VAST Programme

Valuing All Staff Together:
Growing and Training our Future Workforce

North West Paediatric Critical Care, Surgery in Children & Long Term Ventilation Operational Delivery Network

CONTENTS

GLOSSARY AND ABBREVIATIONS

AHP: Allied Health Professionals
C&M: Cheshire and Merseyside
ED: Emergency Department
EHW: Emotional Health and Wellbeing, often synonymous with mental health
GM: Greater Manchester
HCSW: Healthcare Support Workers, including Healthcare Assistants, Support Workers, Family Workers, and other unregistered support staff
HEE: Health Education England
L&SC: Lancashire and South Cumbria
NW: North Wales
NWODN: ODN footprint area
ODN: Operational Delivery Network
PCC: Paediatric Critical Care
POA: Paediatric Observation and Assessment
Regional leads: Educators leading the implementation of the VAST programme based in C&M, GM, and L&SC

1. INTRODUCTION AND BACKGROUND

1.1 COVID-19 Pandemic and Respiratory Surge

Due to the nature of COVID-19 presentations, April 2020 saw a 79% reduction in urgent paediatric referrals from GPs to hospital care (Nuffield Trust 2022). This led to paediatric staff being moved to support adult clinical settings due to urgent workforce needs in an attempt to increase capacity to meet the demand of expected surge pressures, particularly in critical care (Boodhun et al. 2021, NHS England and Improvement 2020). This movement of staff to new areas proved challenging and stressful for those involved (RCPCH 2020). Winter 2021, however brought a rise in demand to paediatric services, with the Nuffield Trust (2022) reporting an increase of up to 47% in urgent GP to hospital paediatric referrals, compared to pre-COVID-19 levels. This spike in illness sat alongside the predictable annual winter pressures, and a significant increase in CYP with emotional health and wellbeing concerns (Nuffield Trust 2022, RCPCH 2021).

Children and Young People's (CYP) services also experienced increased staff sickness and absence, due in part to infection, isolation, exhaustion and the stress of redeployment (RCPCH 2021). This resulted in a deteriorating experience for the workforce. More patients with increased acuity, as well as greater staff sickness and absence, leading to increased pressure on remaining staff. There was uncertainty for how long these pressures would continue and what the impact on services would be in the future.

1.2 Respiratory Surge in Children Programme

The Respiratory Surge in Children Program was launched in 2021, as a collaboration between HEE, NHS England and NHS Improvement, Paediatric Critical Care Society, and London Transformation and Learning Collaboration (Health Education England 2021). Its key aim was to support the cross-skilling of the NHS national workforce to better manage:
- existing demand in CYP
- future potential increases in demand due to RSV and other respiratory conditions
- increased longer-term acuity of illness in CYP

The programme acknowledged the need to be responsive to the different needs of users across the nation. To do this, £80,000 of funding was made available to each of the seven regions of Health Education England, to work with their regional Paediatric Critical Care Operational Delivery Networks. In the Northwest, this was done by the North West Paediatric Critical Care, Surgery in Children & Long Term Ventilation Operational Delivery Network (ODN), who initiated the VAST Programme (Valuing All Staff Together: Growing and Training our Future Workforce).

1.3 VAST Programme

The pandemic experience offered CYP's services a powerful learning opportunity, as there may be a similar demand placed on CYP's services in the short to medium term if, as expected, respiratory surges continue. The VAST Programme sought to identify which pandemic responses should be re-implemented or avoided to allow the opportunity to respond more nimbly and effectively to any future needs. It also allowed any training needs identified in light the of the pandemic to be identified, so that they might be addressed.

Aim:
The key aim of the VAST programme was to recognise the recent challenging times faced by the NHS, and the impact this has had on wellbeing in CYP's areas, to further grow, train and

develop the future workforce. The programme aimed to gather the experiences of all CYP staff during the COVID-19 pandemic and in the post covid respiratory surge to both acknowledge staff experience and inform future staff training for both clinical skills and non-technical skills.

Objectives:
- To undertake a training needs analysis across the ODN footprint's paediatric workforce
- To identify key themes of challenges and areas of best practice derived from the training needs analysis
- To devise an educational or development package and disseminate across the ODN footprint's paediatric workforce
- To develop a clear implementation plan to ensure continuity of this work, and optimise sharing and learning

The VAST Programme was open to all staff who were involved in CYP's services, or were moved out of them, since March 2020. This was to include the COVID-19 pandemic and respiratory surge. The VAST programme was inclusive and strived to embrace clinical and non-clinical staff across all roles. It acknowledged the changes to normal working experienced by staff across the workforce and aimed to reflect this. Although the 'COVID-19 pandemic' is referenced throughout, the VAST programme also encompassed staff experiences of the respiratory surge. This report sets out the key findings of the training needs analysis.

1.4 Who Conducted this Programme?
Educators were employed as regional leads by the North West Paediatric Critical Care, Surgery in Children & Long Term Ventilation Operational Delivery Network (ODN), using funding secured through Health Education England (HEE) to develop and implement the VAST programme. They were also responsible for engagement and rollout within each region that they were based (Cheshire and Merseyside, Greater Manchester, and Lancashire and South Cumbria).

2. Methodology
The VAST Programme training needs analysis followed the process outlined in NHS Digital's national Education and Training Standards (NHS Digital 2021).

2.1 Stakeholder analysis and engagement
Extensive stakeholder engagement was fundamental to the development and implementation of the VAST Programme. The regional educators recognised that it was ultimately on behalf of the CYP's workforce that the VAST Programme was undertaken. These stakeholders were involved throughout the development of the programme. They were drawn from a variety of levels and roles.

2.1.1 Stakeholder analysis
Stakeholder analysis followed the guidance established by NHS England and Improvement (2022a). This was to identify everyone who needed to be involved in the VAST Programme and the level of investment required from them. Determining this was one of the first steps undertaken by regional educators, to reduce the possibility of missing key stakeholders. The four-sector power / impact table in figure 1 outlines this stakeholder analysis. Stakeholders

contacted included representatives from medical, nursing, allied health professional, and administration. They were from a variety of roles including management, education, and clinical practice. This included those involved in both provider and commissioner services.

High influence	NHS trusts Fund holders Health Education England
	The public NHS England & Improvement Health and Social Care partnerships Integrated Care Systems Commissioners

Figure 1: Stakeholder analysis

High interest

2.1.2 Stakeholder engagement

Stakeholders from every trust within the ODN footprint, and integrated care systems, were invited to help shape the development and implementation of the VAST Programme as it progressed. In addition, HEE and the relevant integrated care systems were frequently updated of progress throughout the VAST Programme.

Table 1 shows the proportions of trusts in each region, where any stakeholders reported any degree of organisational reflection or training needs analysis, in light of their pandemic experience. Organisational reflection ranged from trust-wide reviews to reflections on the team or department level on specific issues, such as the winter surge. Training needs analysis tended to be included as part of regular annual reviews, or around specific issues such as critical care or transport. Identifying this allowed the programme to avoid unnecessary duplication.

	Any organisational reflection	Any training needs analysis
ODN footprint	35%	15%
Cheshire & Merseyside	25%	13%
Greater Manchester	83%	33%
Lancashire & South Cumbria	0%	0%
North Wales	0%	0%

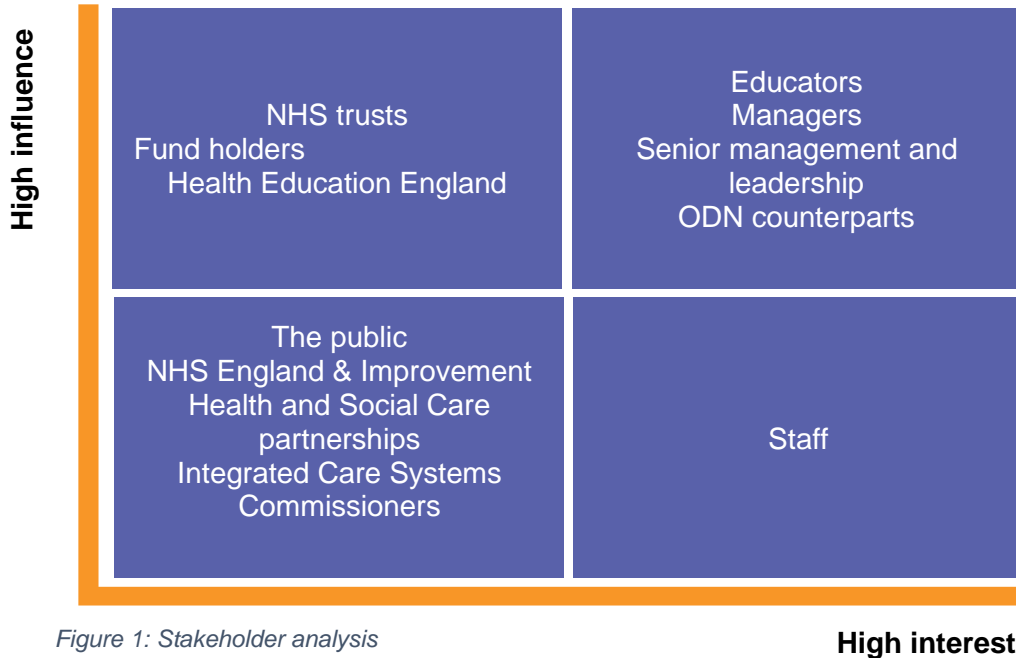

Figure 1: Stakeholder analysis

Table 1: Percentage of trusts reporting any degree of organisational reflection or TNA, considering pandemic experience

The regional educators recognised that the potential scope of the programme was significant. As such, stakeholders were also asked to identify which topics they felt should be considered by the VAST Programme. This was to ensure that the programme remained focused and able to identify the needs of stakeholders. Stakeholders from within the ODN were invited to review findings and areas for learning identified through the VAST programme following the training needs analysis. This also included potential measures to address and mitigate these training needs.

2.2 Survey

2.2.1 Design and development
An online survey was developed to ensure the widest reach across the ODN's footprint. This methodology was used to:

- avoid practical difficulties with data analysis associated with non-electronic formats
- enable the program to reach a wider variety of stakeholders

The scope and content of the survey was based upon stakeholder engagement on which areas should be considered as part of this training needs analysis. Pareto analysis was used to identify the common themes, so that these could become the focus of the survey (NHS England and Improvement 2022b). These areas were:

- working out of their usual setting
- staff absence
- training needs and training access to training
- digital technology
- staff emotional health and wellbeing and morale
- the increased acuity of patients (physical health)
- the increased acuity of patients (emotional health and wellbeing)

Microsoft Forms was used to design, distribute and collect survey responses. Questions were a mixture of both closed and open-ended questions. They were initially developed by the regional educators to address these survey areas. To establish content validity the draft survey was reviewed by the ODN leadership team and expert academic support. (Appendix 1 for survey contents). This allowed the survey to be further refined, with approximately 30 potential survey questions available to participants, dependent upon previous responses. The survey was piloted in three trusts (including one tertiary centre) across Greater Manchester, Cheshire and Merseyside, and Lancashire and South Cumbria to establish face validity of the survey. Feedback from the pilots was used to make changes prior to the launch of the survey across the ODN footprint.

2.2.2 Distribution and collection
The survey data collection period was open for eight weeks during August and September 2022. The survey was disseminated by regional educators using a survey link, QR code, and digital poster through a variety of routes:

- Each trust's communication team
- The stakeholders
- Integrated care systems

Each trust was also provided with physical versions of the poster to put up in staff areas. Reminder messages were regularly repeated through communication teams and stakeholders. This varied based upon what each team was able to accommodate. Service areas were given the opportunity for regional leads to meet with them and their staff, remotely or in person to discuss the VAST programme and encourage survey response. Staff were offered various incentives, including the chance to win a £100 gift voucher.

2.3 Focus group and Interviews

2.3.1 Design and development
Focus groups and interviews were also used to gain a more in-depth perspective from respondents, giving greater context to survey results.

Following a preliminary analysis of the survey responses, key areas for greater exploration were identified by the VAST Programme regional leads. These were:

- the experiences and perceptions of being moved out of their normal setting or role during the pandemic
- the experiences and perceptions of support received during the pandemic
- the experiences and perceptions of training and development during the pandemic
- staffs' perception of their current workplace experience

2.3.2 Distribution and collection
Focus groups and interviews took place over two weeks in October 2022, facilitated by regional educators. The staff who were invited to take part in the focus groups / interviews had all expressed their interest during the completion of the online survey. They were given the opportunity to take part in either a focus group or an interview, in person or virtually. In order to promote uptake and respondent confidence, this choice was left with the respondent. The VAST Programme recognised that some staff may feel more comfortable with sharing their experiences on their own, as opposed to within a group. All participants chose to take part virtually.

