ensure they are getting a break and not at risk from burn out • Valuing time with family and enjoying hobbies can help individuals unwind and take their mind off work

• There is an increase in staff seeking support, but some managers are not accessing the support they need • Many are currently spending their working day in meetings and then using their own time to catch up on work; they are left with no down time	• Managers have an important role in modelling well-being, including taking leave, boundaries around working hours, and openly discussing their well-being • Take each day as it comes; it is an unpredictable situation, but everyone is in it together
Training: • Suicide awareness and prevention training has been put on hold or de-prioritised to focus on infection control • Some Trusts are unwilling to have suicide awareness training online, as the subject matter can affect people • Zero Suicide Alliance training being used by some, but where it is not mandatory it is often not done as staff are so busy	• Training that is being delivered online ensures safe spaces and emotional support for people who are struggling • Some charities are delivering suicide awareness, suicide prevention and self-harm prevention training online (including Harmless and PAPYRUS Prevention of Young Suicide)
Positive Outcomes: • Collaborations with local services have significantly improved and there are more conversations happening around suicide prevention and self-harm support • The services are still these for those who need them and despite what is happening with COVID-19, the services are still helping people in need	

Summary of NHS Discussion, 20th July 2020

Challenges	Ideas and Suggestions from Participants
Demand • Referrals to crisis care are at an all-time high and many organisations are finding themselves at capacity	• Many are adapting the way they are working - more quickly and efficiently dealing with the continual rise in referrals

• Some GPs are struggling to deal with the increase in mental health calls, while others suspect people are still avoiding surgeries, and anticipate an increase in demand as lockdown eases further • Saturation of all care systems, making it difficult for emergency services to know where best to signpost and where there is capacity • Some smaller organisations that offer support are folding adding to pressure on those on the front line • The usual 7 day follow up has now been replaced by 72-hour follow up; some teams are finding this manageable but some teams are struggling to cope with the demand • Some non-health and private agencies (DWP, utilities, banks) are passing people with suicidal thoughts on to emergency services, not taking responsibility for people's well-being themselves	• Train call handlers across health, non-health and private agencies in basic suicide prevention to relieve some of the pressures faced by mental health staff • 'Talk Before You Walk' campaign set up to reduce the number of admissions in hospital by encouraging people to talk things through first
Presentations • Many trauma related symptoms are being shown from those who have been in the ICU during the pandemic • Increase in those presenting in crisis who were not previously known to services • There is a loss of support networks, especially for those 70+, which is increasing risk • End of shielding is causing a spike in anxiety • Some people are reaching crisis because they want life to go back to normal • The end of furlough is causing anxiety - lack of jobs, money, childcare issues as no more after school clubs • Increasing presentations for drug and alcohol abuse, but concern people are being lost between services	
Providing support • When will face to face support be allowed again? • If this is the new norm how can we offer support to those who need it • Staff concerned over signposting appropriately and how to do it remotely	• Encouraging staff and providing training so they feel confident to hold a conversation, hold and normalise distress, rather than always signposting to other organisations • Covid-19 has given us the opportunity and courage to have more meaningful conversations, beyond the weather, and there is an opportunity to support people to hold more courageous conversations within communities

	• Offering staff training on how to deal with people in crisis, including Zero Suicide Alliance offer training (here)
Staff Wellbeing: • Staff wellbeing is a huge concern due to increased pressure at present • Potential second spike of Covid-19 is causing increase in anxiety for staff; what will the second spike look like and how will we cope? • The regular changes in procedures and information is causing stress for staff • PPE is a cause for concern: what they staff be wearing? how is it affecting interactions with patients and service users? • Since lockdown there has been an increase in anxiety in staff due to pressures; many going above the level of support they are trained to offer • Working remotely with no commute, no distractions etc. is bringing back previous trauma as there is too much time to think • Study looking at occupations from 2011 – 2015 found that nurses (here) are a high risk group for suicide amongst females • Important to be aware of risks and talk to staff about what they need	• Many have adapted to working remotely well and are happy with the level of support they can provide despite how hard it has been Support from management • The NHS 'Our People' website has information and support for NHS staff (here) • Onsite external counsellors to be provided on the return to work to help with settling back in • Celebrate the staff that are working hard, and reassure them they are saving lives and going a great job in the hardest of times • Staff Awards to nominate and reward teams and individuals who have gone the extra mile - celebrate them and boost morale • External helplines being put in place to provide support confidentially • Ensure staff are getting rest, taking holidays, taking days off etc. Wellbeing ideas • Spaces are being created for staff – e.g. private Facebook group - where they can be honest about pressures, worries etc. • Peer support "buddies" - someone to vent to and communicate concerns with privately • Online mindfulness, meditation, virtual cafes • Discourage back to back meetings; encourage staff to have a small amount of chit chat after meetings, not just sit at the desk, be active • To help prepare for and unwind after work take a 10-minute walk at the start and end of the day

