NHS Communicators' Emotional Response to the Covid 19 Pandemic

The experience of another front line

"Before vaccinations were available, the only thing that kept the population safe was accurate and timely communication." (Senior NHS Communicator)

A Joint Research Project by Huddersfield Business School and Centre for Health Communication Research

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Foreword

This research project has been conducted as a contribution towards NHS learning arising from the COVID pandemic. It follows and builds on an earlier research programme which was conceived and executed, early in the pandemic, by the Centre for Health Communication Research at Buckinghamshire New University, NHS Providers and the NHS Confederation.

The current research arises from a collaboration between Huddersfield Business School and the Centre for Health Communication Research. Once again, we extend particular thanks to NHS Providers and the NHS Confederation for their significant support for this research project.

While the research draws on the experience and knowledge of NHS professional communicators, both as participants and advisers, the conclusions and recommendations are solely those of the authors.

Ethics approval for this research project has been granted by the University of Huddersfield Research Ethics and Integrity Committee.

Executive summary

This report sets out the findings of research undertaken to investigate the emotional impact of the Covid 19 pandemic on senior NHS communication professionals.

In-depth research with 15 senior communicators discovered six principal 'triggers' which evoked strong positive or negative emotional reactions; working from home, long hours, social media, technology more generally, command and control, and professional recognition. These emotional triggers did not act in a binary way: social media was regarded as a large positive in reaching certain stakeholder groups, but its unremitting nature created levels of stress.

The emotional reactions these triggers generated traversed the continuum from stress and anxiety, guilt, frustration and anger, inadequacy, isolation, pride, excitement and elation and a growing sense of confidence.

These senior communicators took a variety of actions as a result, from varying degrees of compliance with the apparent 'rules' to proactive pushing back and setting their own agendas and ways of working with or without the support of senior leaders or 'the system'.

Emotional support for this group was patchy to say the best. Some were well supported by senior managers, others found peer support groups and others felt alone and disillusioned to the extent that they will leave the service.

The individuals involved have reflected and learned from their experience and have developed a series of system-wide, team and personal recommendations which the research team have added to and categorise as *clarity, professional recognition* and *leading through complexity*.

The overall conclusion from the research is that the communication cadre of the NHS, while not currently recognised as being on 'the front line' were and are indeed workers on a different front line. As such, a set of measures is required to ensure they are properly supported in any future pandemic.

Practical recommendations arising from this work include a significant review and revision of Command-and-Control policies and procedures; greater coordination through the NHS system; acknowledgement that communication is part of the front-line defence in such national emergencies and therefore requires similar levels of resourcing and recognition; and the creation of a professional association for NHS communicators to both champion and facilitate best practice in the profession.

Introduction

This report sets out the findings of a research project which has been undertaken to investigate the emotional impact of the Covid 19 pandemic on senior NHS communication professionals. Its objectives are to

- Identify the major triggers which created significant emotional responses in this group
- Categorise those emotional responses
- Examine the support systems available to those professionals
- Develop policy recommendations designed to ensure the health system is better prepared and more resilient for future prolonged crises.

The research follows an earlier study undertaken by the Centre for Health Communication Research (Nichols & Underwood, 2020) which investigated the overall communication response to the first wave of the Covid 19 pandemic. In that study professional communicators referred to the emotional toll the crisis had and was continuing to take, but this was not examined in detail. This study is the first formal investigation of the emotional impacts of the pandemic on NHS communication professionals.

The study was conducted in November and December 2021, just as the Omnicom version of the virus was striking the UK and comprised in-depth qualitative research with 15 senior communicators. See Appendix for interviewee details.

Methodology

Data were collected for the study in two stages.

In the first stage, a critical incident approach was adopted. This is an open-ended technique that allows specific situations ('critical incidents') to be analysed, placing particular emphasis on the context of the event. Respondents were asked to identify four incidents during the pandemic that elicited a strong emotional response in them, recall the incident and describe the feelings they experienced, their actions and what support they might have liked. They recorded responses directly onto a voice recorder (normally their phone). This approach allowed them to explain their own experiences without intervention from the research team. Analysis of the critical incident stage was used to inform the second stage. The critical incident recordings typically lasted around 20 minutes.

In the second stage, each respondent was interviewed by the research team. The interview started by the researchers describing the main thematic findings of the first stage to interviewees who were then asked which of the themes resonated with them. This approach explored the complexities of the respondents' context and situation further and allowed key themes to be probed for clarification and detail. Interviews lasted approximately 30 minutes.

Ethics approval was granted by the University of Huddersfield Research Ethics and Integrity Committee. Given the potentially sensitive nature of the subject matter, and as part of the review process with project's professional steering group, support measures were put in place to mitigate the risk of emotional distress to respondents during the research process. Measures included dedicated 'phone lines and availability of professional mental health support. Respondents were drawn from a cross-section of NHS employers, both geographically and by type of organisation (see Appendix). In total 15 respondents participated in both stages of the study.