Each focus group and interview was transcribed, anonymised and content confirmed before being stored on secure servers. Once the results had been analysed and processed, the transcripts were deleted.

2.4 Analysis
Thematic analysis was used to analyse the survey, focus groups, and interviews, following the widely used six-step approach of Braun and Clarke (2006). In addition, each step in the process was subject to triangulation by the regional educators. Initial analysis was undertaken using functions of Microsoft forms. Pareto analysis was employed to identify the most impactful or prevalent areas for focus.

3. FINDINGS

3.1 Results

A total of 642 valid survey responses were received. A breakdown of respondents can be seen in figures 2 and 3. As 10 staff reported working across more than one region and three staff reported working in more than one occupation, these represent total cited frequency for each region and occupation.
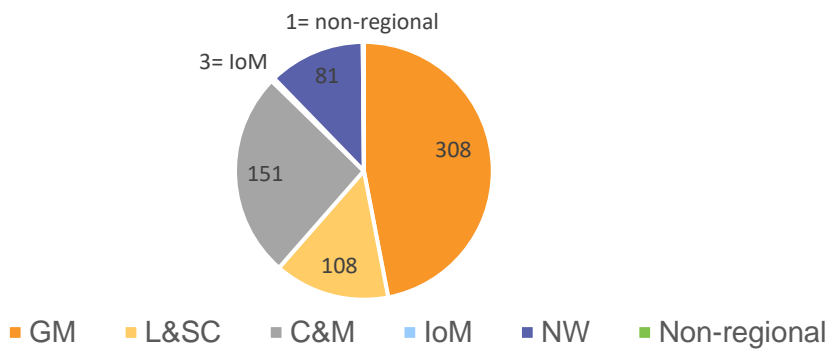
Proportion of respondents per region

Figure 2: Regional breakdown of survey responses (absolute numbers)
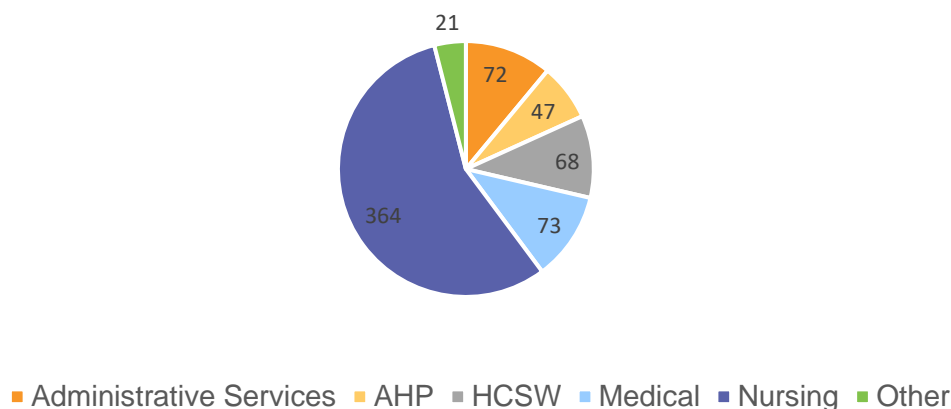
Proportion of respondents per occupation

Figure 3: Occupational breakdown of survey responses (absolute numbers)

A total of 10 interviews were undertaken (C&M n=4, GM n=4, and L&SC n=2) and 12 staff attended focus groups collectively (C&M n=2, GM n=4, NW n=3, and L&SC n=3).

3.2 Training needs and training access

The COVID-19 pandemic had a considerable impact on staff experiences of training, with 70% of respondents reporting their training had been affected in some way. Participants identified several themes related to the impact of the pandemic on training needs and training access. This included impact on training, training needs, and support and access. There was some variation in how staff members perceived effects on their training, as indicated in figures 4 and 5, and this is explored within each theme.
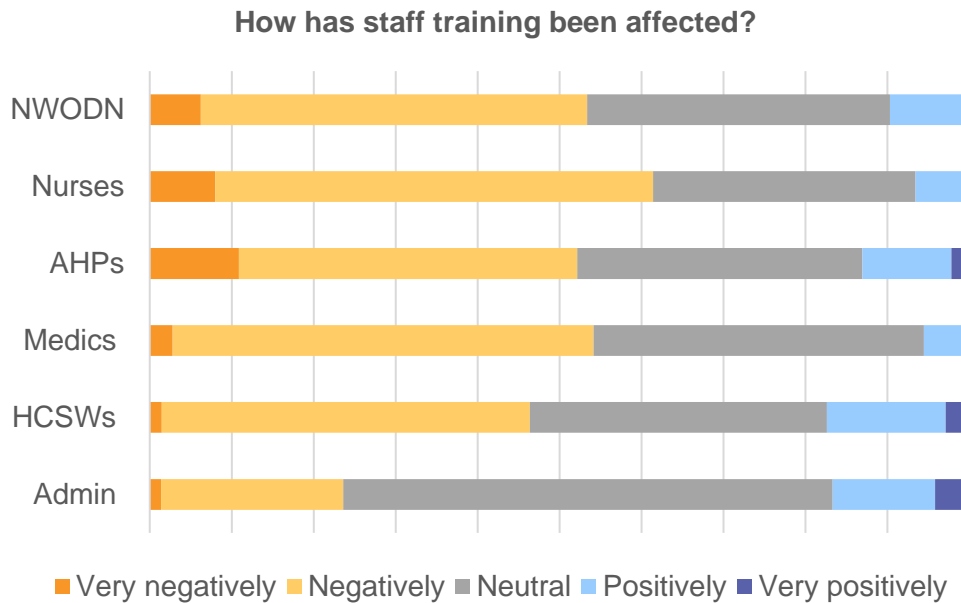
How has staff training been affected?

Figure 4: Effect on training, by occupation

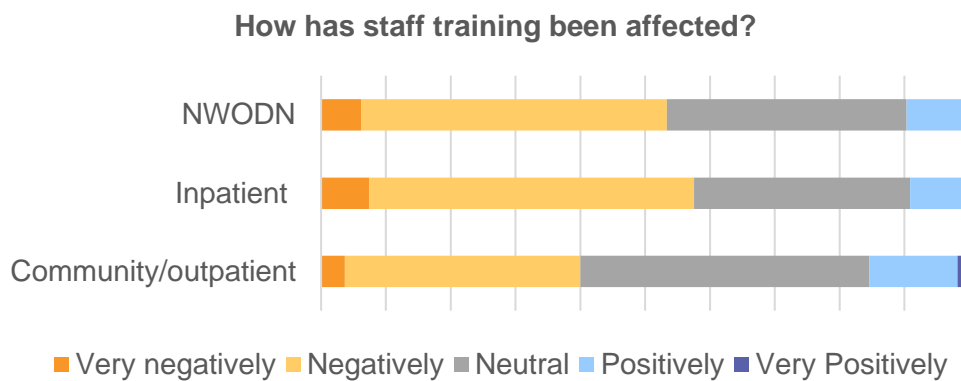### How has staff training been affected?

Figure 5: Effect on training, inpatient vs. community/outpatient

3.2.1 Impact on training

Changes to training
Most training moved online
Non-essential training was cancelled
More remote training
Reduced numbers at face-to-face training due to restrictions
Unable to attend training opportunities due to workplace pressures
Suitable training venues often unavailable

Table 2: Most prevalent changes to training and access experienced by staff (descending significance)

Training and development courses impacted	
Training and development type	**Percentage of staff affected**
All training types	70%
Mandatory training	48%
Continuing professional development	39%
Other training/study days	24%
Conferences	7%
Pre/Post-registration training	3%

Table 3: Percentage of respondents reporting training affected

Effects on training: Staff in clinical settings noted numerous pandemic-related effects on training. Reports of unavailable or delayed training were made across all occupations. Additionally, the medical and nursing staff noted that due to service closures and staff removal from rotations, their training opportunities were not always available. One participant explained that it was hard to get "*competencies that [they] needed to achieve in terms of like clinical examinations*" signed off because "*nobody would have… trainees come to them*". Some nurses and HCSWs brought attention to this change in opportunity by reporting that some trusts discontinued paediatric training, which was previously provided at the trust level. (Table 2 outlines the most widely reported training and access changes, following Pareto analysis, and table 3 shows the percentage of staff reporting that their training was affected).

Negative online training: A lack of social interaction and overall preference for face-to-face training was highlighted by nursing and medical staff in some inpatient and community/outpatient settings. Along with HCSWs, they also reported that they simply found online training harder. One HCSW reported that they "*find learning face to face a lot easier than through like online means*"

Positive online training: Positive trends in training, particularly the move to online systems, have been discussed by some nurses and doctors in inpatient and non-clinical workplaces. These were mainly that training could now be more accessible and more efficient. As one nurse explained, "*I think it really helps a lot of people with attending like shorter sessions*"

3.2.2 Training needs
Responding to training needs: Doctors and nurses in inpatient settings identified ad hoc local training as the primary solution to the changing training needs brought on by the pandemic. One nurse identified that this allowed them "*to put more…sessions on*". Some commented favorably on this method, that it provided an opportunity to better meet their needs, do things differently.

50% of staff respondents reported that they had new training needs as a result of the pandemic that were not met, for example due to caring for a different patient group. Table 4 shows the new training needs which were most frequently reported as not being met.

Training needs which were not met
Use of Personal Protective Equipment
Basic Life Support
Advanced clinical skills
Clinical patient escalation
Leadership and management
Adult critical care
Paediatric acute care
Conflict resolution
Health and safety

Table 4: Training needs, due to the pandemic, which were not met (descending significance)

Specific training needs: HCSWs, medical staff and nurses who worked in inpatient and community/outpatient settings, identified training in CYP's emotional health and wellbeing as an emerging need during the pandemic. Further training needs identified by participants can be found on pages 18 and 19.

Training variation: Several inpatient and non-clinical nursing staff reported having a persistent training deficit as a result of the pandemic. One nurse explained that "w*e have nobody within the team who can do that now (BLS training) ...... due to people, leaving ...., but that is again a risk".* To lessen this impact, one consultant indicated that efforts are being made to make it simpler for experienced personnel to work across trusts by creating a skills passport. The impact of the training gap was made worse due variability in training and standards between hospitals. As one educator explained, "*there's issues and within the fact that different trusts and different hospitals do things slightly differently*".

3.2.3 Support and access
Support and access: Medical staff and nurses working inpatient and community/outpatient settings reported that there is an increased expectation to complete training outside of the workplace. Administrative and nursing staff noted that although they were expected to work more online, they lack adequate training and support on how to manage these changes. This was typified by one nurse, explaining "*I think I felt so basically my whole training experience had to be like driven by me. So that's like very, very wearing at the end of three years*".

3.3 Digital technology

The pandemic saw an increase in the use of digital technology, including virtual meetings, patient consultations, and an increased move towards paperless systems. Most (86%) respondents reported that changes in digital technology were seen in their workplaces and teams, and 52% reported that changes affected their service and patient care. Participants identified several themes related to digital technology use during the COVID-19 pandemic. This included accessibility, communication, education, impact on patients, service impact, staff emotional health and wellbeing, technology difficulties and virtual technology. As shown in figures 6 and 7, there was some variation in how digital technology was perceived to have impacted on services and workplaces between staff groups. These differences will be explored within each theme. Staff who had received training in digital technology were significantly more likely to feel positively about its impact on their service and workplace, as shown in figures 8 and 9.

