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The courage to be kind

Reflecting on the role of kindness in the healthcare response to COVID-19

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Enabling Wellbeing Research

Kindness in Health & Social Care 2020

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Foreword

At the start of this year, there was a gathering momentum to conversations about the role of kindness, compassion and love in shaping a future Scotland. The bold language of the Care Review, the Sturrock Report and indeed the National Performance Framework all indicated growing acceptance of the evidence, and of the importance of values in public policy. In the health and care system, specifically, facing a period of significant reform and challenge to meet the needs of a changing population and adopt new technologies, it felt doubly important that the prevailing culture should allow room for kindness.

Yet, as the Carnegie UK Trust's own analysis has shown, the ease with which people now speak the language of kindness does little to diminish the tensions and complexities of embedding it in practice. For public policy and public services, the implications of kindness are radical and disruptive.

When COVID-19 happened, we entered a period of rapid change across the public sector in which many of the previously insurmountable 'barriers' to kindness appeared to fall away. This was nowhere more the case than in our healthcare system, which was charged with transforming almost overnight to cope with unprecedented demands.

In the spring, as we all clapped for carers, we sensed that there was something happening that the Trust decided to capture – not in a representative, system-wide way, as there were many others better placed to do that – but rather through a deep, relational approach, reflecting on the role of kindness in a manner that was underpinned by the value itself.

We were very fortunate that a group of medics was willing and able to participate in a listening project that was guided by reflective practice. Over a series of open and honest conversations, they told us about the ways that infection control had necessitated changes in practice, and the opportunities this had presented for embracing technology and new ways of working. They spoke about a renewed focus on staff wellbeing and how this sometimes felt in tension with more operational pressures to remobilise. But more importantly, they reflected on their experiences of loss and grief, both personal and observed, and on how they were feeling during a period of prolonged change, uncertainty and intensity, offering a window into the experiences of thousands of NHS staff across Scotland.

As powerful and insightful as their reflections are, we know that they only offer one perspective, and that they do not provide all the answers for health and social care renewal. What they have highlighted though, consistently and clearly, is the importance of creating space to listen. This is critical in the sense that if we want to provide the best possible healthcare, we need to look after the wellbeing of those that are providing it. But it is also clear that the ambitions of health and social care renewal can only be realised if they build on, rather than stifle, the vast knowledge and skill that is found across the workforce.

The response to COVID-19 has shown what can be achieved when our approach is underpinned by relationships and by collaboration. If we are really serious about a renewal that focuses on improving the wellbeing of staff and patients, finding ways to ensure that we sustain the focus on wellbeing and on empowering staff is not optional, it's a necessity.

Sarah Davidson
CEO, Carnegie UK Trust

Background

Kindness is something that feels universal: a word that we all understand and, particularly during 2020, place great value on. Yet every so often it has the power to make us stop and think. The Scottish Government has been talking about kindness and compassion as values that are at the heart of its vision for more than two years.[1] But when John Sturrock QC's report on cultural issues in NHS Highland drew the conclusion that "kindness is what is needed", it felt different: kindness not as a personal quality or an aspiration, but as something that was institutionally lacking and needed to be "restored".

The findings of the Sturrock Review (Sturrock, 2019), and the way that these presented, meant that they resonated far beyond NHS Highland. The Scottish Government Response (Scottish Government, 2019) acknowledged that there was important learning and reflection across NHS Scotland and for the government itself. In establishing a Ministerially-led Short-Life Working Group (MSLWG) to examine the role of leadership and management in workforce wellbeing, the Cabinet Secretary signalled that this was not an individual but a systemic, cultural issue – one that required deep consideration of the closing question posed by Sturrock:

> *"For those who have been affected, how will NHS [Highland] move from fear to safety, from anger to compassion, from blame to kindness, from shame to dignity?"*
>
> (Sturrock, 2019)

The Carnegie UK Trust has been exploring the role of kindness and relationships in public policy and public services since 2016 (Unwin, 2018). Across four years of research and practice, the Trust's work has documented the ways in which kindness can be 'squeezed' from above, by pressures on expenditure and a prevailing audit culture; and from below, by inflexible approaches towards risk and performance management, and by high levels of scrutiny that can foster a 'blame culture'. These systems for accountability are important, because public services have a responsibility to deliver fairness, safety and value for money, and therefore must be open to scrutiny and challenge.

