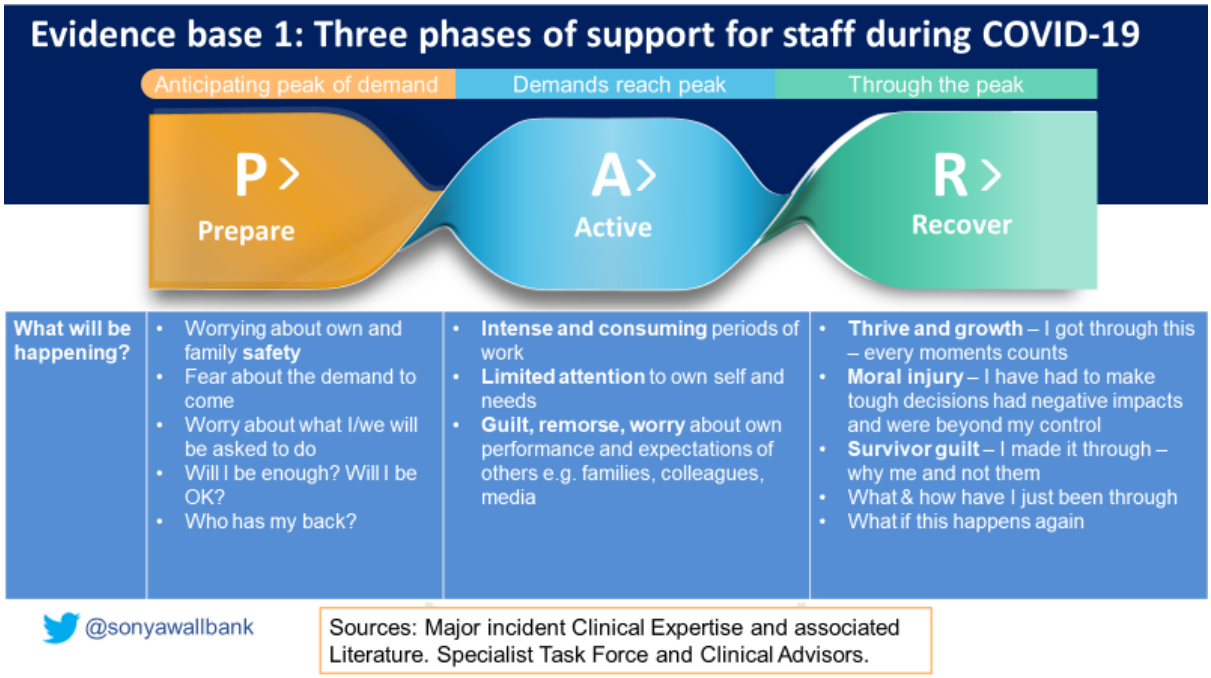
Preparing leaders and organisations in the NHS for the 'New Normal' and the next phases of COVID 19. Reflections from the past month working in the East of England

Four weeks ago, we came together from three different organisations, having never met, with vague brief to pull together the plan for supporting the health and wellbeing of staff deployed to the EoE Nightingale Hospital. Since then, the plans for creating a Nightingale Hospital changed dramatically, to instead building capacity through 'regional surge centres', linked to three hospital bases in order to manage the increased demand. The workforce modelling needs and therefore the context of the challenges staff will face also changed; sometimes hour by hour….

As a newly formed team, we have gone through a range of emotions and forged deep relationships together, despite having never actually met in person, by understanding that we have a shared passion to make a difference, bringing different experience and space to be ourselves; including a passion for horses! Prior to Covid-19, this type of collaborative working across 3 entirely separate organisations would have taken a plethora of bureaucracy to get underway and would have been fraught with political and commercial barriers. This experience has taught us that when like-minded people are connected through a shared purpose and motivation, they can achieve great things in a very short time. The following summarises some of our reflections.

National evidence and support arrangements has been gathered (evidence base 1&2) and put into place, with each local area responding with their own arrangement for staff. Current arrangements are still patchy, needing coordination, communication, targeting to those at risk and enhancement. A key concern is the ability to follow up and predict those with longer term issues such as PTSD in the recovery phase 1 year plus and the mental health provision to meet both staff recovery and (COVID) patient needs. Research from SARS https://pubmed.ncbi.nlm.nih.gov/17592106/ showed a c.50% incidence in depression 1yr after their initial treatment.