	• Encourage staff to communicate with one another about the pressures they face, help them realise they are not alone
Communication: • The reliance on social media to get key messages is not working well enough in the current climate • There is concern about an increase in need for mental health support and the usual methods of communication not working • Finding unique and creative ways of trying to reach different people and create spread of information amongst communities • How to ensure we are reaching maximum amount of people?	• Create directories with local and national support lines in to offer to those who need support, and help structure this so not an overwhelming list. Hub of Hope work nationally to bring this information together - https://hubofhope.co.uk/ • More use of social prescribing and social prescribing teams to improve communication to those who need support • Increasingly connections are being made within community networks, and initiatives previously put on hold are starting to pick up again • Suicide prevention groups are beginning to network with each other again • Reach out to those who have elderly neighbours and provide leaflets on how to support elderly neighbours, relatives.
World Suicide Prevention Day • Use it to also focus on staff wellbeing • Virtual events rather than physical events this year • Pod chats and pod casts • Holding activities over a number of days	

Summary of NHS members online discussion, 1st July 2020

Challenges	Ideas and plans from participants
Presentations to services • At the start of lockdown people presented with loneliness and isolation, then noticed increased in psychosis presentations, and now more around economic pressures – job loss and associated concerns with being unable to provide for families • Men who say they don't usually talk about things like this are calling and asking for help • People are presenting without any mental health problem, except they are having suicidal thoughts – in the past they may have coped with a certain issue, but Covid-19 is making it harder to get universal credit and other support – those services are overwhelmed too • Following lockdown there are issues around money and lack of work that we know are big factors in suicidal thinking, so services need to think about how they can manage what is causing the distress • People without access to Wi-Fi distressed because without it they can't access any other services – it stops all other help-seeking • People who might be too risky for local talking therapies or voluntary services, but the complex team or CAMHS say they aren't complex enough for them to work with, or they don't have the capacity at the moment. Those triaging people can feel lost as to what to offer them	• An increase in presentations suggests that people are seeking help, so they need to be supported • Clinical services are better than they were at acknowledging the broader community support that is available and making those links • Voluntary and community sector are using technology effectively to promote contact with service users and augmenting their face to face support • Risk is very imprecise and difficult to assess - 'need' should predominate, and important to help communicate people's needs and then understand what services might meet that need • More useful to focus on ideation and distress, not risk assessment • Central and co-ordinated messages need to show how to manage distress, with a commitment to supporting staff to talk about self-harm and suicide • Working through NCISH audit tool exploring where our organisation is, how prepared we are, what is in place in terms of staffing and strategy, where the gaps are and how to fill them • Loss and grief helpline launched, helping with upstream suicide prevention work to support people in their grief

• It can take extreme distress and even suicidal behaviours for people to get help, despite asking for it • Risk assessments cannot include or understand impulsive behaviour, or what might be the straw that tips someone into suicidal behaviour	
Suicide prevention groups • Some suicide prevention meetings are happening online, but not high on everyone's agenda • The usual suicide prevention governance, structures and leadership are not in place, the energy has all gone elsewhere • Covid-19 and lockdown has slowed suicide prevention programme considerably, with meetings moved, less connection with others on the group, and a focus on fire-fighting as issues arise • It seems more efficient that we are not spending time travelling to meetings, but the time it takes to get to a meeting can create space to think about it more fully on the way, and there are times over coffee and in breaks when connections are built and ideas generated that don't happen online • Previously people would share ideas and then follow up afterwards, but this is happening less now • Getting suicide and self-harm higher up the agenda varies with service delivery – it's making connecting with some patients easier, and others more difficult • There are lots of plans, but they are taking a long time to get going, and they might already be out of date and not fit for purpose	• Important to re-activate local suicide prevention strategy work • Suicide prevention plans were developed across partnership pre-Covid-19, and are now being refreshed • Need flexibility, fluidity, to adapt to the continuous change • Information about suicide prevention could be embedded in other messaging around staff well-being, the impact on BAME people etc • Suicide prevention high up on the agenda in one ICS, with work they were doing for a year now coming to fruition, so people can see the impact and build on that • Covid-19 has provided opportunities to join other working groups • How to get suicide prevention on the agenda alongside the Covid-19 work – it's important to make the links between the clinical work – exploring distress and the impact of Covid-19 – with routine asking about suicidal thinking