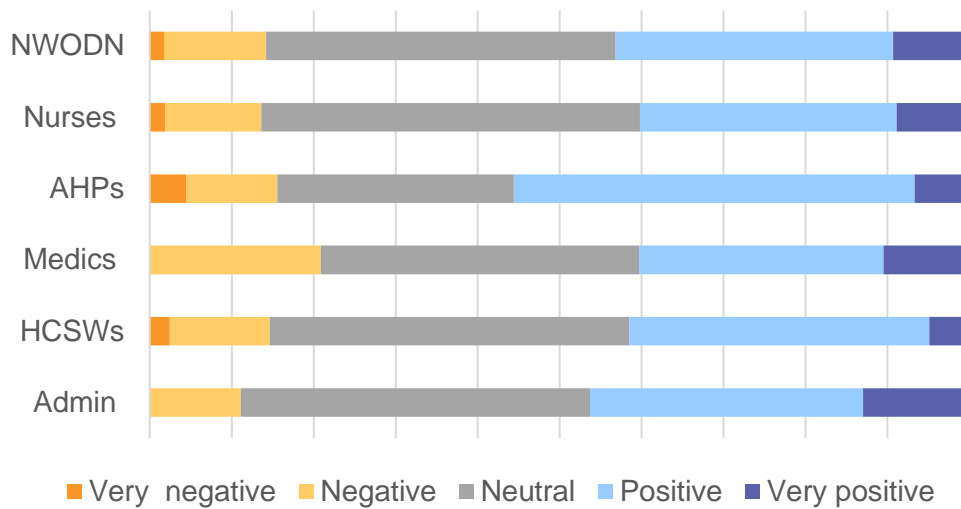**What was the effect of digital technology changes on the workplace?**

Figure 6: Effect of digital technology on workforce, by occupation

3.3.1 Accessibility

Negative impact of accessibility: Staff working within clinical environments, except for doctors, reported having mixed feelings about the use of digital technology. Participants across workplaces, apart from HCSWs, reported that they experienced more unnecessary meetings as the use of digital technology made them easier to arrange. For some nurses, outside of community/outpatient areas, this also impacted work life balance. One nurse reported *"everyone assumed that you can be available at all times"*, as they had a personal smartphone.

Positive impact of accessibility: Many staff, across professions and settings, felt that digital technology had a beneficial impact on accessibility. The ability to work remotely and with more flexibility was made possible by *"excellent changes for technology and support systems for working from home"*, said one AHP. According to reports, this made it easier for employees to access meetings and their coworkers, giving them more choices in how they could contribute or attend. Respondents also expressed strong support for the reduction in travel time, which had the benefit of increasing clinical time for many

3.3.2 Communication

Negative communication: Nursing and medical workers in clinical settings cited the underutilization of digital technologies to aid communication as a drawback. One doctor remarked that this was a missed opportunity to implement new ways of improving team communication and that instead they were forced to have *"silo meetings"*.

Positive communication: Outside of ED/POA, registered and administrative staff reported that the use of digital technology had improved communication and collaboration. A *"greater awareness of patients"* and *"easier communication within clinical"* teams were at the center of this, for nursing staff. Medical and nursing staff from inpatient and community/outpatient settings reported that as digital systems advanced, access to and the quality of record keeping both increased.

3.3.3 Education

Negative education: Some staff members did not feel that online training improved their experience. Nurses and HCSWs in areas apart from ED/POA suggested that education

utilizing digital technology was less effective, with a HCSW describing it as *"tiring"* and *"hard to follow"*.

Positive education: Digital technology was widely felt to have a positive impact on education and training. Staff in clinical areas reported having an increased access to education due to digital technology. In addition, staff outside of ED/POA, apart from medics, noted that they have been able to learn new skills and confidence in informatics and digital technology during the pandemic. One nurse talked positively about how these "*gained skills [could be used in their] current role*".

3.3.4 Impact on patients
Negative impact on patients: Clinical professionals in the inpatient and community/outpatient settings identified several negative effects that digital technology has had on patients. It was raised that it could disadvantage patients who may not be able to afford devices. At the same time, several nurses found that that some parents felt *"fobbed off"* by virtual consultations. This may be made worse by the challenges associated with clinically assessing patients virtually; according to one nurse. It was feared that this may impact patient diagnosis and treatment; according to one nurse, *"this has had a negative impact on diagnosing and treatment (especially from consultants)"*.

Positive impact on patients: The use of digital technology during the pandemic, according to many staff from all professions working in inpatient and community/outpatient settings, improved patient access to services. They argued that it gave patients and families choices and empowered them to care for their children without often visiting professionals. Participants from clinical areas also noted that the patient experience had improved, with some nurses mentioning a "*hugely positive*" impact, being more convenient for families, and enabling CYP with social difficulties to continue feeling secure.

What was the effect of digital technology changes on services provided?

Legend: ■ Very negative ■ Negative ■ Neutral ■ Positive ■ Very positive
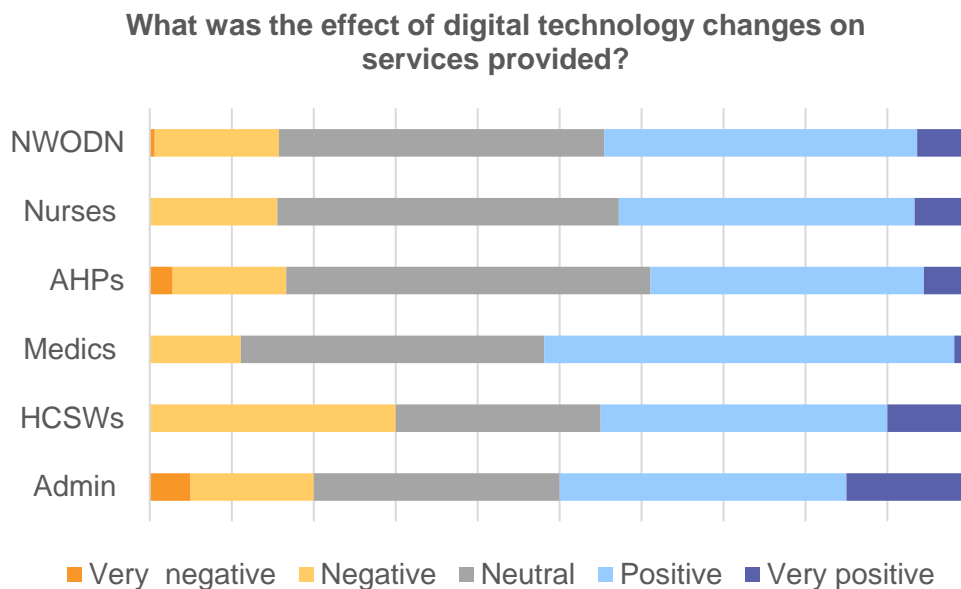
Figure 7: Effect of digital technology on service provided, by occupation

3.3.5 Service impact
Service changes: Respondents in all clinical settings indicated that they thought future improvements in digital technology were likely and that changes would be permanent. The only group of employees who did not predict any future developments were doctors. Some

nurses and AHPs have also noted that the use of digital technology may result in services becoming more environmentally friendly in the long run, especially as paper use decreases.

Service continuity: Staff in workplaces other than the ED/POA talked about how digital technology has impacted service continuity. They were able to *"continue supporting injured children through online activity"* and *"care could be coordinated with multiagency services virtually"*, as a nurse discussed. Some nurses, AHPs, and administrative staff found that being more flexible during the pandemic contributed to their ability to deliver care effectively.

3.3.6 Staff emotional health and wellbeing

Negative social interaction: There was a lack of face-to-face and social interaction reported by staff in settings besides ED/PAOs and non-clinical areas. Many registered clinical staff reported preferring face-to-face contact. Conversations around this centered on a feeling of loss, with one administration worker commenting that they think *"we've lost the human factor"* and that this made communication more difficult. Nurses working in inpatient areas also reported that this affected their ability to network and build social relationships in work and training.

Positive emotional health and wellbeing: It was widely reported that digital technology had a positive impact on nursing, administrative, and HCSW's emotional health and wellbeing. This is mainly due to the ability to communicate with others online for support, which was allowed them "*to boost morale*", as one HCSW reported.

3.3.7 Technology difficulties

Equipment and resources: A lack of sufficient equipment and unreliable technology was ubiquitous during the pandemic. This often involved poor connectivity and insufficient Wi-Fi and was seen as just another barrier amongst staff. This was particularly felt by some staff working remotely who, not having access to devices to do their work, *"expected to use [their] own devices"*, as a nurse reported. Clinically based staff also reported struggling to care for patients because they had less access to digital devices.

Negative experiences of technology: Participants from all professional groups, except AHPs, reported inadequate or no training in digital and technology. Not feeling confident and finding it difficult to keep up with the rate of change was particularly common. Some staff discussed the difficulties that *"older"* workers faced, which affected how they provided services. This was observed in all workplaces, except for ED/POA. As a HCSW reported, some staff received *"no proper training"* and were *"just expected to get on with the job"*, many believed that this was made worse, with inadequate IT support, inadequate technology training, and feeling uncomfortable with technology.

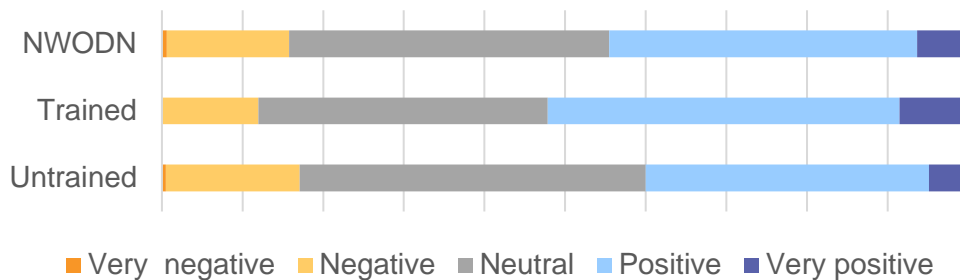**What was the effect of digital technology changes on services provided?**

Legend: ■ Very negative ■ Negative ■ Neutral ■ Positive ■ Very positive

Figure 8: Effect of digital technology on service provided, by training status

What was the effect of digital technology changes on the workplace?

Legend: ■ Very negative ■ Negative ■ Neutral ■ Positive ■ Very positive
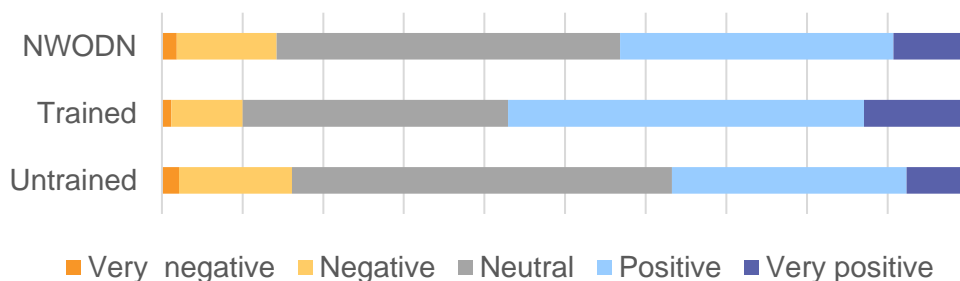
Figure 9: Effect of digital technology on workplace, by training status

3.3.8 Virtual technology

Negative impact of virtual technology: Across occupations and settings, there was a universal problem with communication. This included a prevalence of distractions when using technology, as well as finding it difficult to read the room or work with larger groups. Having to use these systems in an inappropriate environment was also brought up by many workers, which raised issues regarding confidentiality. At the same time, nursing staff in both inpatient and community/outpatient settings were also concerned about how digital technology might affect safeguarding. These were centered on how it was *"difficult to have challenging conversations with families through a screen",* as one safeguarding nurse explained.

Positive impact of virtual technology: Apart from HCSWs and ED/PAOs, many people reported experiences of working more efficiently and effectively with digital technology, as an administrator reported, it was made "*easier to arrange meetings*". Inpatient and community/outpatient doctors and AHPs also reported that virtual technology allowed them to see more patients. Inpatient staff members also said they prefer to use virtual technology for their work, especially in meetings.

3.4 Increased Acuity of Patients (Emotional Health and Wellbeing)

During and post pandemic there was a rise in the number of patients presenting with emotional health and wellbeing needs. This is noted by 78% of participants seeing an increase in the number of emotional health and wellbeing patients across the North West. Only 22% of participants reported that they felt adequately prepared to care for these patients and families (see figures 10 and 11). Themes were identified around the increase acuity of CYP with emotional health and wellbeing needs including the effects on staff emotional health and

wellbeing, due to the increased number of patients, and the lack of training to support emotional health and wellbeing patients.
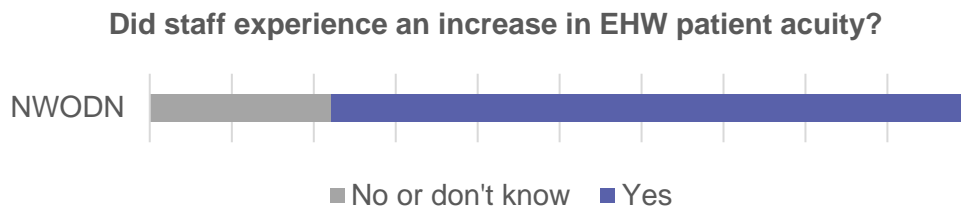
Did staff experience an increase in EHW patient acuity?