Evidence base 2: What we need to be doing during the phases

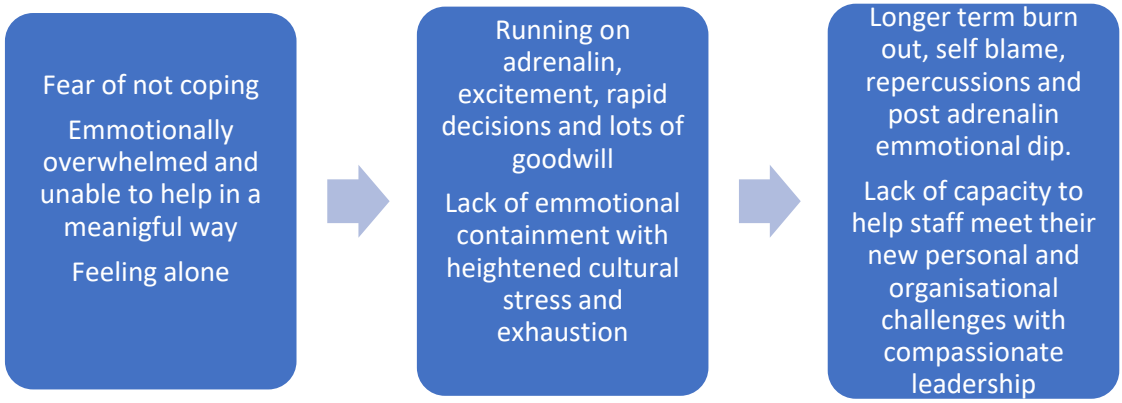
Do not rush in with Psychological intervention – on average 70% of people recover without the need for intervention given the right support

Phase	Prepare	Active	Recover
What support we will need to offer *The range of support offered will consider the promotional, access or workplace inclusivity requirements of all staff – including those with protected characteristics*	1. **Collective messaging is key** – 'we' are here, together and behind you 2. **Enhanced** line management support – we will make collective decisions – I have your back 3. **Safety provision**, honest, open and transparent messaging about how we will keep front line workers safe 4. **Expectation** – preparing people for what is to come and how we will support them 5. Line managers trained and ready to have **psychologically informed conversations** 6. **Teams** who understand what is expected of them and how to work together well	1. **Physical** provisions, prompts and messaging to support care of basic needs 2. Places to **decompress** – even if not frequently used – serves to emotionally contain and demonstrate "we are here together' 3. Clear protocols for **normalising** stress response, opportunities for **debrief** and networks of support within the workplace 4. Anonymous opportunities for discussions 5. Line **managers trained** in signs of stress and trauma – specialist psychological services equipped to respond	1. 12-24 months post active period 2. Can take a while to seek help and **triggered** by other non-related events 3. **Services** in place to support the range of presenting conditions e.g. anxiety, depression through to PTSD and complex grief 4. **Line managers** who know what to look out for and how to manage discussions 5. **Fast access** for staff to mental health services where complex treatment required 6. Return to work strategies which may require short term redeployment

We recognise that leaders are also facing inordinate challenges in supporting staff with emotional and physical wellbeing, meeting the complex needs of patients, and significant operational pressures. Leaders are also realising that, not only will the work environment never be quite the same, but the 'new normal' will have new challenges such as additional capacity demands from work that has been paused in the current climate, even greater financial demands as recovery from the crisis begins, greater staff shortages and unprecedented emotional strain from the aftermath of the sustained period of crises management.