Training • Unable to do lots of training because of staff shortages • There is elearning, but all face to face training on hold • Many NHS Trusts have forbidden zoom and/or won't allow it on their IT equipment as MS Teams is preferred, but for Trusts working with community organisations MS Teams is not great, as Zoom or Facebook Live is simpler and easier	• Working to move suicide awareness and prevention training programme developed with State of Mind moved online and get people booked in • Previous NSPA discussion on training is here
Staff support • There are lots of communications about staff support, but less clear on how it feels to frontline staff • Staff are worried about catching Covid-19 themselves, especially if they have to visit people's homes • Those working in offices are finding it difficult to keep safely socially distant, and some people are not understanding or respecting people's need for isolated spaces • Staff feeling burnt out and exhausted, who had been active and managing OK • Some roles are quite isolating, and so not necessarily on people's radar for support	• Covid-19 has made it clear that staff are a very important resource who need to be supported and valued • Having supervisions helps people feel supported • Vital to take leave and look after ourselves, and model that for our teams • Previous NSPA discussion on staff wellbeing is here

Summary of NHS members online discussion, 19th June 2020

Challenges	Ideas and plans from participants
Service users and emerging issues • Many patients on rehab wards are having their release delayed by months because of Covid-19, negatively affecting their mental health • Those released from intensive care following Covid-19 admission may have significant trauma from that experience, with risk of suicidal thoughts, so post-discharge support vital • Increase in presentations from people who have never presented before and never had to navigate the systems before • Increase in psychotic presentations, including delusions, paranoia and self-harm, sometimes linked to a sense of being monitored by all the devices used at present, sometimes 5G conspiracy theories feeding in too • Increased presentations from middle aged men in crisis due to financial challenges, running out of savings, unable to feed families, feeling hopeless • Children and young people bereaved by Covid-19, and challenges of providing appropriate support with schools not fully open and under so much pressure • Questions whether some of the unusual presentations to services might be related to changes in drug suppliers due to Covid-19, and drug users finding new suppliers and/or new substances • Isolation – both for service users and staff, particularly if don't have the technology so many are using to connect • Assessments may be less effective because staff can't see body language etc, which is particularly problematic with those at risk of suicide, who can be deemed low risk • People's usual coping mechanisms are not available, support groups not meeting etc	
Staff health and well-being • Increasing workloads • New and challenging technology needed to keep in touch with service users and colleagues	• PHE's free online Psychological First Aid training (here) has good content on supporting colleagues • Delivering guided relaxation sessions for colleagues and peers in CCG and Local Authority via Teams. Just 15 minutes twice a week to encourage people to take a break, and to see each other's faces

• Those re-deployed now returning to previous roles and having to pick up projects again • Though teams have found ways around the challenges of working from home and developed some support structures, staff still miss the informal support and connection in the kitchen or corridor • Harder to carry emotional burden from supporting service users without informal support from team • BAME staff, who are at greater risk from Covid-19, need care and support, especially with the additional trauma that may have been brought to the surface with the Black Lives Matter protests • Mask-wearing by clinical staff can increase distress for non-clinical staff as well as patients	• Lots of options for being together online – daily huddles, collective supervisions, and people are getting more and more used to online interactions, but the longer this goes on the more we notice what we're missing • Useful to have regular space to connect with no agenda • Starting conversations about the etiquette of video calls – in an office you might knock on a door, but with video you can just barge into someone's living room! • Important to take leave • Set up opportunities for staff across the organisation to share their practice – inspired by these calls! - staff who wouldn't usually meet can raise issues and share approaches • In peer supervision, a facilitator is bringing in staff well-being as well as the usual discussion of patient cases – anxiety around Covid-19 and how that is affecting workforce well-being
Online training • Better to do something rather than nothing, but concerns about how to do it effectively and safely • Aware that by losing face to face delivery courses lose much of the sharing and questioning • Tech limitations in some Trusts make delivering suicide prevention training for primary and secondary care difficult	• Will try both online learning and small face to face groups when the rules allow • Moving training to e-learning and zoom training • Keen to get training providers to link together rather than all reinventing the wheel • Summary of previous NSPA discussion on online training here
Communications	• Important for suicide prevention messaging to be included across services, not just siloed into mental health or vulnerable groups • Task and finish group working on getting positive messages shared