All data were audio recorded and transcribed, supported by transcription software. Data analysis focused on identifying themes using the Maxqda software. Using an iterative approach, several high-level themes were identified which form the structure of the analysis.

Results

The data provide a rich picture of the emotional experience of the pandemic on NHS communication professionals, highlighting differences between a person's role and context, such as type of organisation and position in the 'tier' of NHS hierarchy; geography and demography; size of team; seniority and reporting structure in the organisation; closeness of links with other system players (Integrated Care system (ICS), Region, National).

Individual responses to the pressures experienced are more complex to unearth but appear closely linked to their wider personal and professional context. There was broad acceptance that the pandemic was a journey into the unknown which would inevitably throw up unforeseen challenges, exacerbated by its length and unremitting nature. However, the bureaucratic nature of such a large system, operating under the legal requirements of the Emergency Preparedness, Resilience and Response Framework (EPRR) (NHS England, 2020), introduced sector specific issues such as lack of agility, and organisational clumsiness and extended timeframes for decision-making which influenced communicators' experiences.

Notwithstanding, there was considerable pride in the response of the communication community in relation to the quality of work and its ability to work at speed and within a very uncertain and dynamic environment.

The results of the research presented combine findings from both the audio recordings and interviews. The results are organised under five headings which reflect the main areas of focus in the research: major triggers of strong emotional responses; the emotions evoked; actions taken; support available and, how changes/improvements may be made for the future.

Triggers for emotional responses

The following nine 'triggers' were identified as generating strong and sometimes prolonged emotional impacts. They range from centralised 'command-and-control' to working context issues such as 'working-from-home', long hours and technology to professional recognition.

1. Command and Control

One of the strongest triggers that elicited emotional responses for respondents was the implementation of the national emergency provisions requirements that they were working under. While there was a clear understanding of the legal requirement for command and control and that the pandemic called for extraordinary measures, there was almost universal concern over how it had been enacted. An interesting finding in the study was that individuals differed in the extent to which they believed they had the 'right' to challenge central control or not. Some felt their work was controlled almost completely and felt compelled to comply. Others actively and consciously resisted that control and, instead, took measures to exert their own autonomy and acted in ways they believed to be right in their context and for their audiences. The latter group reported facing consequences, from mild reprimand when something worked well, to bullying. However, one respondent held the strong opinion that the adverse impacts on command and control were largely down to the communication community itself:

> *"Where I think a lot of my colleagues have really fallen down, is they allowed themselves to be bullied… it is our profession that allowed itself to be cowed and bullied and … I don't really understand it. I've raised this in other forums, I don't get it."*

There were several elements to command and control that caused issues.

There was a widespread perception that different parts of the NHS system operated in parallel universes. Central organisations (that oversaw command-and-control) appeared most concerned about a unified approach which conveyed 'one message'. They were very sensitive to national risk management and appeared dominated by political/policy perspectives and concerns with a particular sensitivity to the national media agenda. On the other hand, local organisations were much more concerned about their local agenda relating to patients, staff, stakeholders, and local system resilience and co-operation. The lack of autonomy felt by communicators to 'do the right thing' for their local area was strong and this led to a diminution of trust with 'the centre' and by local communities:

> *"NHS England in Skipton House does feel part of that Whitehall bubble, so I think they get caught up in that political Westminster bubble and all of that is incredibly important to them"*

> *"If you see everything through the lens of what's going to be on a national front page the next day, you will entirely miss the point of communicating about peoples' NHS experience and with the community that uses the NHS… So, if people who didn't have to deal with the community had our experience they may respond differently. Equally for those of us that don't have the pressure of what's going to be on the front of the Daily Mail the next day…… it is that walking in each other's shoes and developing that understanding But I don't think there's any scope or desire for that to be honest."*

Timescales in decision-making were a matter of concern to respondents who noted that when central organisations made a decision or issued 'an edict', local organisations were expected to implement this immediately. Conversely, when local organisations sought to take action, they were expected to obtain extensive permissions and were subjected to lengthy and protracted decision making:

> *"You're not in control of what you're doing because you're waiting to be told and the waiting sometimes went on for longer than you'd have hoped and then you're sort of being chased for it at the other end, saying 'what are we doing with this?'"*

Respondents were critical of a lack of trust in local expertise and felt that central organisations had little understanding of the reality that local circumstances differed considerably from organisation to organisation and locality to locality. A lack of willingness of central organisations to 'trust the experts on the ground' made locally based communicators feel their knowledge

and competence was in question and has resulted in a breakdown in relationships between many of those organisations and 'the centre' which needs repair:

> *"It was almost like Big Brother is watching you. You can't do anything without telling them about it. And the simplest interview turned into it needs to go up to national team."*
>
> *"They think we're all hicks, you know they think we do not have this sort of experience that they have because they're dealing with the Mail every day."*
>
> *"You responding to diktats all the time, it's really difficult, I think, to sort of feel kind of self-worth in what you're doing and any kind of motivation for it and stuff."*

Respondents had mixed views of the role of NHS Regions. Several respondents felt that NHS regional bodies were to an extent 'piggy in the middle' and were perceived as acting as either a buffer and were facilitative or were seen as also being controlling:

> *"He's [regional colleague] being was very, very supportive, but he had to do that in the context of the national command and control system. And I don't, you know, and he was constantly trying to broker for us if we needed stuff doing. I mean, there wasn't lots to be honest, but and I know other regions haven't had the same experience."*

The issues surrounding command and control appear to be partly organisationally contingent, with the larger and more system influential organisations able to assert their own positions more easily.