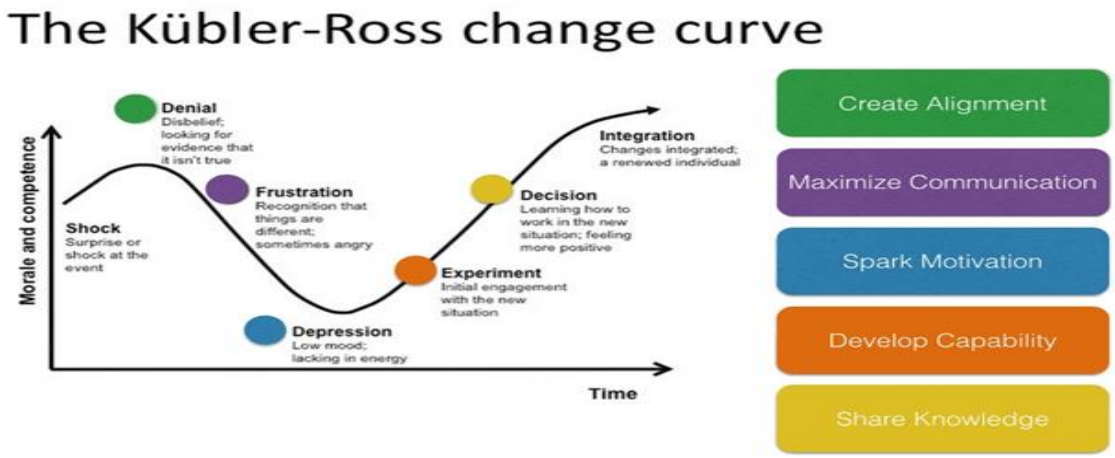
Our leadership capability must be prepared to adapt to the 'new normal', holding enough certainty and psychological safety to re-negotiate and re-align our usual systems and processes, taking account of the best of what has been done, whilst being compassionate about errors and mistakes; noticing the quality of **how** we work together, rather than **what** we do together to make things work to adapt to a constant state of rapid change and pressure.

This has led us to think about the emotional journey of leaders and organisational resilience preparation, mirroring the journey of 'prepare, active and recover' depicted above:



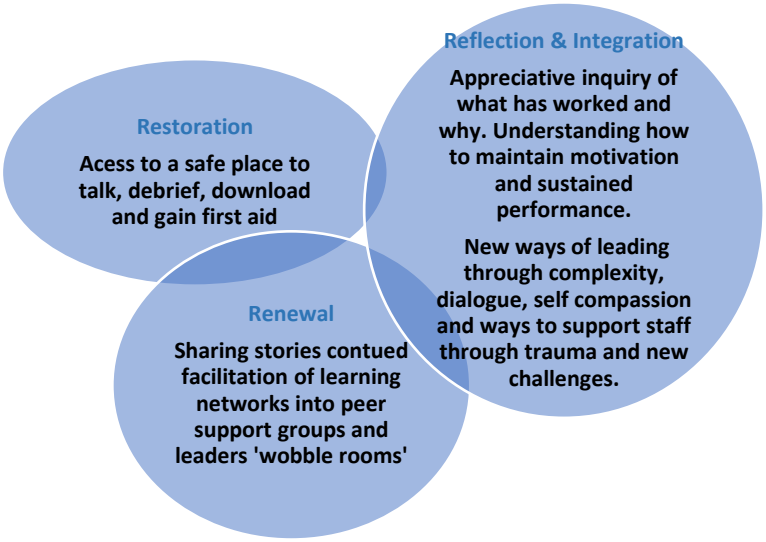
The psychological state of leaders, their emotional intelligence, self-awareness, and associated behaviours, intrinsic to the culture and environment they create for staff to maintain psychological wellbeing is well understood.

Maintaining resilience for positive behaviours whilst leading and implementing rapid change, integrating new ways of working into every day, and, providing psychological safety for staff working under constant physical and emotional pressure, is of critical importance if services are to be sustained and sickness levels not escalate exponentially. The well-known and accepted Kubler-Ross grief cycle is also often used as a model of what happens in change.



It also mirrors our neurological responses where in crises there is a high and an upsurge in adrenalin, endorphins and team spirit, but as that falls there is a rapid deterioration in energy and mood. Having reached the end of the 1st phase of COVID response, we are also now starting to see the downturn in this curve, just at the point when there will be a new phase including new capacity and management of the backlog of clinical activity. We are likely to go through several phases of COVID related change, as well as the emotional consequences of anger, helplessness and burn out, with the resulting impact on culture and outcomes, as is seen in the Human Factors work undertaken by the DH http://www.england.nhs.uk/ourwork/part-rel/nqb/ag-min/ This brings an urgent need to provide resilience into the system to sustain staff and high quality services for our patients.

We are now in early discussions about how we will put in a regional psychological resilience programme for leaders to receive training in mental health first aid, places to download and reflect, and ongoing peer learning and support groups. The model being explored is akin to that of a supervision type model for coaches - **Restore, Reflect, and Renew**. **The three R's**



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