• Significant reductions in people wanting or willing to be in hospital or clinical environments – how raise awareness that it is safe? • Despite, or possibly because of, the clear command and control system in place, our knowledge on suicide prevention is not being made part of the Covid-19 response and communications • Some multi-agency group meetings are being cancelled • So many Covid-19 messages out there it can be hard to get other messages heard – whether about suicide prevention, training available etc	• Directory of over 300 support organisations to help people find support on a wide range of issues – debt, welfare, housing, mental health – also searchable by postcode as local support key at present • Reaching out to young people the youth forum developed their own leaflet, working with an illustrator, to share a messages from young people to young people, and has taken off on Twitter. The leaflet is here, and an interview about its creation is here. • Lancashire and South Cumbria ICS have used animations with key messages around well-being – take a break from social media, check in with friends etc – now getting those animations in shop windows, to teachers. Read about the campaign here, the images are here, and more resources here.

Summary of NHS members online discussion, 22nd May 2020

Challenges	Ideas and plans from participants
Vulnerable people • Concerns that due to lockdown there may be increases in domestic abuse, family breakdown, and distress due lack of personal time and space • Increasing numbers of people not previously known to services are asking for support and expressing need to a range of services • People who have English as a second or other language, and people with learning disabilities will also need support, including bereavement support • Drug and alcohol services in many areas are seeing increases in demand, and with a very different cohort of patients who have not accessed services before, including more professionals. Possible that virtual contact and support is facilitating that, and services are keen to maintain that offer post-lockdown. • Older patients who do not want to go into hospital for fear of contracting Covid-19, but also at greater risk of other health problems • Families bereaved by a suspected suicide, may be affected by delayed inquests, and need support over a prolonged period	• Helplines set up both for people who need support in crisis, and those with concerns about their mental health • Developing a programme of events for specific groups, including those fleeing domestic abuse, those working in care homes • One area is developing a counselling offer for people with learning disabilities and for those with English as a second or other language • Some organisations are using MS Teams or Zoom to continue to deliversupport groups • More resources added to Recovery College website, both suicide-related and broader subjects, and that work continues to develop rapidly • One community-facing initiative has seen a huge increase in interest in suicide awareness and prevention training, so adapting delivery methods and capacity • Developed a document for local workplaces (guidance for employers and employees) with advice on working well from home including around looking after their mental health and physical health • Many areas seen increased willingness across communities to build connections, develop safety nets and networks • Worked with a Professor of Music to create playlists for well-being • Rolled out the Stay Alive app
Staff and volunteers • All staff training has been put on hold in some Trusts	• A number of Trusts are supporting staff and building their confidence to notice signs of someone struggling, ask about self-

• Key workers are under pressure, and there are concerns that the 'hero' mentality is adding to that, alongside concerns around the impact of moral injury • One area implemented a helpline for those needing help getting food and medication, but volunteers were not prepared for the level of psychological need of people struggling with lockdown, so theyhighlighted the Zero Suicide Alliance training and Samaritans resources on having difficult conversations	harm and suicide if they sense there is a need, and know what to say and do next, including safety planning, checking protective factors etc. • Developing a safety planning resource, to empower staff and help them understand what is expected of them and what support isavailable for them • One area has noticed increased willingness across the Trust to work together on suicide prevention – staff seem more open and engaged • Implemented welfare checks for all frontline staff, and one of the welfare staff sits on our suicide prevention group • Lots of people are volunteering to help in the community, including those who are shielding but keen to offer phone support to others
Emergency and crisis support • Initially, acute liaison psychiatry service were not getting referrals through. Lately referrals are increasing again. • On some mental health wards staff are seeing people extremely unwell, increased anxiety and psychosis, including among older adults where some Covid-19-related worries have then become psychotic, including paranoia about being monitored and some suicidal thinking • Decreases in demand for hospital psychiatric liaison services, but an increase in demand for home-based treatment, alongside increases inthe complexity and number of people being treated at home, including among people new to services. Home-based	• Working with hospitals to share data around presentations to A&E with self-harm and suicides attempts, ensuring data includes those as well as deaths by suicide • Creating a pathway between A&E or urgent treatment centre and other local and third sector mental health services for people in crisis • Gathered resources from mental health and suicide prevention charities to put out in urgent treatment centre, supporting people to understand themselves and what they are feeling, and ask for help if it's needed