2. Working from home

The order to work from home where possible was a considerable disruption to normal working practice and responses indicated that this had a differential impact on individuals. For some it was a largely positive experience giving them, for example, a level of control over work because they had fewer office distractions; time to step back and think; and the ability to work more flexibly to factor in other life priorities and challenges such as caring responsibilities and home education for children. Thus, taking walks during 'normal' working hours and working later became a pattern for the working day. For some, being safe, that is physically removed from work locations where Covid 19 was prevalent was a positive, especially if they had health conditions themselves. A number found it a positive experience:

> *"I have to say I feel quite guilty 'cause I absolutely love working from home. Absolutely not the same for some of my team who find it very isolating and that's a challenge in supporting them"*

For others, however, the experience was largely negative with reasons offered including lack of visibility to others, especially senior managers; inability to take an 'organisational temperature check' by walking around the workplace and having casual conversations; adverse impacts on teamwork and having to dedicate significant amounts of time on looking after their team in more structured ways; and, the lack of work/life/family balance, with work taking over most waking hours.

> *"One of the challenges of working from home is there's far more meetings than I ever had before in the office because everything is a meeting, isn't it? Rather than just a chat over your desk ... you're having a meeting with them, and then your diary is soon really full"*

The results were not binary. For most respondents there were positives and negatives to working from home, with the reasons given above forming a mixed response. The individual circumstances of respondents also varied considerably. Some communicators had team members who did not have the right equipment to work from home, especially in the early stages of the pandemic, or who had poor broadband connections, and this impacted on teamwork allocation, efficiency and effectiveness.

Family circumstances varied between respondents. Some, predominantly female respondents, had caring responsibilities, mainly relating to children. Some had very young families and others had older children at different stages of education. During periods of lockdown when childcare was not available and/or children were being educated at home, the pressures on these individuals were intense:

> *"You had some people with small children who had a lot more to cope with home schooling…. You had some people who had kids that were home schooling on the broadband, wife working from home, them working from home. Just, you know, if you live in rural xxxx that can sometimes be quite challenging and, you know, having the space to do it…. I have a room I can come into, at the end of the day I can walk away and leave all my crap everywhere, close the door and then I'm at home."*

(The extent to which these circumstances may impact future [particularly female] career progression is speculative and beyond scope for this study but a very real concern). Some respondents reported that they were required to be physically present at work throughout, in some cases due to their seniority and in others due to a perceived culture of presenteeism and a sense that communication staff had to be available as 'a comfort blanket'. For some who were required to be present at work it was not a matter of significant concern given their role as senior managers and so was 'part of the territory':

> *"(It was) absolutely sacrosanct that I had to be on site. (But) what we've proved with the pandemic is that we are truly mobile. We can work anywhere..."*

When asked about preferences for working at home or in an office environment most respondents expressed a preference for a hybrid working model. Planned working at home gave them time to undertake focused work but being in the office was valued for fuller human interactions, team working, visibility and availability:

> *"I think it's going to be a real challenge going back into the workplace because we are looking at different models of working now…… such as blended working, more flexible working. I've been on calls now and there's people in their car picking their kids up from school, which would have never happened two years ago."*

3. Long hours

There was full recognition that most people in the NHS were working excessive hours and all respondents spoke about the additional hours they worked, confirming the results reported in the earlier study (Gregory, Nichols & Underwood, 2021). Respondents spoke about being 'always on'; the blurring of work/personal time boundaries; the relentless nature and volume of work. In particular, they spoke about there being no lull in April/May 2021 when it appeared the pandemic was subsiding, so there was no recovery time before the onset of the next wave.

Some respondents pointed to a lack of institutional understanding of the nature of communication work and the underpinning activity that had to be undertaken to ensure campaigns and events were effective. "Things do not happen by magic":

> *"Even though the COVID rates are coming down the fatigue levels, the stress you know. It's almost like the staff, and I think we felt that in comms, didn't have time to kind of just breathe, so we were straight in [to]a transformation project. That's a huge comms task, comms is fully immersed in all of that which … is how it should be, but we never we never got time to breathe… I think it almost felt like COVID was done but ...actually it wasn't done, and it's never been done, I'm still doing the COVID comms stuff, but all this other stuff was being piled on top of it, so there was just no sense of just breathing."*

There was a broad acceptance that the unrelenting pace of activities was perhaps inevitable given the scale and scope of the task and the unpredictability of developments. Notwithstanding, duplication in the system was unhelpful, as was the timing and manner of national decision-making. For example, major policy decisions about restrictions of citizens were made at late afternoon Government briefings and often had major implications requiring communication colleagues to act immediately and into the night-time to prepare and distribute statements, internal and external briefings and public information. In addition, official guidance and briefings from Government and other parts of the NHS system were typically issued in 'official language' which required interpretation and then re-purposing to meet the needs of different audiences and constituencies, sometimes different languages for minority groups.