Figure 4: Staff perception of acuity increase

Did staff feel adaquetly prepared to care for higher acuity EHW patients?
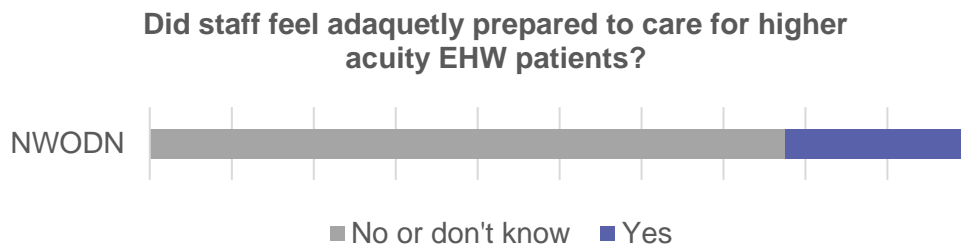

Figure 11: Staff preparation for increased acuity

3.4.1 Effects on Staff Emotional Health and Wellbeing
Effect on staff emotional health and wellbeing: Nurses from inpatient wards and community/outpatients, discussed the impact seeing more patients with emotional health and wellbeing needs had on their emotional health and wellbeing, with one reporting that it is "*exhausting [and] mentally draining*"

3.4.2 Increased patients
Increased patients: Nurses and medics from all areas apart from critical care, commented on seeing a spike in serious mental health problems in CYP. One As one nurse reported, this included "*anxiety, self-harm and ticks as well as continence concern*s".

3.4.3 Unprepared for Emotional Health and Wellbeing Patients
Specialist staff: A small number of staff (nurse and medics) from inpatient wards and community/outpatients, discussed wanting more mental health staff on their wards. Other staff (medics, nurses and AHPs) from all areas, commented on wanting better support from specialist staff.

Placement of patients: All staff (apart from AHPs) mainly from inpatient wards and community/outpatients commented on patients with emotional health and wellbeing needs being in a hospital setting as an inappropriate environment. There was a desire for more "*appropriate placements/support in community to avoid inappropriate admission to medical wards when not acute medical need*", as one nurse explained.

Under resourced: It was discussed by nursing, medical and AHP staff about the lack of resources that areas have for supporting the care of patients with emotional health and wellbeing needs. One nurse explored a need for things such as "*sensory training, sensory environments*", to "*distraction techniques [and] places to signpost child and families to*".

Team support: A small number of staff (nurse and HCSWs) discussed wanting more support from senior experienced staff e.g., Ward sisters when caring for patients with emotional health and wellbeing needs.

Training Need: All staff groups (apart from administrative services) across all areas discussed wanting more specific emotional health and wellbeing training. Table 5 shows the result of Pareto analysis of all identified preparation needs for caring for patients with emotional health and wellbeing needs, across the ODN footprint.

Preparation required for staff to support CYP
Basic/essential emotional health and wellbeing training
Specialist emotional health and wellbeing support
Escalation/de-escalation management training
How to access/navigate services
Eating disorder training
Awareness of signposting for support
Communication training
Easier access to emotional health and wellbeing services
Face to face emotional health and wellbeing training
Increased resources
Training/support from mental health nurses

Table 5: Preparation needs to support CYP with EHW needs identified by staff (descending significance)

3.5 Increased Acuity of Patients (Physical Health)

It was found that 42% of participants reported an increase in acuity of physical illness severity of children, and 16% of respondents felt like they were not adequately trained or prepared to care for these patients (see figures 12 and 13). Two themes emerged, the effects of higher acuity patients, and being unprepared. Staff who reported that they felt inadequately trained or prepared were given the opportunity to suggest what would need to change to address this. Pareto analysis was used to identify the most prevalent needs, which can be seen in table 6.
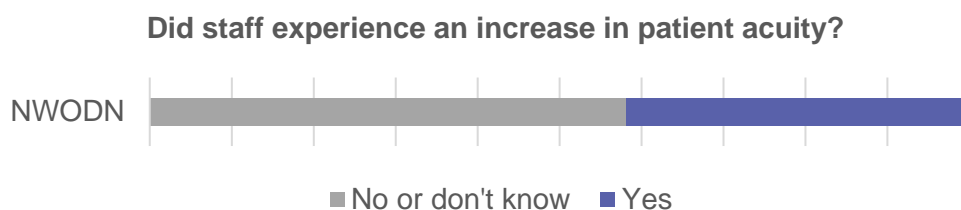
Did staff experience an increase in patient acuity?

■ No or don't know ■ Yes

Figure 5: Staff perception of acuity increase

Did staff feel adaquetly prepared to care for higher acuity patients?

Figure 13: Staff preparation for increased acuity

3.5.1 Effect of Higher Acuity of Patients

Ratios impacted: Some nurses from inpatient wards commented on the unexpected higher acuity of sick CYP they were having to care for. Medical staff, nurses, and HCSWs from inpatient wards also discussed the impact of having higher acuity patients and managing this with insufficient staffing ratios, with one medical staff member saying it led to longer waiting times for reviews for patients. All staff groups apart from HCSWs from all areas except community mentioned that it led to an increased workload for staff and leaving one with the feeling of "*not giving the best care you can give due to having high acuity [patients]*". As one nurse reported.

3.5.2 Being unprepared

Under resourced: All staff groups from inpatient general wards and community, apart from medical staff, mentioned having insufficient resources to deal with the increase in acuity of patients. These included things such as saturation probes and CPAP machines, meaning they felt like they were "*unable to absorb the increase in capacity*", as a nurse revealed.

Lack of competence: Nursing and medical staff from inpatients and ED/POA have discussed being deskilled in dealing with sick CYP, due to lack of experience either because of being newly qualified, or not having exposure during the pandemic. One nurse commented that they "*were not trained on the things usually done in the ward [to care for these patients]*". Table 6 shows the most prevalent preparation needs reported by respondents.

Perceived preparation needed to care for higher acuity CYP
Sufficient equipment/resources
Equipment training
PIMS-TS management
Intubation/ventilation management training
Non-invasive respiratory support (includes both HFNC and NIV) training
Safe staff numbers
More skilled/experienced staff
Training to care for paediatric patients
PCC Level 2 care training

Table 6: Preparation needed to care for higher acuity physical health CYP (descending significance)

3.6 Working Out of Area

During the pandemic and following winter surge, staff had to work out of their usual area for various reasons. The survey identified that 34% of participants reported that they worked out of area during the pandemic, this included 32% of inpatient staff and 50% of community/outpatient staff. Of these participants, 45% reported feeling supported when they moved to a new area.

A detailed breakdown of where staff were most frequently moved to can be seen in table 7. Although there is some variation, moving to adult services (general adult ward or adult critical care) were a near universal experience across work settings and professions. Only a small minority of staff who were moved to adult areas reported feeling prepared for this, as seen in figures 14 and 15. Across the ODN footprint, the three most common areas were adult general wards, adult critical care and paediatric inpatients (general wards). The experiences of staff groups and areas can be seen in figures 16-19 and were developed into themes comprising adult care, logistics, new area, and staff emotional health and wellbeing.

Most frequent areas staff were redeployed to during the pandemic
Adult General ward/area
Adult Critical care
Inpatient (General wards)
Community/outpatients
ED/POA
Remote working
Inpatient (Neonates)
Inpatient (Critical care)
Non-Clinical

Table 7: Most frequent areas to which staff were moved across whole ODN (descending significance)

3.6.1 Adult care

Preparation: Nurses, HCSWs and AHPs from all areas have discussed the adult training (if any) they received. This ranged from half a day to 2 weeks with opportunities to shadow staff. Some staff stated that they were already trained to care for adults. Medical participants also discussed the challenges in needing to adapt to caring for adult patients within a paediatric setting. One medic stated, "*all of a sudden, they were having to learn how to do adult intensive care, having not even done adults anaesthesia for however many years*"
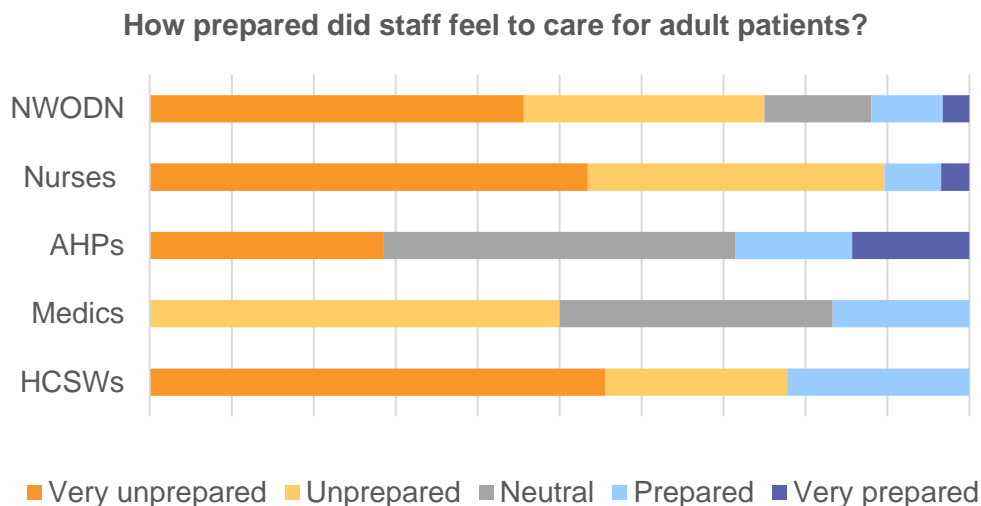

Figure 14: Staff preparation for caring for adults, by occupation

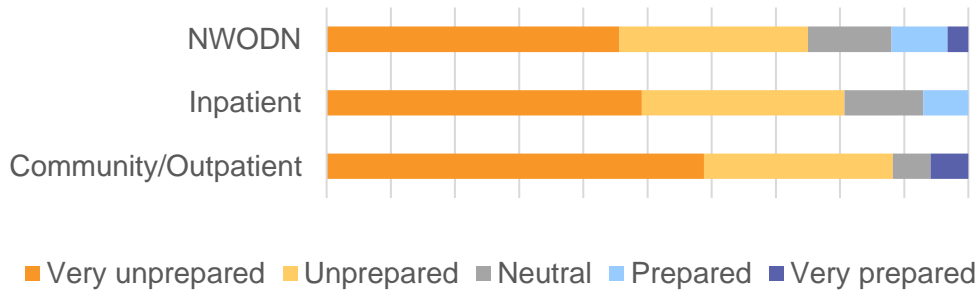**How prepared did staff feel to care for adult patients?**

Figure 15: Staff preparation for caring for adults, inpatient vs. community/outpatient

3.6.2 Logistics

Moved: Medics discussed being formally redeployed at the start of the pandemic, with one explaining that "the *entire anaesthetic department…all became intensivists".* Other staff, especially nurses, from inpatients discussed their area closing and being sent to work elsewhere within paediatrics or reflected on having staff from other areas coming to work within their team.

Change in services: Nursing and medical staff from inpatients and ED/POA reflected on the change in service during the pandemic. Some staff reported that the changes they experienced were to prepare for a worsening demand on services. One nurse explained how their service changed to "*take as much [pressure] off the adult services…we redirected all children and to the ward so no children came through our ED department during COVID*"..

3.6.3 New Area

Negative experience of being moved: The experience of some nursing staff from non-clinical and inpatient settings was negative. Some felt there were different expectations of them, for example one nurse explained "*the adult side were really keen for extra staff, but there wasn't any definitive description of what we'd be doing as paediatric nurses…[sometimes] staff were expected to be more like a registered nurse, and sometimes they're expected to be like healthcare's*". Others spoke about inadequate training when moved to other areas.

Nursing participants also mentioned having inappropriate responsibilities when moved to other areas, one reflected "*some of the girls had an awful time…they were expected to take full responsibility for the ward*". Nursing and administrative staff discussed the lack of support they felt they had from their own team and others discussed a lack of support from the new area that they had moved to. Nursing staff within inpatients also felt that being moved increased staff absence in their experience, with one nurse saying that being made to go to adult wards sent a lot of people off sick. Staff perceptions of their experiences of being moved can be seen in figures 16 and 17.