treatment has mainly been delivered through phone and virtual contact.	
Collaboration • Initially, in some areas, members of multi-agency groups and networks focussed on their own organisations, which meant there was less systemic thinking. Connections are being made again, but it still feels fragmented in some places. Other areas did continue to bring together multi-agency groups, who kept each other in touch with what work was happening and progress on suicide prevention initiatives.	• Many areas are working with IAPT services to ensure they are ready, including provision for those experiencing complex bereavement – grief is not clinical depression, nor is there likely to be a big improvement in 6 weeks of treatment, so IAPT services are changing some measures to ensure they can support people in need • One area has held talks with the Customer Experience Directorate at the Department for Work and Pensions to understand their safe-guarding measures: they have a 'Six Point Plan' in place for staff speaking with those expressing suicidal thoughts. Staff are supported themselves when dealing with such calls, and there is a list of resources and support on their internal intranet for staff to utilise and refer to. Money management issues is a huge issue for many, and they have a Support for Schools team that helps educate young people on money management, but they are open to extend this offer to Further education colleges etc.
Bereavement support • Many areas preparing to support people experiencing complex grief, particularly a risk as people are less able to prepare for the death, say goodbye or attend the funeral • Increase in calls to suicide bereavement service, and those bereaved in the last 0-6months are noticeably struggling • Some reports that people have found that if their loved one didn't die of Covid-19 then there is less care and support, so those	• Many areas are researching all the local organisations that provide bereavement support, to ensure they can signpost people appropriately and that any gaps in provision can be filled. Also checking they are BACP-accredited, to be sure of quality of support • A local women's mental health service has extended their service provision to include supporting those bereaved by Covid-19

bereaved for other reasons, including suicide, may need additional care	
The future • Deep concerns about impact of ending furlough payments, the expected recession and the economic impact on people which may increase risk of suicide • Important to focus on what risk factors we do know about, as well as Covid-19-related ones that we don't know about • Considering what we can do now to be prepared for an anticipated increase in attendances as lockdown eases	• Some multi-agency groups are preparing for predictable risks, so increasing effort for at-risk groups, including those experiencing financial distress • Important to be aware of patients who don't meet the threshold for secondary care but will need support, so building third and voluntary sector pathways for people coming out of A&E • All the preparations to prepare the NHS for Covid-19-related strain on services may well help prepare the system for any increases in demand due to deferred help-seeking (whether for physical or mental health problems) • Improvements to use of technology and digital platforms because of Covid-19, joining up and integrating services and sharing data, all of which will be valuable in future • Building capacity in bereavement support service, as anticipate a rise in demand 6-12 months after a death

Summary of NHS members online discussion, 4th May 2020

Service delivery challenges	Ideas and plans from participants:
• Expect additional need for bereavement services for all those bereaved during this period, as they are likely to experience complex bereavement, and additional support will be needed for next 3-6 months at least	• Moving work to reach men online, hoping to have online sessions out in a few weeks

• Reaching and supporting service users who don't have access to technology and/or the internet • Some areas may be seeing an increase in psychosis referrals • A&E attendances for self-harm are down, but unclear why or where people are going? Are they with family and so distracted and not self-harming? Or not seeking medical help they usually would? • Are there additional risks to consider if consultations and risk assessments are not being conducted face to face?	• Considering how to meet the needs of people who don't have English as a first language, or who may want culturally-specific support (particularly bereavement support) • Acknowledgement that there are limitations to face to face consultations as well as online – people will only reveal what they are willing to reveal. • Consultations can be supported by ensuring clinicians have a list of prompts to encourage them to ask a range of questions about people's well-being – no recommendations on that yet, which would be helpful • Anecdotal evidence that telephone and online support is leading to long-term patients/clients opening up about issues they have not talked about in person, as they feel safer and less ashamed because not face to face

Staff well-being and needs
• Staff would value support and guidance on a range of issues:
  ○ Innovative ways of working
  ○ Thinking about how the people they work with might be impacted by Covid-19 - both those with existing mental health needs and those without,
  ○ How to manage phone consultations effectively
  ○ How to risk assess people in their own homes
  ○ How draining video calls can be etc
• Guidance to staff is often coming top-down, but not much evidenceofstaff consultation – would be good to see more staff engagement in future
	• The Manchester Resilience Hub was set up after Manchester Arena bombing and is now funded to help provide psychosocial support for health, adult social care and emergency services staff, to reduce impact on these cohorts, support staff and retain the workforce
	• Some Trusts starting to think about feedback mechanisms with staff:
	  ○ i-hub in one Trust is a way for any staff to post ideas, at present one of the 'themes' is how to respond to Covid-19
	  ○ Regular staff feedback channels not being used, but Facebook staff group is being used more than usual