4. Social media

The influence and impact of the more extensive use of social media during the pandemic was a strong theme from the data, triggering both positive and negative emotional experiences. From a positive perspective, communication professionals reported that prior institutional resistance to use of social channels vanished, and the pandemic opened new and important ways to connect with staff/patients/stakeholders. This created a sense of achievement and vindication for staff who had long been battling for the adoption of social media channels amidst an NHS culture which was hitherto hostile and resistant to change.

> *"We changed how we use some of our channels and introduced things like a staff only Facebook so we could get to those staff that were on the ground. They don't look at their emails, but they'll look at Facebook. They all love Facebook, so we changed it two years ago and we've got well above 4000 staff on staff Facebook group now ……it's probably about a third of our workforce in a Facebook group"*

> *"Social media and that was a huge enabler"*

> *"Social media, it's grown exponentially through the pandemic. We've increased our followers by something like over a third, it's gone up phenomenally on both platforms, we use Twitter and Facebook"*

Inevitably, the greater adoption of social media as a core communication channel with a wide range of stakeholders presented challenges. Several respondents reported that social media required them to be 'always on' as they had to assume the burden of monitoring and responding all social media contact for their organisations:

> *"If you have a holiday, you know have a break and you go away, you still gotta check the social media accounts."*

The nature of communication through social media also presented new challenges. Communication staff had to contend with disinformation, misinformation and abuse via social media channels and, in the early stages of the pandemic, there was seemingly very little guidance or protocols about how to deal with this consistently as a system:

> *"The cumulative impact of receiving abusive messages, which are by their nature threatening, has an impact on people."*

> *"Facebook live, you know, even how do you react to that when it's actually happening there and then?"*

A further observation made by respondents was that managing social media accounts seemed to have fallen – without discussion - to communication teams, and that it differed significantly from other communication channels. As the 'owners' of social media, communication teams found themselves in the position to act as 'first responders' to social media posts queries which put additional strain on all, but particularly on small teams:

> *"We get people 10:00 o'clock on a Friday night in all sorts of distress"*

> *"It's quite complex on the liaising, we've got that personal responsibility where we don't just pass this person over, we actually manage it through a process so they get the information, and it may be that we go through numerous sources to get the information to pull a reply together back for them."*

By its nature, social media cuts across conventional organisational and content boundaries and was used for all types of content, from clinical, service user satisfaction and to information giving. For example, social media was used by people who were ill themselves or looking after people extremely ill with Covid, to solve their queries relating to lock-down rules as well as NHS services, interpretation of instructions to those with particular conditions, accessing alternative services, offers of voluntary support and so on:

> *"In our social media we get DMs, and we get posts from people who have got very complex health needs. They need to get a vaccination, they've heard such and such information that's the latest breaking news, so can they take such and such a vaccination and they want very detailed, specific information about their eligibility, the impact of it, how they get it in their particular case…They've come through our social media because they can't find the answer."*

Over the pandemic, the volume of social media traffic increased significantly raising challenges with resources:

> *"We were having discussions here as a team about how we resource social media … we need to think much more creatively and flexibly about how we, how we resource comms teams to manage social media more effectively."*

Senior communicators were acutely aware of both the positive and negative aspects of the increase in social media, noting a change in tone as the pandemic progressed. Initially enquires were information seeking and broadly supportive of the efforts of the NHS, but the mood changed as the pandemic lengthened and that in turn impacts on communication staff who themselves are dealing with a prolonged crisis:

"For much of the start of the pandemic it was quite buoyant. You know everybody was celebrating what we were doing. We were getting absolutely phenomenal traction on some of our social media posts from staff on the wards and as time has gone on, that's got more difficult as we've had to cope with some of the anti-vaxxers, conspiracy theorists. I think in the main we're still seeing a positive side to social media, but there definitely are some more challenging things that we're having to deal with."

5. Technology

As was the case for other NHS staff, communication teams faced a steep learning curve in relation to technology adoption at the outset of the pandemic. Unlike others however, they were expected to be immediately familiar with technology and be able to advise others on its use. This 'double jeopardy' of having to be ahead of others and proficient in technology in order to be able to help and advise them, emerged as a trigger for stress and frustration:

"I think the sort of basics of Teams and Zoom we're all au fait with now, but everybody was looking to comms to kind of guide the way on everything to do with the technology as well."