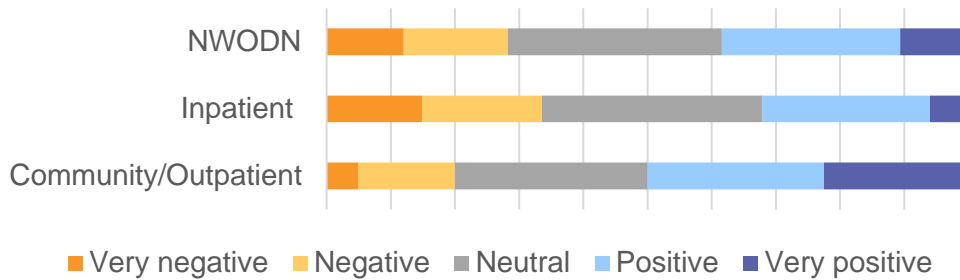**What was the experience of staff working outside of their usual role?**

Legend: Very negative, Negative, Neutral, Positive, Very positive

Figure 16: Staff experience of working outside their usual role, inpatient vs. community/outpatient

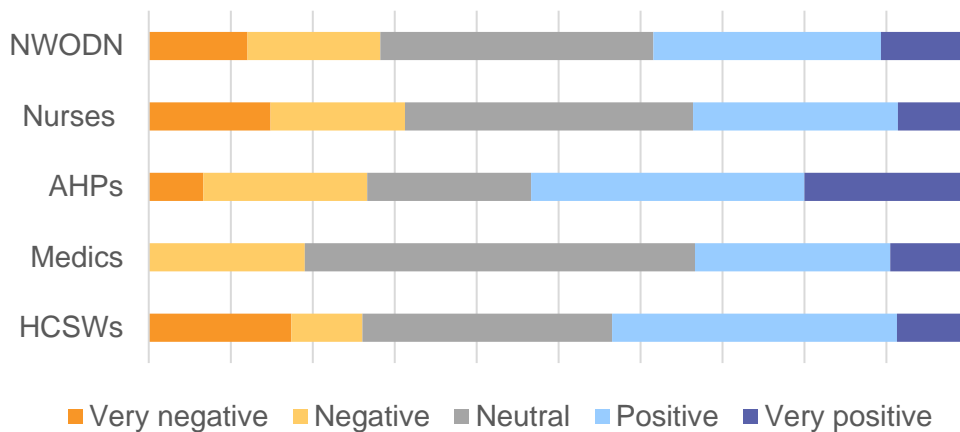**What was the experience of staff working outside of their usual role?**

Legend: Very negative, Negative, Neutral, Positive, Very positive

Figure 17: Staff experience of working outside their usual role, by occupation

Positive experience of being moved: Nursing and medical staff from non-clinical settings, with a few from inpatient wards, discussed their positive experiences of being moved. One nurse reflected on the support she received within their new team, explaining "*the relationships with the group of other people redeployed was one I will treasure and the peer-to-peer support unmeasurable to me*". Other staff spoke of how protected they were when they were moved, with one participant saying they were reassured by their new team that they were simply there to support whilst being supernumerary. Staff perceptions of support when moved can be seen in figures 18 and 19.

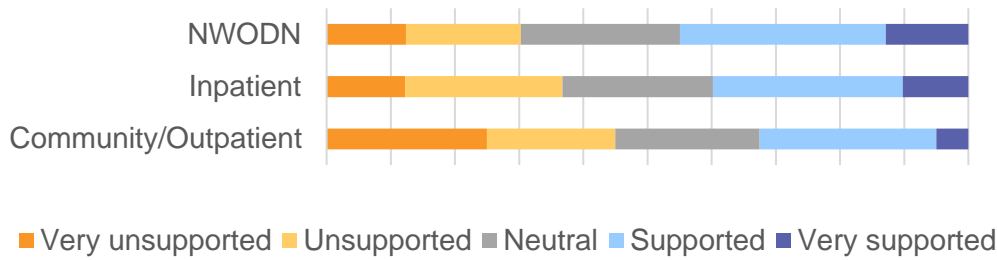### How supported did staff feel working outside their usual role?

Figure 18: Staff support when working outside their usual role, inpatient vs. community/outpatient

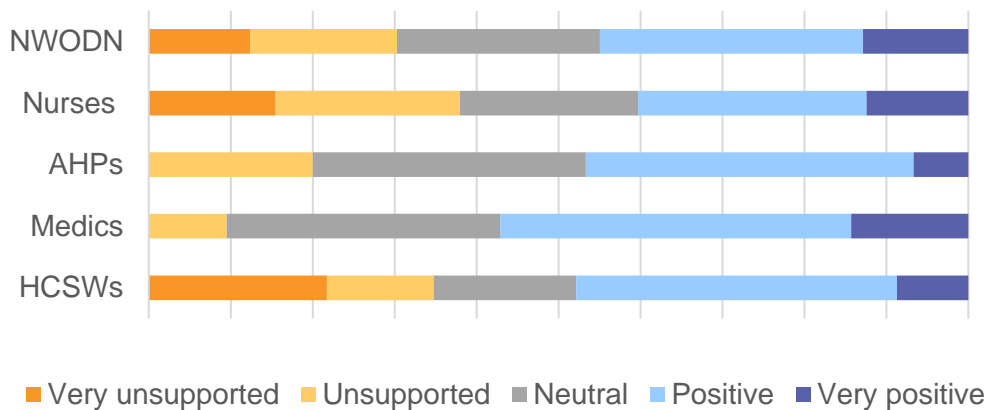### How supported did staff feel working outside their usual role?

Figure 19: Staff support when working outside their usual role, by occupation

3.6.4 Staff Emotional Health and Wellbeing

Risk of COVID-19: Non-clinical nursing staff discussed the fear of catching COVID-19. For some staff this was exacerbated by a fear of taking it home to a loved one, which was sometimes associated with increased anxiety in staff. As one participant explained, "*every minute I was frightened [of covid risk in new area]*"

Negative staff emotional health and wellbeing: Several nursing and administrative staff from inpatient, community/outpatient, and non-clinical areas discussed the impact the COVID-19 pandemic had on their emotional health and wellbeing. One nurse described their experience as "*frustrating, it made my anxiety worse*".

Unfair allocation: Within nursing staff, particularly in inpatient wards, the lack of choice in being moved also came up, along with a sense of unfairness. This was typified by one, who explained that staff had "*no choice in the matter. They weren't asked for volunteers. They were just told that they were going*".

3.7 Staff absence

Across the ODN footprint, 76% of staff reported observing a significant increase in staff absence, 80% of whom said that this had a negative impact on their workplace. There were some differences in how successfully workplaces were thought to have handled staff

absences across inpatient, and community/outpatient settings, as well as staff groups, as illustrated in figures 20 and 21. Staff identified two themes resultant from staff absence: the impact of staff absence and perceptions of staff.

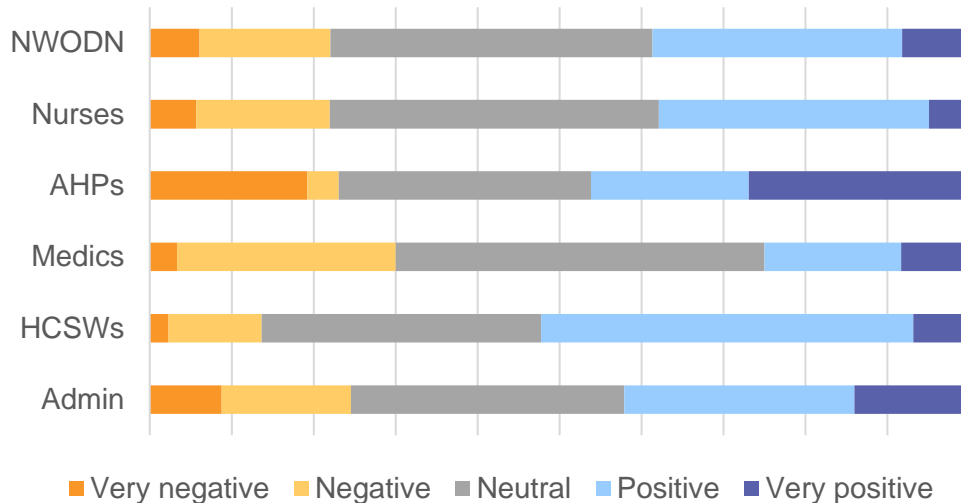**What was the perception of workplace response to staff absence?**

Figure 20: Workplace response to staff absence, by occupation

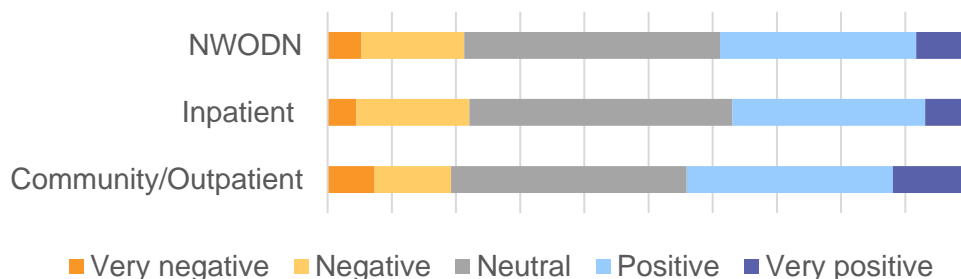**What was the perception of workplace response to staff absence?**

Figure 21: Workplace response to staff absence, inpatient vs. community/outpatient

3.7.1 Impact of staff absence

Negative impact of absence: Staff reported a multitude of negative impacts that staff absence had. Feeling understaffed was a ubiquitous experience across staff groups and areas of work. The same was true for staff reporting an increase in pressure or workload, as one nurse described, they *"felt pressured to keep going due to the lack of staff"*.

Clinical staff in inpatient areas reported difficulty in covering shifts. In some cases, services stopped because there were not enough staff to cover the required hours. Nurses within non-clinical, inpatient areas and ED/POA identified an impact on skill mix due to more experienced staff leaving or being absent. Additionally, those in community/outpatient settings also felt isolation from COVID-19 exposure contributed, particularly as it could be so short notice. With these varied factors at play, medical staff and nurses found that they were unable to work efficiently due to delays in care, long wait times for results, and things running less smoothly.

Negative impact on patients: Staff identified an impact on patient care in both inpatient, and community/outpatients. One nurse reflected *"how can we provide a proper service? How can we provide proper care?".* This sentiment was shared across clinical staff. Some medical and nursing staff, in inpatient settings and ED/POA, highlighted that when staffing levels fall below what is considered to be a safe level there is an impact on patient safety. This was most seen when patient to staff ratios exceeded safe staffing limits.

Retention: Nursing, administrative services, and AHP staff in inpatient, non-clinical and community/outpatient areas reported colleagues leaving. Some reported that this was a long-term loss of staff, and others that large numbers of staff left the profession together.

Staff emotional health and wellbeing: Registered clinical staff, reported increased stress levels, low morale, burnout, and emotional health and wellbeing issues. As one nurse stated, *"the emotional impact affected a lot people".* Staff in non-clinical areas, excluding administrative staff, also experienced an increased low morale, burnout, and staff emotional health and wellbeing issues.

Staff working out of area: Working outside of their normal clinical setting was cited as a factor in staff absence by nurses and HCSWs working within inpatients, and community/outpatients. This ranged from short-term assistance to other areas to longer-term service closures.

Team and management: Clinical areas reported a lack of support or supervision. One nurse said that they were ordered to *"step up and support [other staff]"* themselves and that they were *"unsupported [by managers]".* This was made worse for some nurses working in inpatient areas by a change in management and leadership, with one commenting that management *changed job from the ward manager and matron level* and that they *experienced considerable changes in leadership.* Teams that underwent changes occasionally experienced breakdown due to a *"lack of resilience"* and *"loss of friendliness among the work team".* Nursing staff from inpatient, community, and outpatient, as well as non-clinical teams, highlighted this.

Work life balance: Clinical staff from inpatient settings, and community/outpatients, spoke about an expectation to work more than their contracted hours. This took a toll on staff, with one medic sharing that they had to pick up many more shifts which were very busy and tiring. This overtime could also be unpaid at times. One medic noted that their tiredness *"impacted [their] family life",* an experience shared by nursing staff.

3.7.2 Perceptions of staff
Resentment of staff absence: This was particularly centred on staff who had been off shielding and then utilised their annual leave or became unwell, as explained by one administrative services staff member who said, *"this built resentment particularly where staff who were shielding for months returned and then took their annual leave".* They went on to explain that this impacted *"the exhausted staff who had to cover them once again".* Medical and nursing staff shared similar experiences in inpatients.