• Some staff are feeling they have a bit of breathing room, and permission to work dynamically – what will come out of that long-term?	• One area has an expert reference groups including clinicians to assess any guidance that might go out – ensure it is relevant for this stage in the lockdown, valid and useful offer
The future • Lack of clarity on what will happen over the next weeks andmonths(including changing government advice, when and where staff will return to work) and what that means for the risks for self-harm and suicide. Makes anticipating demand very difficult, and our assumptions may be wrong. • Once lockdown restrictions lifted, concerned there may be a surge in demand, possibly linked to increased access to means, people not spending as much time with family and so at increased risk • Trusts thinking about recovery phase, but how to balance staff well-being with operational and business needs? • Lots of new services – 24-hour referral, crisis line etc – don't necessarily want them to become the new normal • Ultimately, as a recession seems likely, we know we are likely to face lots of risk factors for suicide, including isolation, job losses, financial distress, increased problem debt. But they are not happening yet	• Identifying gaps in support, and preparing for additional demand in 6-12months • Some work is being done on recovery planning looking at demand linked to a range of economic options over 2-5 year period (document attached)

Summary of NHS member online discussion 22nd April 2020

Training challenges: • Staff need well-being and mental health training both personally, to support their own well-being, and professionally, to feel better able to support others struggling with their mental health • Front-line staff have no time to do training, even if virtual solutions found • Training around how to respond to someone presenting because of self-harm continues to be important	Possible solutions: • Some Trusts working to break previous face to face training down into modules that can be delivered virtually • Many charities already offering online training courses (NSPA will be tweeting to raise awareness of lots of these on Thursday 30th April)
Service users: • Concerns about national messaging – 'don't put additional pressure on NHS' risks seriously ill people (mentally or physically) not asking for the help they need • Concerns that people who are new to services may not have a good enough relationship to feel supported in the new virtual service • Children and young people and parents – reduced numbers of referrals to services compared to this time last year, but many interacting factors – not returning to school, no exams, COVID-19, and change in mode of support to phone/online	• Some Trusts are gathering data on presentations, so that they can compare that with pre-COVID-19 presentation data, and examine if fewer people are presenting, and if so why • Possible need for communications for both NHS staff and general public, encouraging them to speak to their GP/ go to hospital when they need to, otherwise we could see an increase in non COVID-19-related deaths and illnesses.
Staff:	

• Many people are working in different roles, including being moved from suicide prevention work onto more or pure COVID-19-related work • Students and trainees are being deployed on the frontline and areofparticular concern • Concerns about staff who have minimal training on looking after their own well-being, as may not recognise warning signs • Some staff may be struggling because they are working from home on distressing issues, and can't de-brief to colleagues as they usually would • People are hearing anecdotally that some staff (e.g. in A&E) are struggling, but there is a stigma about asking for help – they feel that they have to be strong and tough • With a 'macho' culture, if support is being delivered by colleagues that may make it additionally difficult to ask for help • Some internal support is not sustainable – staff on support lines are also expected to deliver their day jobs, so when people call they don't get anyone to speak to • Messages around resilience can put pressure back on individuals to 'cope', whereas some issues, particularly at present, aresystemic,which needs acknowledging. • Trusts are already experiencing bereavements from COVID-19 and staff will need support around that.	• In some Trusts senior leaders are giving daily updates for staff, including messages around it being OK to struggle, asking for support and where to get it • Trusts are exploring how to develop platforms for staff to enable conversations, share well-being guidance including 10-minute yoga videos and mindfulness sessions online • It might be helpful to remind people of their normal coping mechanisms, to acknowledge this can be distressing and painful,andwecan find ways through • The BMJ article '*Managing mental health challenges faced by healthcare workers during covid-19 pandemic*' may be useful (here) • NHS staff have their own mental health support helpline, provided in collaboration with Samaritans, SHOUT! and Hospices UK. More here.
Communications:	

• On paper lots of staff support being offered in-house, but there is almost too much information and too many options. Needs some gate-keeping - which are appropriate and effective? • Less collaboration across ICS is affecting messaging, as each organisation seems to be sending out a different message	• As organisations find their way in the crisis, more ICS suicide prevention groups and multi-agency groups are now meeting, which will support co-ordination
Future: • Concerns about impact on staff in 2 months, 5 months and longer-term, including increased risk of PTSD • Changes to service delivery now will have an impact longer-term – more services delivered/offered online, patient consultations online	