However, the Trust's research has shown that significant risks also exist in a system that does not foster and reward the building of strong, trusting relationships. All organisations are made up of people, and an organisation's performance is therefore hugely affected by how happy, engaged, purposeful and safe its people feel.[2] Leadership really matters, and compassionate leadership is associated with high performance, effectiveness, wellbeing and credibility (West et al., 2017).

This understanding forms the backbone of Sturrock's report, in which he foregrounds the importance of a leadership culture underpinned by a commitment to compassion and kindness; and indeed it is at the heart of the government's own vision for Scotland. Yet, by Autumn 2019, the language of kindness was in short supply in the public narrative about the NHS in Scotland. A number of health boards were placed under special measures, as government responded to operational challenges by increasing the pressure on audit and scrutiny, encouraged by a parliament and media dialogue that focused on the personal accountability of individuals in leadership roles.

[1] "We are a society which treats all our people with kindness, dignity and compassion…" (Scottish Government, 2018).

[2] For a more detailed look at the impact of social support, cohesion, and sense of purpose on wellbeing at work, see (Irvine, White, & Diffley, 2018)

In this context, the Trust approached Dr Elizabeth Kelly, to begin an exploratory conversation about the place of kindness within health and social care in Scotland. In particular, it sought to explore the relationship between individuals and the system that they work in, which creates the context for the ways they behave; and to interrogate what might need to be done to create the conditions for healthier relationships – conditions that bring the best out of Scotland's health and social care workforce, and the people they care for.

Throughout Autumn and Winter 2019, talking to leaders in healthcare using a snowball approach, it became clear that there was a desire among segments of the clinical and leadership community – in Scotland and indeed across the UK – to talk about kindness. Sometimes this was framed in terms of psychological safety (Jones & Seager, 2019), at other times compassionate care and relationship- or person-centred care; elsewhere it was a broader conversation about values-based leadership. But throughout was a recognition of the influence of a triangular axis of politics, media and audit culture, which puts pressure on staff working at all levels of 'the system'; and of the importance and urgency of focusing on staff wellbeing.

There was particular energy among a smaller cohort of emerging leaders: four members of Project Lift and the Scottish Clinical Leadership Fellowship were interested in exploring this conversation further as part of their leadership programmes.[3] Coming into 2020, this cohort created platforms and opportunities at a series of engagements at national conferences,[4] the purpose of which was to widen the conversation and further explore *how* to create the conditions for kindness and compassion within the healthcare workforce.

Across six months of exploratory conversations there was an urgent feeling that the health and social care system – with an ageing population and rising demand, with the regular deployment of special measures, with increasing levels of staff sickness and absence[5] – was staring at a crisis. In March 2020, a very different type of crisis emerged, one that forced the cancellation of the cohort's planned engagements, but also opened up an array of new thinking and possibilities.

The immediate response to the COVID emergency saw rapid change: many things that previously felt impossible suddenly became a reality, as people and organisations united with a sense of common purpose. While the focus remained, rightly, on managing the public health crisis, at the same time it felt important to capture the experiences of those working within this time of change. To understand what was being learnt about new ways of working, to reflect on what was being valued in decision-making, and consider what this might reveal about priorities for recovery and renewal.

The Trust therefore developed a model that provided a safe space for the cohort of leaders to reflect on changes in real time. By working with a cohort that offered a range of backgrounds and perspectives, it aimed to 'walk alongside' the NHS during the crisis, and capture learning and insights on the project's key question: *What can we learn from the COVID-19 crisis about relationships and collaboration in Scottish healthcare environments?*

3 For more information about Project Lift and the Scottish Clinical Leadership Fellowship scheme, see https://projectlift.scot/ and https://www.scotlanddeanery.nhs.scot/your-development/leadership-and-management-development/scottish-clinical-leadership-fellowship-scheme/.

4 These included: the Scottish Access Collaborative, Evolve Scotland, Faculty of Medical Leadership & Management, Scottish Medical Education Conference, NHS Scotland Conference.

5 For the financial year 2019-20 the sickness and absence rate across NHS Scotland was 5.31%, set against a target of 4% or less (Health Performance & Delivery Directorate, 2019); NHS data in England shows that anxiety, stress, depression and other psychiatric illnesses account for nearly a quarter of the staff absences (Copeland, 2019).