Technology had a positive impact on the working practices of communicators, opening opportunities, making the work and value of communication more visible, allowing communication professionals to connect with more parts of the system and facilitating inter- and intra-organisational working:

"It [online technology] meant that we were visible. It meant that the entire discipline was transformed. I was able to do the pivots to technology. We were given extra funding and resources 'cause people could see the value of what we were doing to staff morale, to public, to patient experience."

"I think it has certainly allowed us to work very differently and from a comms perspective it's allowed us to really embrace new technologies and really opened the way we do comms to our many stakeholders. But I think where it's hard for us, the biggest impact is around internal comms. We've never done virtual staff briefings before. We've never been able to get everybody together in one place at one time and I think is a really striking new way of working for us, which I think has come about as a result of the pandemic."

Using technology was seen as a permanent change:

"Being able to use technology in new ways is something that we will take forward for the future no doubt."

Despite the evident benefits afforded by of the adoption of new technology, the speed at which new skills had to be acquired and consolidated, was a stressor in the short term.

> *"I needed to do a team briefing for 100 and something people which had traditionally been face to face and all of a sudden it was 'can you just run a Teams with breakout sessions', and I'd never even used Teams we didn't have teams in our organisation. I hated doing those because I knew I could do it, but I always felt a bit like I couldn't do it and that the technology would let me down. So, I always found like a slight level of stress about something that shouldn't have been that stressful really."*

A further negative implication of the use of technology was that the behaviour patterns that developed around online meetings – for example, (i) the tendency to engage immediately on the substantive meeting topic and (ii) that meetings following one after the other in immediate succession – did not give respondents an opportunity for incidental discussion, nor reflection time.

6. Professional recognition

Communicators felt that external recognition and understanding of their role increased during the pandemic, enhancing their own sense of pride in their professional identity. They were increasingly trusted/depended upon by local senior leaders (in the main) and respondents acknowledged that their advice was respected. Positive regard for their profession had the impact of making them feel like a vital part of the emergency response, particularly because they engaged with such a broad range of stakeholders.

There was considerable pride among communicators that they had been at the forefront of new ways of working. Not all aspects of this were positive: one of the costs of being a vital service was the assumption that communication staff would be available 24/7 and always 'step up'. There was a widespread view that the long hours they contributed were not appreciated, nor were the stresses of the job fully recognised.

In addition to the main triggers outlined above, there were a number of more individual prompts for strong emotional re-actions which are listed briefly below.

7. Redeployment/Changes in role.

A small number of respondents changed role during the pandemic, either through choice or to get out of their situation. For others there was no choice. Covid has coincided with system re-organisation to ICSs etc. which has been an additional challenge.

8. Keeping the team going.

Some respondents noted that online working posed challenges in terms of managing their team. They had to learn new ways of leading in an on-line environment and set up systems to look after emotional well-being and celebrating team achievements in addition to organisational achievements.

9. Danger of burn out.

A related, but distinct issue to the issue of long hours, was the unremitting nature of work. Over the course of the pandemic, some teams were able to innovate and adapt to some degree by shaping rotas and sharing work across the system. However, these options were by no means available to all.

Principal emotions experienced by communicators

As a result of the main triggers outlined above, professional communicators experienced a range and wide variety of emotions. Eight are highlighted. These are listed in order below (five negatives followed by three positives). Again, it should be stressed that these emotions were not mutually exclusive. Many respondents felt them all at some stage and sometimes together. For example, they felt inadequate in that even their best efforts were not enough compared to clinical colleagues, but at the same time pride in the work they were doing.

Stress and anxiety. Considerable feelings of stress and anxiety were generated by not knowing what was going to happen; unpredictability of changes in and timing of national policies/ priorities; lack of capacity, budget and an inability to get help for some; unrealistic demands from central and local leaders at times; pressure to get communication right (and for every decision there was unusually a communication requirement); working at speed (for some that was motivational – an opportunity to shine in a crisis); tensions between organisational priorities and system/external priorities; learning new skills at pace; a tremendous sense of responsibility to do their job at exceptional levels; weariness and the unremitting nature of work – with no end in sight; and, the lack of any previous experience to draw on for such an extended crisis.

Guilt. Some respondents reported that they felt 'guilty' because, despite all the work they were doing, they were not on the 'front line' in the same manner as their clinical colleagues. This related to be being away from immediate danger of Covid by working from home. This feeling was not universal, however. Others were robust in defence of the value of their work pointing out that trustworthy and timely communication had saved many lives.

Frustration and anger. This was a common emotion. It was targeted predominantly at 'the centre' and at senior leaders who lacked understanding of local context and/or assumed that communication work subsided as the clinical curve was declining.

Inadequacy. This was linked to the feeling that communicators did not have the skills in place to cope with new ways of working. Inadequacy was also linked by some to the challenge of juggling home and work responsibilities.

Isolation. This was felt especially when working from home, but also for senior communicators who felt they had to hide their emotional response from their team and others at work and elsewhere in the system.