The same staff being off: Some medical staff suggested that sickness absence was due to a *"lack of drive and love for the job".* Nursing staff in both inpatient and community/outpatient settings also talked about feeling that high levels of staff absence, was often due to the same staff being off numerous times" and staff using guidelines to *"manipulate time off".*

3.8 Staff emotional health and wellbeing and morale

The COVID-19 pandemic had a marked impact on staff morale, with 57% of respondents reporting that staff morale in their area was lower post-pandemic (see figure 22). Some workplaces have been taking steps to improve staff morale, as suggested by 43% of respondents (see figure 23). The most prevalent actions taken, can be seen in table 8. Table 9 shows which actions were highlighted by participants who rated their workplace's response most and least favorably, although it is not possible to draw a causal relationship.

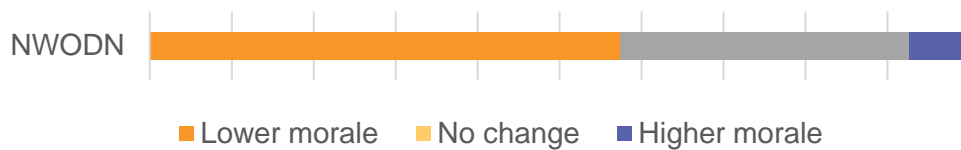### How did morale change from before the pandemic?

Figure 22: Morale changes, by region

Did workplaces try to improve morale?

Figure 23: Morale improvement attempts, by region

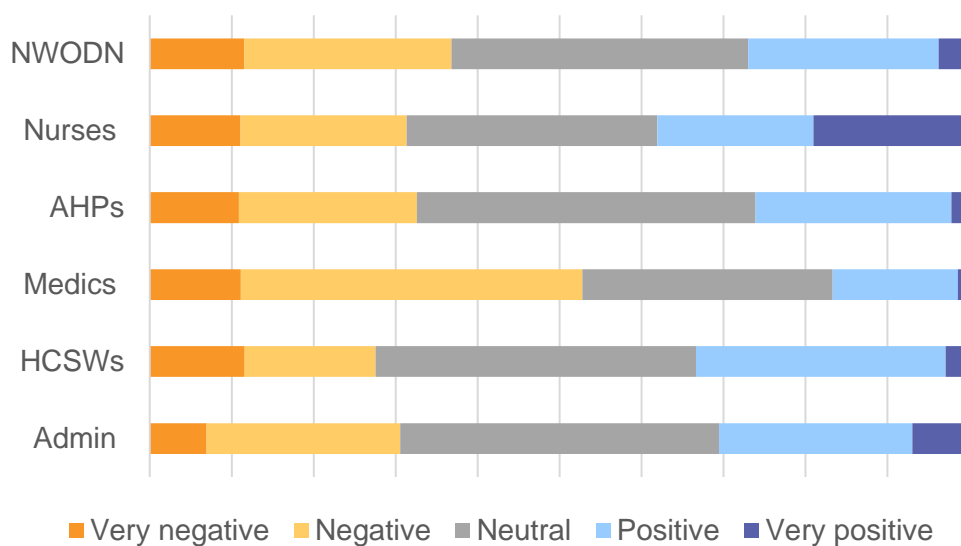### How is morale currently?

Figure 24: Current morale, by occupation
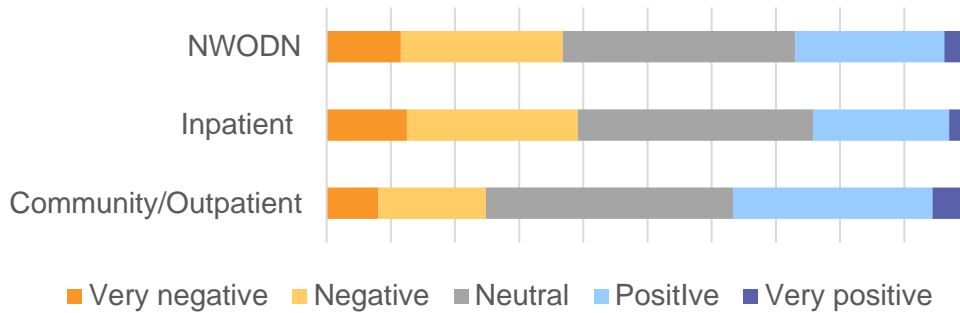
How is morale currently?

Figure 25: Current morale, inpatient vs. community/outpatient

Morale improvement cited approaches
Team meetings/briefing
Walkaround/visits
Recruitment
Social events
Wellbeing champions/team
Teambuilding
Emotional Health Wellbeing Support
Award/recognition
Increasing staffing
Away days
Information about Emotional Health and Wellbeing
Cake and treats
Communication
Positivity board
Supportive management/leadership
Wellbeing meetings/check-ins
Professional nurse advocate
Supervision
Flexible working
One to ones
Peer support
Supportive team
Wellbeing programme

Table 8: Most widely used morale improvement approaches (descending significance)

Morale boosting approaches in areas with lowest reported morale	Morale boosting approaches in areas with highest reported morale
Team meetings/briefing	Award/recognition
Wellbeing champions/team	Supportive management/leadership
Recruitment	Team initiatives
	Team meetings/briefing
	Team building

Table 9: Morale improvement approaches associated with highest and lowest reported morale (descending significance)

Just over half 53% of participants who identified that their emotional health and wellbeing had been adversely affected during the pandemic, reported that they had sought some sort of help. The largest proportion, 38%, identified that they consulted their line manager. 10-14% accessed occupational health/health professional, psychological, or other (e.g., friends, colleagues, family) support. 70% of staff stated that they have easy and confidential access to mental health and wellbeing support in their workplace. Table 10 shows those factors, which respondents most highly cited as improving their wellbeing and decreasing stress during the pandemic.

Most effective staff perceived factors which improved wellbeing and reduced stress
Peer to peer support
Free parking
Supportive management or leaders
Regular team meetings for communication
Offered/complementary refreshments
Supportive multidisciplinary team

Table 10: Most highly identified factors which improved wellbeing and decreased stress (descending significance)

Participants identified several themes related to the impact of the pandemic on staff emotional health and wellbeing. This included COVID-19 risk, impact on staff, support and recognition, team impact, and working out of area. According to figures 26-28, during the pandemic, there was a significant negative impact on emotional health and wellbeing, but participants report improvement post-pandemic.
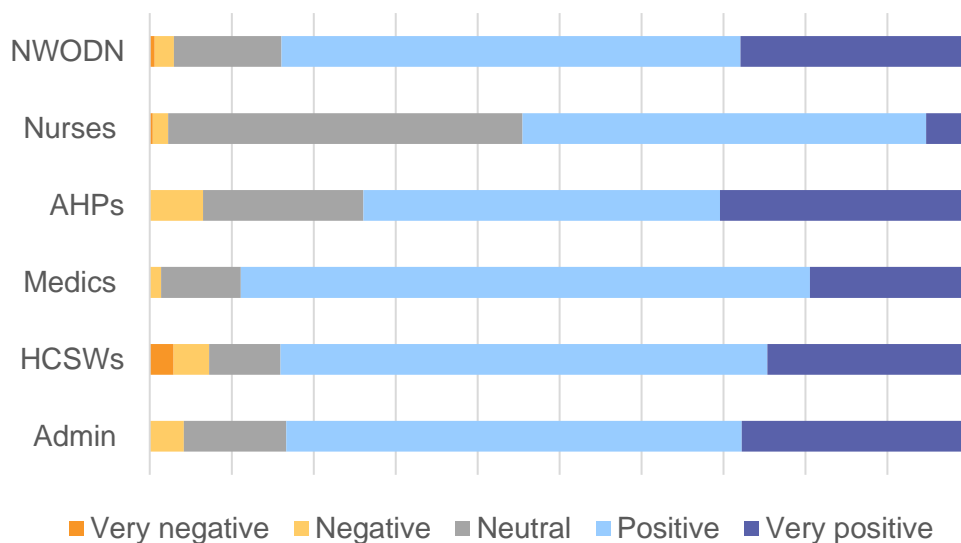
How was staff EHW before the pandemic?

Figure 266: Staff perception of EHW before the pandemic, by occupation
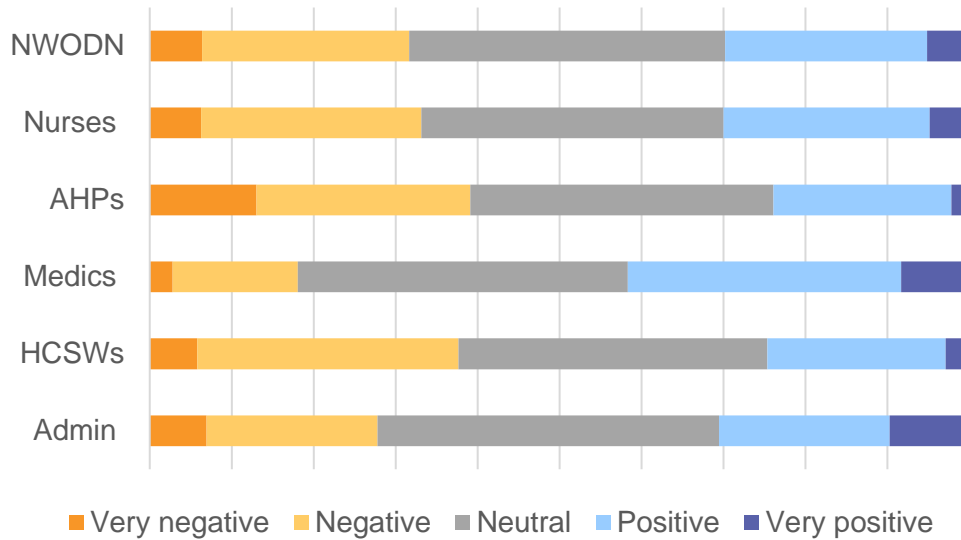
How was staff EHW during the pandemic?

Figure 27: Staff perception of EHW during the pandemic, by occupation

How was staff EHW post pandemic?
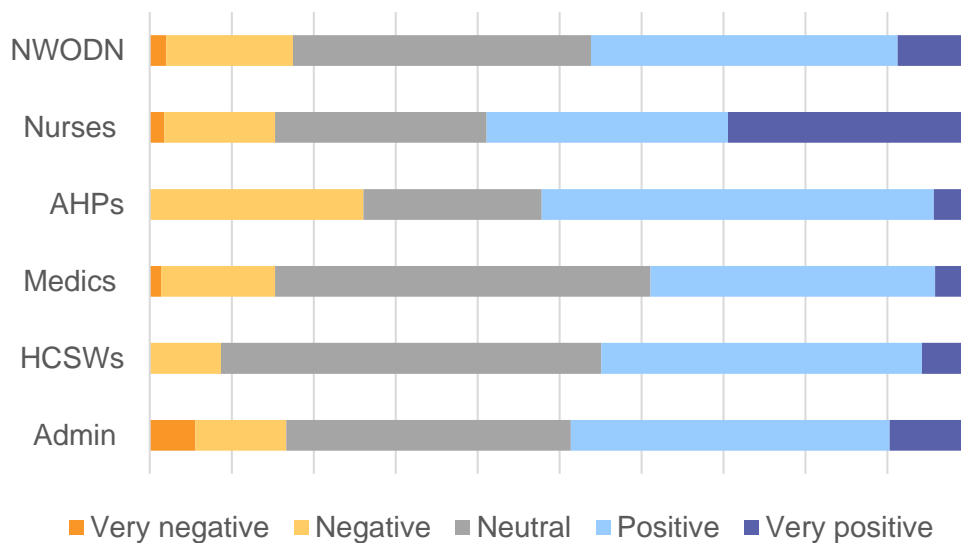
Figure 28: Staff perception of EHW post pandemic, by occupation

3.8.1 COVID-19 risk

Negative COVID-19 risk perception: Medical, nursing, and administrative staff across all work areas reported experiencing fear or anxiety around COVID-19 risk. Inpatient nurses and HCSWs discussed how anxiousness was exacerbated by changes to COVID-19 guidelines. Additionally, many had unfavorable opinions about wearing PPE due to the effects of wearing it over a long day as one nurse described, "*full PPE and working 12 hour shifts [is] physical and mentally draining*",.

3.8.2 Impact on staff

Lasting impact of COVID-19: Clinical staff reported the physical effects of COVID-19 over the longer term, including a perceived lack of resilience and "*struggling to cope*", as a nurse reported. Additionally, nurses and HCSWs described the long-term effects it had on their

emotional health and wellness, with some staff members feeling unable to make decisions or support coworkers as a result. All work settings, aside from ED/POA, reported this. Services need time to recover from the physical effects of COVID-19, as well as the long-term effects on emotional health and wellbeing. Some inpatient staff members believed this would delay the recovery of their services for a long time.