The evidence consistently shows the importance of relationships and the quality of interactions for health outcomes. While insights from these conversations are from the perspective of clinicians, they relate to both patient experience and population health, and indeed, throughout the project, conversations consistently returned to this theme:

"…it's important to be kind to staff, otherwise they won't have the reserves to bring that into their work and interactions. [But] if you have staff that are being looked after, this will permeate into how they are with patients."

The approach

In April 2020, the Trust invited the cohort of four emerging leaders plus Carnegie Associate, Dr Elizabeth Kelly to take part in a series of reflective conversations. With those involved in elective leadership programmes having returned to clinical practice, the five participants in the project were able to reflect on the COVID response from roles within Scottish Government, local health board management, hospital medicine, emergency department and general practice. This meant that they offered a range of different perspectives; but their insights remain a snapshot, rather than an attempt to portray a representative picture.

In particular, it is worth noting that all five participants were medical doctors in the NHS; and while they spoke of practical change in health *and social care*, their reflections are one particular perspective, albeit one that chimes with the Trust's understanding about kindness during COVID across a much wider range of settings.[6]

From the outset the project timeline was fluid, in order to accommodate the uncertainty of the duration and impact of COVID, and the way that the changing situation might affect those working in healthcare environments. The aim was for the Carnegie UK Trust Project Officer to conduct bi-monthly one-to-one conversations, that were loosely structured around working through the following questions:

- What are you noticing and learning about relationships / kindness?
- What reflections do these prompt about how things were before COVID?
- What changes in practice and behaviours do you want to keep post-COVID?

In the end, the project completed two rounds of one-to-one conversations in May and in June / July, at which point participants saw value in coming together for a final group reflection, which was held in early September.

After each round of conversations, the Project Officer and Carnegie Associate spent time analysing the key themes, which were summarised and shared with participants for input.[7] As such, the boundaries between 'researcher' and 'participant' were somewhat blurred: this was not a formal research project, but rather a collaborative reflective practice (hence the use of the term 'conversations' as opposed to 'interviews').

The aim of the project was to create a space for open, honest reflection that might not be possible in normal workplace settings. This was enabled, in part, because of the relationships that had been developed before the project began. The approach to these conversations was also influenced by elements of Values Based Reflective Practice® (NHS Education for Scotland, 2020), with participants given space to reflect in both a personal and professional capacity on themes that align with the five 'NAVVY' questions.[8] In structuring the conversations in this way, it was hoped that they would be beneficial to participants in and of themselves, through offering a safe, non-judgemental space for listening at a time of heightened pressure and anxiety (West & Coia, 2019) (this theme is discussed further in the thematic analysis).

6 This includes a case study on kindness in North Ayrshire (Thurman, 2020), a UK communities listening project (Coutts, et al., 2020), as well as unpublished conversations with members of the Trust's Kindness Leadership Network.

7 Emerging findings were also shared in real time with a small group of people at the Scottish Government.

8 **N**: whose **needs** are met; whose needs are overlooked?
A: what **abilities/capabilities** are at work?
V: what **voices** are present/absent, included/excluded?
V: what is being **valued**/undervalued/overvalued?
Y: what does the situation reveal about **you**?

Because of the openness and honesty with which participants shared their experiences – both personal and organisational – and because of the relatively small numbers of people in each Project Lift and Scottish Clinical Leadership Fellowship cohort, confidentiality has been an important consideration. This is particularly the case in the presentation of examples, where the report anonymises the individual and, at times, the context, which is to ensure insofar as possible that the identity of both the participant and those they work with is not discoverable by others.

The remainder of this report presents a thematic analysis of what was heard across these reflective conversations. It is structured chronologically and, in doing so, it tells a story of people's experiences of change across the NHS through three distinct phases: lockdown (April-May), lifting lockdown (June-July), and remobilising (August-September). Each phase is broken down into key themes, with the voice of participants woven between. The report finishes with a discussion that summarises what has been learnt about kindness and relationships in the first six months of COVID, and considers what this might mean for the future.

Phase one: lockdown (April-May)

The first round of reflective conversations was held with each of the five participants between Friday 1st and Monday 25th May. Several participants had recently returned to clinical settings that had "changed beyond recognition"; others had spent several weeks reacting and adapting to a rapidly changing environment. This round of conversations, then, focused primarily on what people had noticed across April and May: they blend a sense of energy and fulfilment in what had been achieved at pace in the immediate COVID response, with a powerful recognition of the emotional impact of change and loss, as well as a mix of optimism and anxiety about the future.