Pride. Many respondents reported that they were proud of the work they did and the self-recognition that communications is doing a good job. They were proud of having learned new skills quickly and well and were serving their communities well. They also linked a sense of pride to acknowledgement from senior leaders that communication does make a difference

Excitement and elation. Some respondents enjoyed being 'in the thick of it' and the fast-moving nature of their environment. They were motivated to turn things round quickly, make complex messages intelligible and accessible, and use channels effectively.

Confidence. Over the course of the pandemic, some respondents reported an increase in confidence as they proved that their communication strategies and tactics were effective. These successes provided them with confidence to challenge and advise senior managers more directly.

Actions taken

There were marked differences in approaches to dealing with the pandemic. Some communicators were more re-active and less resistant to control from 'the centre', but others took control to greater or lesser extent. Interestingly, their responses caused some to reflect deeply on their position in their own organisation and the wider system, on how they interacted/asserted themselves with senior management, on their own management style and on how work should be tackled.

Examples of proactive actions that communicators took included:

- Negotiated a structural role as part of the broader emergency organisational response team, thereby contributing to the overall response.
- Set up clear priorities for *what* would and would not be done, *how* work would be undertaken (levels and times of sign off and of autonomous action) – in effect a two-way service-level agreement (SLA) - and obtained Exec/Board agreement to the proposal. This demonstrated proactivity in setting and managing Board expectations of what (work-volumes, dependencies, timescales etc.) the communication team was able to deliver.
- Established clear structures and processes for how the team would be managed and operate (regular team and other meetings, packaging up work, resisting knee-jerk responses; standing back and thinking through the best way to tackle things; implementing rotas and re-setting role responsibilities). Having allocated team responsibilities and accountabilities clearly, they monitored/evaluated/supported as required.

Support

Support given to respondents varied from high levels from other executives and the regional team to little support and a reliance on self-initiated systems. All attested to levels of tiredness, but experienced different reactions: some 'had a good war' and felt supported throughout, others experienced exhaustion, depression, loneliness and disillusionment. As a result, some will leave the NHS at some stage, but others see the opportunity to take on larger roles and not necessarily in communication, because of the experience gained. What became apparent in the interviews were that some reactions are personality driven and some largely down to circumstances. Other observations relating to support mechanisms included:

- For the team, some respondents created space for their staff to talk about feelings and pressures, not just tasks (at team/org level, not national and held one to one meetings about well-being separate from work updates).

- Most of these senior communicators created their own networks for personal support, including other communicators elsewhere in the system, people within their own organisations, outside support systems and instigated well-being self-help such as regular walks, practicing mindfulness etc.
- Some (those able to argue their case) were able to access additional human and financial resources including psychological support.

It is notable that, overall, the relationship with the centre was not perceived to be helpful or supportive and was characterised as a 'parent/child' relationship. Little support was also reported by respondents who were redeployed and who experienced obvious additional pressures as a result, such as having to build new working relationships and to find their 'place' in established or new management teams.

Reflections from respondents

There was an overall recognition from research participants that everyone was facing the unknown in the pandemic and it was inevitable that there had to be a level of 'unfolding' where everything was in flux. However, they were also keen to reflect on experiences and they identified lessons that could be learnt - both for themselves as individuals, but also for organisations and the profession – in four broad areas.

Improvements to command and control

While it was recognised that command and control was needed in a time of crisis, several improvements were suggested:

- Better timing of Ministerial Briefings and other national announcement with longer lead times for implementation;
- Better co-ordination between various national NHS and other bodies such as the Royal Colleges so that there was one policy/message and consistent guidance;
- Better co-ordination between the tiers of the NHS system with clear parameters for command and control including what is in and out of scope;
- Expansion of the national command and control team to include different NHS organisations so that a perspective wider than political/national press is taken;
- More structure and regularity (less but better) of guidance/announcements etc. through system;
- Centrally produced collateral that could be re-purposed locally;
- National advice on dealing with social media;
- Quicker decision-making for local initiatives.

Team support

Teamwork was considered vital in the pandemic and respondents suggested several ways this could be enhanced:

- Model structure/template for communication teams in various parts of the NHS, including the new ICS/ICB (rather than each organisation plotting their own course);
- Mutual aid agreements between communication teams to cover emergency situations;
- respite and reflection time built into working patterns;

- Recognition that comms teams have well-being and mental health concerns themselves and are not solely the deliverers of well-being messages;
- Review of the appropriate allocation of social media responsibilities recognising their impact on the whole organisation and activities;
- Recognition that communication activity is considerably broader than messaging and channels.

Personal support for communication leaders

There was significant insight from respondents on the learning they could take from the pandemic as leaders who needed to give and receive emotional support in different ways to the 'working norm':

- Greater institutional recognition of the differential impacts on communication professionals – some have families, some thrive on pressure etc... Respondents wanted the psychological safety to talk about challenges (e.g., parenting, overwork) without being judged or potentially jeopardising future progress.
- Communication leaders have to support their teams in a crisis as well as look after themselves. This takes additional time which needs to be factored into working practices.
- Guidance on expectations of working hours, taking breaks, working from home protocols etc. so that there are common benchmarks through system.