Negative emotional impact: There were numerous detrimental impacts on emotional health and wellbeing. Throughout staff groups, stress, low morale, and isolation were reported. Aside from HCSWs and those in ED/POA, staff said that their pandemic experiences had affected their job satisfaction, with many expressing feelings of being forgotten, uncertain, and overwhelmed. Some employees expressed how overwhelming things were and how they or their coworkers had been traumatized by their experiences. Clinical staff in inpatient settings and community/outpatient settings raised this issue, and several nurses even expressed accomplishment at having "*survived.*"

Negative impact on staff: Staff across all settings reported that the pandemic had a negative influence on their emotional health and wellbeing. Several issues causing this were identified by staff. Inpatient doctors and nurses have discussed the challenges of dealing with more challenging situations and visitors who became more aggressive. Clinical staff members expressed concern about how difficult it was for them to function due to a lack of staff and a growing workload. Staff members other than doctors and HCSWs noted that what was formerly the expectations for services only in escalation levels is now the norm. There were worries about the effects of the respiratory and post-COVID-19 surge throughout clinical areas. Nurses in both inpatient and community/outpatient settings highlighted the emotional distress they experienced when witnessing a child's deteriorating emotional health because of the pandemic. This was particularly, as one nurse reflected, "*children are dying of… the impacts of lockdown and… I think that was probably just a bit distressing in general*".

Positive impact on staff: Staff widely reported the positive impact on their emotional health and wellbeing when workplaces actively recruited new employees, fostered teamwork, and camaraderie. Some nurses working in inpatient settings or community/outpatients also felt that when education and training was prioritised, this contributed to improved mental well-being, as "*being able to work, prevented mental health from deteriorating significantly".*

Positive remote working: The benefits of remote working were highly prevalent, present across all staff groups and work settings. This was due to the convenience of flexibility, but also "*being able to work, prevented my mental health from deteriorating significantly.*" Staff seemed to value being able to work to the best of their ability, despite the restrictions caused by the pandemic.

Impact on life: HCSWs, medics and AHPs who worked in inpatient and community/outpatient settings discussed how the pandemic experience affected their work life balance. They spoke about how the move towards flexibility and what they prioritized led to having an improved work-life balance. Nursing and administrative staff, however, highlighted that their work-life balance was made worse during the pandemic. This seemed to be mostly centered on safety, with one nurse recalling that they struggled "*juggling being safe at work and safe at home*". Nurses and AHP staff also said that their personal lives impacted their work life with stress factors, such as managing family health making it harder to perform their jobs.

3.8.3 Support and recognition
Lack of emotional health and wellbeing support: Some staff across work settings, except medical and AHP staff, talked about a lack of emotional health and wellbeing support from their workplaces. However, it was noted that this generally improved as the pandemic

unfolded. A few working remotely felt guilty accessing what support was available, as those who worked clinically were thought to have a worse experience.

Lack of support and recognition: All staff groups reported that the support they received was not sufficient. Non-clinical nurses also talked about issues in the implementation of offered support. One senior manager said that they have a number of staff unable to access the written information on support distributed by their workplace, due to its complexity. These issues were exacerbated, with one nurse reflecting that "*lots of support was maybe made available but it's how the support was received and then how it could practically be implemented*". This also affected people feeling minimized, which was shown by nurses and administrators in community/outpatient sites.

Negative support and recognition: HCSW complaints only covered unsupportive or ineffective leaders and managers, however poor experiences of support and recognition were pervasive across all work environments and job positions. The incidence and effects of inappropriate staff recognition and support were very emotive among the workforce. One nurse talked about her indignation after receiving a chocolate biscuit in "*recognition*" of their difficulties, which appeared to trigger a visceral reaction. One nurse's explanation that "*token gestures are meaningless*" and another's question, "*How can anyone be expected to happily work and support a Trust like this?*" best exemplified the staff's response. Participants who mentioned the matter seemed to agree that taking no action is preferable to making token gestures. Many staff lamented that they felt undervalued, and that they were not considered or consulted.

Positive support and recognition: A small proportion of the nursing and medical professionals that work in inpatient settings and community/outpatient settings reported feeling supported. A few people mentioned that their workplaces employed formal measures to support staff, such as supervision or meetings with their direct manager. Apart from ED/POA, participants from other occupations and areas expressed that they felt that their organizations were making an effort to be proactive in supporting staff in some form.

Positive recognition has a big influence, according to some nurses who work in inpatient settings, as "*the smallest things. Sometimes it can just make you feel so much better*". Access to psychological counselling was also reported, along with team briefings and wellbeing advocates. Other than HCSWs, staff groups in the inpatient and community/outpatient settings also discussed initiatives to raise morale. Staff from all work settings and professions discussed the value of informal support. This was mainly peer to peer support offered through everyday conversations. Social media and messaging services were also seen as helpful to stay connected and offer support, particularly when staff could not meet up so easily. The importance of trying to support the team was also shared by administrative staff. Staff experience of support can also be seen in figure 29.

How supported by their organisation did staff feel?

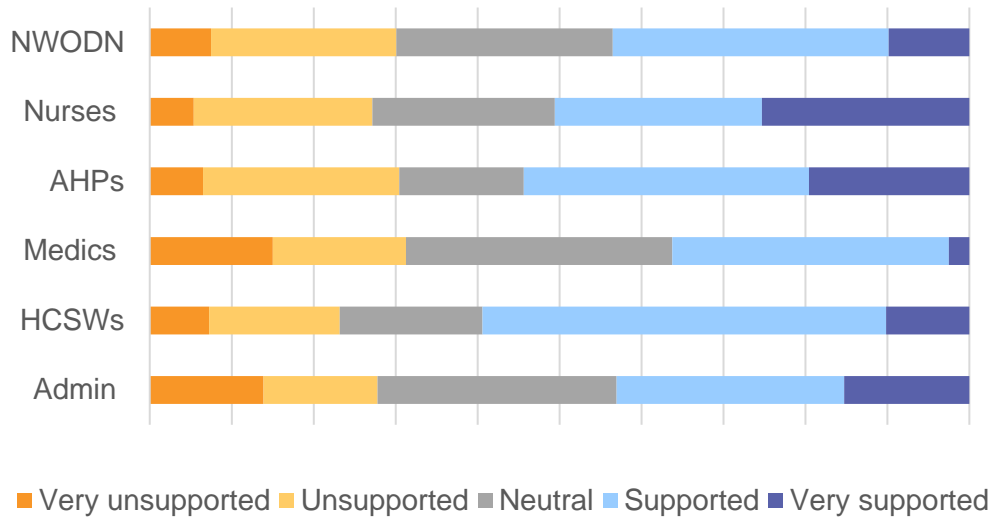■ Very unsupported ■ Unsupported ■ Neutral ■ Supported ■ Very supported

Figure 29: Staff experiences of support, by occupation

3.8.4 Team impact

Negative team impact: As one nurse reflected, when relations between management worsened and workers *"lost kindness for each other"*. Several medical and nursing personnel who work in community/outpatient settings reported detrimental effects on their teams due to this. This notably included team breakdown and a lack of camaraderie or teamworking.

Perceptions of absence: Many nurses and doctors who work in inpatient settings expressed their disapproval of some staff absences. Since the pandemic, there has been a concern that certain employees are "*just more willing to ring in sick*", and "*something needs to be done*" about this, as a senior medic reported. Additionally, both inpatients and community/outpatients acknowledged the growing role that staff emotional health and wellbeing were playing in absences. It was widely discussed that some colleagues needed to take some time off so they could allow their emotional health and wellbeing to recover.

Team development: Staff groups apart from medics and AHPs, working in areas outside ED/POA talked about how their wellbeing was positively influenced by team developments. These focused on an increased effort on social team building, and reflection and learning at the team level. This gave staff the opportunity to positively contribute to team and service development.

3.8.5 Working out of area

Experience of working out of area: Nurses working in inpatient and community/outpatient settings reported several factors which impacted their emotional health and wellbeing when they worked out of area. A key issue was experience of working outside of their comfort zone or confidence when they were moved, such as being expected to care for adult critical care patients without training. Some staff also reported that their own managers did not support them when they moved. This was shared by one HCSW, who talked about band three staff being moved "*with no support from their managers*". There was also general anxiety among staff around being moved.

4. Recommended Training and Development Solutions

To support the provision of paediatric critical care across the ODN footprint, with appropriately skilled staff who can make best use of available resources.
Whilst most staff reported feeling prepared to care for higher acuity patients, concerns around staff skill, and resource were raised. Concerns around services ability to care for increased numbers of critically unwell CYP during a future respiratory surge are apparent. The VAST Programme recommends that:

- The ODN proactively leads in identifying training needs and resources across its footprint, working with local educators, particularly regarding paediatric critical care and ventilatory support (invasive and non-invasive), through the development of an ODN education team.
- The ODN works with partner agencies across its footprint to promote the standardised care of critically unwell CYP. This should include the pooling of resources, such as through a shared repository of training and guidelines.

That staff across the paediatric workforce have the knowledge and skills to effectively care for CYP with emotional health and wellbeing needs. The COVID-19 pandemic saw a perceived increase in the emotional health and wellbeing needs of CYP accessing services. At the same time, only a minority of staff reported being adequately prepared to care for these patients. The impact of this has the potential to diminish services' ability to respond to a future respiratory surge. The VAST Programme recommends that organisations:

- Provide training on the 'essentials' of care for CYP with emotional health and wellbeing needs to all patient-facing staff.
- Ensure staff have clear processes for accessing advice and support from specialist emotional health and wellbeing staff, as well as how to navigate services.
- Provide training on effective escalation and de-escalation management to all patient-facing staff.
- Review any specific training requirements to meet the emotional health and wellbeing needs of their patients, dependent upon service.
- Ensure staff can effectively signpost CYP and their families to support from other services where appropriate.

That systems are in place which enable staff to continue accessing service essential training and development, especially during potential disruptions. The negative impact on training and development, shown through this training needs analysis, has been stark. Many staff were unable to access mandatory or service essential training, such as basic life support, when they needed to. Some services reported ongoing issues with this. This represents a significant concern when considering a potential future respiratory surge. The VAST Programme recommends that organisations:

- Review training processes to ensure that alternative methods are considered
- Review the availability of online training and support for staff in accessing this
- Consider systems which can prioritise provision and availability of service essential training

That the benefits offered by digital technology can be effectively realised. The pandemic has seen an increasing move towards and reliance of services on digital technology. If services are to be able to continue to provide safe and effective care, staff must be able to effectively utilise and navigate this. This is particularly evident when there is an increased demand on services, due to a respiratory surge. Digital technology literacy should be treated

as being as essential as English and mathematical literacy. The VAST Programme recommends that organisations:

- Treat the current digital technology capability of their workforce as a priority.
- Consider assessment of staff digital technology literacy, particularly at recruitment, to support to access digital technology
- Provide training on the fundamentals of digital technology literacy for all staff
- Provide training and opportunities for staff to develop further confidence and capability in digital technology across a range of levels.

To support staff to have confidence if asked to provide care outside of their usual setting. Being moved to a different setting was amongst the most widespread experiences for paediatric staff. Staff talked about a lack of clear support or expectation and agreement about the work to be performed. These issues could resurface in a future surge. The VAST Programme recommends that organisations:

- Develop guidance for what work may be expected by staff who move outside of scope of competence.
- Develop clear systems for support and supervision for any staff who may work in an area outside of their usual workplace.
- Consider what guidance may be required to support new members of staff on a temporary basis to different work environments

That staff, particularly leaders and managers, have the skills and confidence needed to positively support and influence colleague emotional health and wellbeing. Staff across the ODN footprint's paediatric workforce have highlighted the impact the COVID-19 pandemic had had on staff emotional health and wellbeing, and how this in turn has affected their ability to provide safe and effective care. Maintaining and growing staff emotional health and wellbeing is vital for the workforce and services to continue effectively through a future respiratory surge. The VAST Programme recommends that organisations:

- Make emotional health and wellbeing 'first aid' or similar training available to staff.
- Ensure that leaders and managers are trained in the recognition of emotional health and wellbeing needs in staff, along with how to access and provide appropriate support for staff.
- Develop a pool of resources to support staff EHW.