Staff wellbeing. Participants spoke passionately about the renewed focus on staff wellbeing, not as an added extra but as a core part of 'what we do'. There was a sense that lots of the things that had been talked about, but seen little action, had suddenly become possible; and there had been a realisation that you have to be kind to staff, if you want kindness to be present in their interactions and relationships.

"…things that had been talked about for a long time were suddenly possible. Overnight people provided free transport for health workers, set up staff lounges in hospitals… The way that barriers just parted for wellbeing and support was amazing to watch."

There was some scepticism about wellbeing initiatives that prioritised tools and (online) resources for individuals. When thinking about their own wellbeing, the things that participants valued most were protected spaces for reflection (like those provided within leadership programmes and by this project); and the sense that they were listened to by senior management and decision makers.

"One of the positive things was being asked by clinical management what we think is working well. It made us feel valued and listened to, and that's the best thing for group wellbeing: knowing that senior management value our experience and insight."

But overall, the feeling was one of cautious optimism that the importance that had been placed on staff wellbeing would sustain beyond COVID-19

"Perhaps that could be one mitigation of this whole environment – the PPE, the separation, the feeling of being unkind – that this idea will carry through: if you have staff that are being looked after, this will permeate into how they are with patients."

Personal impact. The focus on wellbeing, and (for some) the knowledge that they worked in an environment where it was easy to say if you were having a tough day, was of great importance because of the personal and emotional impact of COVID. Conversations were underpinned by a sense of loss: direct loss of patients, loss of human connection in clinical environments, loss of Project Lift / SCLF opportunities and a broader recognition of the loss experienced by people and families across the country.

"The last two months have been couched in change and uncertainty. As a doctor, the loss of practice as I know it has been really tough."

Although some were energised by working in an environment where it felt possible to get things done, the "intensity of it all" was challenging (a theme that developed throughout the summer). In addition,

participants reflected on the diversity of experience within the NHS. They spoke of the levels of redeployment and underemployment across the health service: the necessity of infection control and temporary pause of certain operations left some people feeling frustrated and impotent – a striking counternarrative to media discourse at the time.

> *"[It's not like] the narrative in the media. I hate the war metaphor, and the NHS heroes metaphor. There are all those images you see in the media of ICUs – but then there's a whole swath of departments that are mothballed. It felt like there was so much energy around where we might be deployed at the beginning, but it's all come to nothing."*

Common purpose. Across the piece, people spoke about the speed of change, reflecting on how much could be achieved when urgency and a common purpose demanded working together.

> *"This was possible because of a shared understanding and a shared fear. There was no space for personal ambitions and agendas, because there was something bigger and more frightening that demanded our attention."*

In all settings, communication had become more regular (despite the challenges of physical distancing), an investment of time that participants felt had strengthened relationships. Territorialism and hierarchies fell away, unlocking partnership and collaboration "that wouldn't have happened before", particularly in health and social care integration and the recognition of "community solutions".

> *"The main change is the common goal: everyone feels that the only way to get through is working together, which has taken away a lot of the barriers and made a huge difference in the way we relate to each other. There is also a sense of pace: both the urgency of the situation and desire to make it better, which has driven a positive individual and group response."*

Participants perceived that the crisis had seeded a response that prioritised health outcomes and was less concerned about governance and procedure – and that "a lot of things that would have been barriers, weren't a factor because of the emergency nature." But there was also an undercurrent of worry about what would happen when this common purpose subsided, with some already noticing the return of certain behaviours and people trying to "own their space".

Re-evaluating performance. Several conversations highlighted that COVID-19 had "given permission" to stop doing things that are non-essential. They recognised that previously certain procedures and appointments were "often done for the benefit of the service rather than the person"; and noted the impact of dialling down pressure on targets, which, in some places, had given staff greater understanding and flexibility to provide a person-centred response, and generated a less punitive environment around performance management.

> *"Overall, the four hour target is a good thing […] We know that we have to be as vigilant as we can with targets, but being punitive and aggressive towards staff is not helpful. It we take each one on case-by-case, and always ensure the best thing for patient, we shouldn't be criticised."*

At the same time as recognising the importance of lifting some of the weight of 'audit culture', participants also noticed growing pressure to get services operating again. In 'returning to normal', people wondered about the risks of reinstating the previous performance management structure, which could squeeze out the space for wellbeing of both workforce and patients.