Professional support for communication leaders.

There were clear views from the respondents on how they could learn as a professional community, from the pandemic experience:

- Some senior communication leaders developed closer relationships with senior NHS leaders during the pandemic and this was recognised as creating value. It is recommended that this practice endures.
- More generally, during the pandemic communicators were able to extend their networks beyond their own professional community and derived considerable support by being more embedded in general management/leadership cadre work. This should continue.
- Other clinical and non-clinical colleagues have official supervision or peer group networks for professional support –something to consider for this group.
- Greater opportunities should be available to share and learn about best practice.

The pandemic revealed different preferences in senior communication professionals, including their appetite for leadership. There was a stark contrast between those who were 'driven' by external events and those who took a measure of control over the 'driving' forces.

As a cohort, there was an impressive sense of professionalism, responsibility to colleagues and partners and seeing themselves as part of the collective effort to deal with pandemic. This was partly evidenced by their level of hard work and time commitment, their flexibility and willingness and ability to learn quickly At the heart of much of the experience was a desire to show the value of the communication contribution and to maintain recognition of its crucial role beyond the pandemic. This can be summarised by a quotation from one senior communicator.

"Before vaccinations were available, the only thing that kept the population safe was accurate and timely communication."

Discussion and recommendations

From the foregoing several observations can be made that bring together the main issues surfaced by the participants in the research. These might be regarded as cross-cutting imperatives that can be drawn from their experience and from which several recommendations can be made.

Clarity

While it is accepted by all that the Covid 19 pandemic was a health crisis like no other encountered to date, since 2005 the UK Government has produced a National Risk Register (NAO, 2021) and from "2008, the Register has identified an influenza pandemic as the UK's top non-malicious risk and an emerging infectious disease as one of the most significant" (p. 7). However, the National Audit Office Report on the UK Government's preparedness for Covid 19 (NAO, 2021) found it to be "not fully prepared for the wide-ranging impacts that this pandemic had on society, the economy and essential public services" (p.8).

Some of the problems encountered would have been surfaced if such plans had been fully developed. In addition, some of the rough and grating edges were foreseeable even without such a plan and may be categorised under the heading 'good management' of the system. It is not unreasonable for communication professionals to have clarity around how they may operate and what support they can expect, as is the case for clinical and other colleagues. The most obvious elements where clarity is needed are:

- Pandemic governance: clarity on how the NHSE centre relates to its regions and beyond to the 400 constituent NHS organisations. This includes the exercise of command and control and its boundaries and the governance of 'market relationships', for example, provider versus commissioner, Regulator versus Foundation Trusts.
- HR policies: regarding, for example, working from home, rotas and on-call for non-clinical staff, mental health support.
- Structures: model communication teams for different types of NHS organisations, location, size and capabilities.
- Technology: base-line requirements, what may be used, by whom and how.
- Relationships: what communication people may expect from one another, cross-team, cross-organisation and cross system.
- Media: policy on national and local media (not all national media is handled nationally) and on social media.

Professional recognition

Communicators still struggle with recognition of their professional status, yet it is clear that they played a seminal role in keeping the population as safe as possible and in facilitating crucial internal communication and change programmes. Their fear is that once Business as Usual is resumed, that contribution will be forgotten, and their professional expertise relegated. This points to a range of issues for this professional community:

- Their relative isolation as a professional group at three levels: personally (there is no formal personal support network, and each individual has varying quality and amounts depending on organisational or personal relationships); professionally (there is no formal professional network); managerially (in many cases there is a lack of understanding at senior levels of the communication function).
- Their struggle to obtain resources. During the pandemic time had to be spent on constructing complex business cases for what were relatively minor (compared to clinical demands) amounts of additional money when the leap in demand was obvious.
- Questioning of their professional judgement. There were instances when, for example, the Communication Department's use of social media and other on-line platforms was questioned, yet the use of the same platforms by clinicians was not, indeed it was encouraged.
- Lack of national recognition of the profession. Unlike clinical colleagues (with their 24 Faculties and Royal Colleges) or some operational colleagues (e.g., finance with the Healthcare Financial Management Association [HFMA] with its strong resources and publications) or HR with its own NHS England-based 'Chief People Officer', Communication has no professional base, charter or champion.

Leaders through Complexity

An outstanding feature of these professional communicators is their ability to deal with complexity both as individuals and organisational advisers. In many ways, communicators must deal with the double whammy of crises: they must make sense of and advise senior colleagues while they are themselves trying to make sense of new and emerging situations. Their ability to deal with this complexity is manifest in several ways:

- Making sense of and finding a way through complex webs of relationships and power-structures, system-wide, organisationally and externally.
- An ability to learn and negotiate their way through new IT and digital systems quickly and then advise others on best use.
- Their skill at adapting communication strategies and tactics to an ongoing crisis and upskilling and advising organisational leaders who also had to earn new ways of communicating.
- Their ability to create a sense of togetherness and community through skilful and resonant communication at a time when colleagues were going through profound change and personal grief.
- A willingness to take calculated risks for the sake of their communities, patients and colleagues – and to take the consequences of those risks. These are brave individuals determined to do the right thing irrespective of the pressures put on them.
- A professional community that recognises that people are the heart of the system, not processes and structures. This means that they recognise the need to humanise communication, to celebrate the small as well as the large steps forward and that often rapid, incremental change generates a momentum that takes away the fear of change and indeed, makes it also most infectious. It creates a 'can do' attitude and a forward propulsion that clears away barriers and bureaucracy for the sake of the greater good.