That staff receive the recognition and support that allows them to feel cared about and valued. This is not necessarily a training need. Staff throughout the ODN footprint have emphasised their negative experiences of support and recognition from leaders and managers during the pandemic. This became a powerful emotional focal point, particularly where this was seen as inappropriate or tokenistic. There is the potential for this to adversely affect the work experience of staff during a future respiratory surge, particularly if they are being asked to work in extremely challenging, stressful conditions, and are left feeling as though they are not valued. The VAST Programme recommends that organisations:

- Review their processes and methods of support and recognition, particularly team support.
- Ensure that leaders and managers are aware of any opportunities and processes for support and recognition for staff within their organisation.

5. Limitations

During the VAST programme a training needs analysis was successfully carried out. However, this was subject to a number of limitations. The main restrictions were limited access to staff and services for communication, the level of engagement, and uncertainly around the workforce.

5.1.1 Challenges of accessing staff and services

Gaining access to staff and services was a key challenge. The VAST Programme had no method or permission to contact all staff directly in order to distribute the survey. Therefore, communication was made primarily by cascading from local service leads and trust communication departments. This presented problems as the VAST Programme was not easily able to obtain the identities of key personnel, nor the full extent of paediatric services within each organisation.

Contact with staff was also hindered by areas who were actively reticent about involvement with the programme. One example is a deputy medical director who felt that their staff took part in too many surveys. Another is a communication team initially refusing participation on the basis that it was not relevant to their trust. Although responses were received from every trust and efforts were made to reach staff through a variety of approaches, the VAST Programme was unable to confirm that every single paediatric team in the region was successfully contacted.

5.1.2 The impact of staff and stakeholder engagement

Although the level of engagement in some places appears to be relativity high, there was a low level of engagement from some trusts and areas for both staff and stakeholders. In some sites, initial attempts to involve local stakeholders were largely unsuccessful. As it was stakeholders who identified the areas to be explored within the training needs analysis, it is possible that the distribution of those who did or did not engage with this part of the process had an influence focus of the training needs analysis.

To increase staff engagement across all areas, regional leads were highly flexible in responding to local requests and proactively reached out to teams. However, this could not completely remove the effect of low engagement from some areas. Responses to the training needs analysis varied greatly between the regions. This may mean that certain areas are disproportionately represented. The regional breakdown has been provided in addition to the whole ODN footprint data.

5.1.3 Uncertainty around the workforce

It is not possible to say whether the participants are fully representative of the make-up and experiences of the paediatric workforce during the pandemic, as the data is not available. To be able to assess how representative the participants are to this work force would require data on the movement of staff, as well as the numbers and composition of the paediatric workforce. However, this was not available within released NHS Digital data and the ODN was unable to obtain this through other bodies.

5.1.4 Other

None of the regional leads had undertaken a training needs analysis on this scale, across multiple trusts, previously. It is possible that this inexperience may influence the quality of the training needs analysis. The VAST programme was also subject to a strict schedule, with

funding only available for a twelve-month period. This, coupled with financial limitations, restricted the resource that could be devoted to engagement and data collection. Regional leads used their time and resource as effectively as possible to maximise their impact. The best practice guidelines established in NHS Digital's Education and Training standards (2022) were followed to ensure this.

6. Conclusion

The VAST Programme recognised that to effectively manage any future respiratory surge, it is essential to understand the effects of the COVID-19 pandemic. This included changes to service delivery and their impact on staff emotional health and wellbeing. In fact, participant responses suggest that the greatest impacts were not necessarily those directly resultant from COVID-19 itself, but the secondary impacts. It is through learning from and addressing the training and development needs resultant from these impacts, that the most effective measures against a future respiratory surge can be taken.

The sudden requirement to change their area of working, particularly moving from paediatric to adult services, led to a high degree of distress amongst staff. This was exacerbated by a feeling of being underprepared, under-supported, and being uncertain about their roles. Ensuring that staff had a clear guidance around expected roles, and the opportunity to develop the skills and knowledge for this, may go some way to addressing these issues.

The COVID-19 pandemic had negatively impacted staff emotional health and wellbeing. This has been impacted by several factors, including staff absence, increased pressures, and the stresses of working outside their usual area. It is vital that staff can receive effective support from their managers, leaders, and services within their trusts. Participants have highlighted the risk of continued absence, burn out and attrition if this is not addressed. Ensuring that managers and leaders, who unquestionably shared these experiences and pressures, have the skills and confidence to support their staff may help address this.

The development of digital technology throughout the pandemic gave new opportunities for greater efficiency and accessibility for patients and staff. However, many found they lacked the skills and confidence to fully take advantage of this. Addressing the digital technology literacy of the workforce will be essential to ensuring the continuity of services, teams, and patient care.

The increased acuity of CYP with emotional health and wellbeing needs was widely reported. Staff felt unprepared to adequately support their needs, which impacted services. Staff require the knowledge and skills to be able to care for the essential needs of these patients, as well as knowing how to navigate systems and access specialist support, this may reduce the overall burden on services. The ODN wonders if there is an argument to reconsider nursing pre-registration training to reflect a more generalised approach. It is vital that patients receive the right care at the right time in the right place. This is also true for CYP with physical critical care needs. By acting now to ensure they can be cared for in the most appropriate place, with appropriately trained and resourced staff, the future impact of a respiratory surge may be reduced. The ODN has a leadership role here, in reviewing current provision, processes and training.

Training and development were greatly disrupted during the pandemic. This was even felt in mandatory training and critical skills such as basic life support. Some areas reported that these

disruptions are having an ongoing impact on services. It is vital that contingency measures are considered to avoid such a scenario in a future respiratory surge, as well as how current training can be optimised.

It is clear that the COVID-19 pandemic has been a highly challenging experience for paediatric services. However, it has also offered a powerful opportunity to review ways of working and assumptions, to develop insights and identify learning needs. These may allow services to navigate a future respiratory surge more effectively and reduce the negative impact on the workforce.

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8. Well-Being Resources

Practitioner Health

Practitioner Health is a free, confidential NHS primary care mental health and addiction service with expertise in treating health & care professionals.

Nurses, Midwives & Healthcare Support Workers - ShinyMind

ShinyMind is an evidence-based, proven mental health and wellbeing app, co-created with the NHS

Home - Doctors in Distress - Support For Healthcare Workers (doctors-in-distress.org.uk)

Doctors in Distress provides mental health support for all health workers across the UK through confidential facilitated peer support groups.

Your wellbeing (bma.org.uk)

We have a range of services and information to help support you. Our counselling service is open 24/7 to all doctors and medical students - by telephone and in person. It's confidential and free of charge.

Member Support Services | Royal College of Nursing (rcn.org.uk)

As an RCN member, you can get free, confidential advice, representation and support on a range of issues that affect you at home and at work.

Wellbeing videos

Webinar 3: Bereavement - What has Changed? - YouTube - https://www.youtube.com/watch?v=HBb4xjBu4IE

How do we relax and recharge? - YouTube - https://www.youtube.com/watch?v=A7IDjGIE3y8

9. REPORT INFORMATION

Title: Valuing All Staff Together: Growing and Training our Future Workforce

Version Number: 1.0

Date: 2023

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Organisation: North West Paediatric Critical Care, Surgery in Children & Long Term Ventilation Operational Delivery Network

Project: VAST Programme

Available from   https://northwestchildrensodnhub.nhs.uk/

10. APPENDICES

10.1 Appendix 1: Survey content

VAST Programme Survey battery	
Question	**Response options/type**
Since the start of the pandemic, have you/do you work within CYP's services? *[Required to answer]*	Yes/No
Did you work within a Tertiary Centre at any point during the pandemic? (Alder Hey Children's Hospital or Royal Manchester Children's Hospital) *[Required to answer]*	Yes/No
Where do you work? Tick all that apply *[Required to answer]*	Select trust(s)
How long have you worked in a Healthcare setting? *[Required to answer]*	Select option
Job Role *[Required to answer]*	Select job category
What Agenda for Change Band are you? *[if applicable]*	Select Band or not applicable
What Grade doctor are you? *[if applicable]*	Select Grade
What paediatric area(s) did you work in during the pandemic? *[Required to answer]*	Select area(s)
Did you work out of your normal workplace area or care for a different patient group at any point during the pandemic? *[Required to answer]*	Yes/No
Why did you work out of your usual workplace area or care for a different patient group? *[if applicable]*	Select reason
What workplace area did you move to or which patient group did you care for during the pandemic? *[if applicable]*	Select area(s)
If you were only child specific trained or only work with CYP and moved to adult services, did you receive further training to enable you to care for adult patients? *[if applicable]*	Yes/No or not applicable
How long was the training for and what did it involve doing? *[if applicable]*	Free text option
How well prepared did you feel to care for adult patients? *[if applicable]*	5-point Likert scale
How was your experience working out of your normal workplace area or with a different patient group during the pandemic? *[if applicable]*	5-point Likert scale
Did you feel supported in your new workplace area?	5-point Likert scale
How would you describe your mental health and wellbeing at work <u>before</u> the pandemic? *[Required to answer]*	5-point Likert scale
How would you describe your mental health and wellbeing at work <u>during</u> the pandemic? *[Required to answer]*	5-point Likert scale
How would you describe your mental health and wellbeing now at work <u>post</u> pandemic? *[Required to answer]*	5-point Likert scale
If your mental health and wellbeing was adversely affected during and/or after the pandemic, did you discuss this with anyone? *[Required to answer]*	Select options

VAST Programme Survey battery	
Question	**Response options/type**
Do you have easy and confidential access to mental health/wellbeing support in your workplace area/department? *[Required to answer]*	Yes/No/Don't know
How supported did you feel by your organisation during the pandemic? *[Required to answer]*	5-point Likert scale
What are the top 3 things that helped improve your wellbeing and reduced stress levels during the pandemic in your workplace area? *[Required to answer]*	Select options
Did you notice a significant increase in staff absence in your workplace area during the pandemic? *[Required to answer]*	Yes/No/I don't know
Did you perceive this to negatively impact your workplace area? *[if applicable]*	Yes/No/I don't know
Please describe how you think this impacted your workplace area? *[if applicable]*	Free text option
How do you feel your department and management responded to this problem? *[if applicable]*	5-point Likert scale
How do you perceive staff morale in your workplace area at the moment? *[Required to answer]*	5-point Likert scale
If you worked in the same place before and throughout the pandemic, do you think staff morale is higher or lower than before the pandemic? *[Required to answer]*	Select option
Is your workplace area currently trying to improve staff morale? *[Required to answer]*	Yes/No/I don't know
Please explain what is being done in your workplace area to improve staff morale *[if applicable]*	Free text option
In your workplace area, do you think staff have left their job because of the pandemic? *[Required to answer]*	Yes/No/I don't know
Since the pandemic, do you think that the CYP you manage and/or care for are sicker or have a higher acuity? *[Required to answer]*	Select option
Did you feel adequately trained and equipped to care for these CYP safely? *[if applicable]*	Select option
If no, what aspects did you not feel trained on? *[if applicable]*	Free text option
In your workplace area, do you perceive that there has been a change in CYP's mental health and wellbeing since the pandemic? *[Required to answer]*	Select option
Do you feel sufficiently educated and prepared to care for the mental health needs of these patients? *[if applicable]*	Select option
If no, what further training or preparation do you feel that you need to care for these CYP and their families? *[if applicable]*	Free text option
Have you gained any new knowledge or skills that were needed in your workplace area due to the pandemic that you didn't have before? *[Required to answer]*	Select option(s)
Was your training and development affected by the pandemic? *[Required to answer]*	Yes/No/I don't know
What training was affected? *[if applicable]*	Select option(s)
How did your training change during the pandemic? *[Required to answer]*	Select option(s)
Overall, how has your training been affected? *[Required to answer]*	5-point Likert scale

VAST Programme Survey battery	
Question	**Response options/type**
During the pandemic, what training did you need that you didn't have? [*Required to answer*]	Select option(s)
Did your use of technology and digital devices change aspects of care for your patient group? [*Required to answer*]	Select option
How did this affect the service/care you provided? [*if applicable*]	5-point Likert scale
Did your use of technology and digital devices change within your professional team? [*Required to answer*]	Select option
How did this affect your service/workplace? [*if applicable*]	5-point Likert scale
Did you receive training or support on these new technologies and devices? [*if applicable*]	Yes/No
What have been the positive and negative impacts of the changes in use of technology and digital devices throughout the pandemic? [*Required to answer*]	Free text option
Is there anything else you would like to comment on about the impact the pandemic has had on you at work and your wellbeing? [*Required to answer*]	Free text option