In the light of this discussion, it is therefore possible to propose a series of *eight* concrete policy and practice recommendations. First, summarising the above reflections on their pandemic experience and learning, NHS professional communicators themselves make *three* major calls for wider NHS reform to the design, operation, and delivery of communications. These three calls apply both generally and specifically to ensure a high level of preparedness that will enhance management effectiveness in any future pandemic or similar extended crisis:

1. Clarity in all matters of governance and communications/media policy (who controls what, when and where), HR policies (e.g., WFH), model communications structures for the range of NHS organisational types and technology utilisation. (The current progressive development of the NHS's ICS/ICB structure may offer an ideal opportunity for such clarification).
2. Consistent professional recognition including a widely promulgated understanding of what Boards/Executive teams should (i) expect from communicators in terms of professional advice and judgement and (ii) necessarily provide to them in return in terms of support and resources.
3. Consistent executive recognition for, and utilisation of, professional communicators' special 'fix-it' competency in coping with complexity, resolving ambiguity and establishing stability in their organisations and communities by creating meaningful and resonant communication.

Second, we extrapolate and develop a further five specific recommendations that:

4. The health system devote resources to training and simulation for pandemic communication and that this covers increasing knowledge of the challenges and operational imperatives of different types of organisations.
5. The proposed clarificatory review and revision of pandemic governance, including command and control, should allow maximum autonomy to those closest to the 'front line', that is (i) sensitive to contextual requirements, (ii) recognises the complex inter and intra organisational linkages and (iii) actively encourages wider NHS communications engagement between centre, regions and individual organisations.
6. Recognised career pathways for health communicators be developed which also embrace opportunities to work in other management roles and with other management groups.
7. Structured, funded and on-going CPD is factored into health communicators annual staff development plans in the same way as clinical professionals also engage in structured development programmes.
8. A national health communicators professional association be established which will champion communication, set standards on training and capability and provide input to national training programmes for senior managers not in communication roles.

A national health communicators professional association be established which will champion communication, set standards on training and capability and provide input to national training programmes for senior managers not in communication roles. This will emulate other existing associations such as the Healthcare Financial Management Association (HFMA) which undertakes a similar role.

Of these eight recommendations, we see the last – the call for a professional association - as the necessary 'facilitator' that will lead on both (i) the promotion of, and consultation about, wider organisational change and (ii) the execution of e.g., educational and training developments that fall within its own competency. The power to enact such an association (#8) lies clearly within the communications community as, by extension, do #6 and #7. The research team, accordingly, advocates that #6, #7 and #8 be taken forward immediately to ensure the sustainability and resilience of this essential front line and to enable the promotion of points 1 – 5.

CONCLUSION

The overall conclusion that can be drawn from this research is that the NHS is well served by a dedicated, professional community of communicators who have played a significant role in the protection of the citizens of the UK during the Covid 19 pandemic. This protection has come at some personal cost to this community who, along with clinical colleagues, have worked long and hard and to the limits of their professional abilities to serve the people of the UK. They share many of the frustrations of their clinical colleagues at the lack of timely, coherent, coordinated and structured guidance and support from the centre, while realizing and recognising the constraints and restraints placed on those colleagues in the centre and the highly politicised environment in which they work. All want to learn from the experience and be better prepared for the future.

The emotional toll on these professionals has been considerable. They too have known loss, have been in direct contact with grieving relatives and have felt the weight of public anguish, hope and expectation. While not on the clinical front line, they have been on the front line. They have guided and supported the UK population at a time of immense danger; they have advised their seniors on matters that concern life and death and they have borne the emotional burden of knowing that their words and actions are a substantial part of the national defence.

If proof were ever needed that communication makes a strategic contribution, the Covid 19 pandemic provides ample evidence. It is now incumbent on the system to learn the lessons from the pandemic to ensure that this acknowledged contribution can be even more significant in the future.
-ends-

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Appendix

Profile of respondents at the time of their participation in the research

Organisation type	Number of respondents	Geography	Grade	Gender
Acute hospital	7	4 south 1 midlands 2 north	Band 8a and above	3 male 4 female
Community and MH trust	2	1 midlands 1 north	Band 8a	1 male 1 female
ALB	1	1 national	Band 8a and above	1 female
Ambulance Trust	1	1 midlands	8a and above	1 female
CCG	3	2 north 1 south	Band 8a and above	3 female
ICS	1	1 north	Band 8a and above	1 female