"How do we keep the system going in a new way without going back to the old way? Who gives permission that this time next year we start to look at a different type of performance management? We know what can happen when we have consensus on priorities; but something has to be taken out of the system to create the space for kindness and relationships."

Changing practice. Alongside shifting attitudes and approaches at a systems level, conversations also brought up more specific changes in practice, noticing how infection control measures had necessitated rapid changes in the way healthcare is delivered, some of which could improve patient outcomes. First, the sudden availability of hospital beds and a transformed layout and approach in emergency departments provided an opportunity to look at hospital capacity: specifically, to ensure that 'corridor care', which impacts both patients and staff, does not return to the healthcare system.

"Hopefully the emphasis on infection control will prevent there ever being such a problem with corridor care in ED […] This can't happen anymore due to infection control. There is an opportunity to never go back to having patients stacked up in a corridor, where we felt we weren't providing very good care – and where the evidence shows outcomes are much worse."

There was also recognition that the sudden widespread use of remote consultations, enabling outpatient and follow-up appointments to be managed at a distance, had the *potential* to deliver a more person-centred service. This perception linked to the theme of COVID putting non-essential functions on pause, presenting opportunities for renewal to refocus on responding flexibly to the needs of individuals, which vary across situation and geography. It was, however, noted that the starting point must be the wellbeing of patients and staff, using technology to complement this, rather than as a tool to drive performance and efficiency.

Alongside the more positive changes, there was also a great deal of uncertainty. Participants voiced anxiety about those who were not seeking medical attention for serious health issues, and the impact this may have in the coming months. Similarly, they worried about the long-term impact of physical barriers to human connection. While everyone spoke of doing what they could to mitigate the dehumanising nature of PPE and restrictions on visitors, there was concern both that this was reducing their ability to understand what is important to patients, and that operating in what feels like an unkind environment for a sustained period of time would take a toll on workforce.

"It doesn't feel like a very kind place right now […] We want to be someone who is accompanying a person, who is with them in their suffering, but it is really hard to portray empathetic listening without people seeing your face. "

Command & control. Two months into the pandemic, there was a broad consensus that a centralised approach had been necessary and had resulted in broadly effective decision-making in the immediate response. Participants did, however, reflect on the medium- and long-term approach to decision-making. They perceived potential tensions between central government and NHS boards; and a risk that sustaining this approach would undermine the ability to respond to local and regional circumstances, and thereby cut across person-centred care.

"We've been able to deliver huge amounts of change – as individuals, society, professionals and at a political level. But if we don't change the model of decision-making soon, we will have an increasingly centralised framework [that is] very operational and performance driven."

This final point of reflection epitomised the conflicting emotions in the conversations that were held in May. Because of the speed of change there was a sense of opportunity to build on what had been achieved in the immediate response to COVID-19, by creating space in the system to allow people to focus on relationships. But participants also recognised the risks of "going back to the old way", and the critical importance of leadership to strike the right balance between performance metrics and governance, and valuing staff and patients.

"There's huge amounts of opportunity to deliver relational services. We have taken away performance management and micro management; we've fostered creativity and working together; there's been a real cohesion between previous turfdoms. We need to celebrate the really good stuff that's happened and build a better society."

Phase two: lifting lockdown (June-July)

Across the second round of conversations, held between Friday 5th June and Thursday 2nd July, participants reflected on a period of change and transition, from 'hard lockdown' towards a resumption of health services. At times, the energy and optimism that was present in May remained; but there was also a growing fatigue as workload intensity, decision-making responsibility and prolonged uncertainty began to take a toll. People were also noticing that elements that were strong in the immediate response – the common purpose, the flexibility, the focus on listening and on wellbeing – were fading away. This perception, alongside increasing pressure to return to normality, triggered a sense of urgency to grasp opportunities for change.

Staff wellbeing. Three months into the crisis, there was a subtle change in the way that people spoke about workforce wellbeing. Participants continued to recognise the energy that had been put into particular initiatives, like rest and relaxation hubs and psychological support. But they also began to perceive a tension between investing time and resource in staff wellbeing, which could otherwise be directed at patients.

> *"I'm nervous about this. There is a level of weariness among people who have been managing the response, and a fear that, despite all the emphasis on staff wellbeing over the past three months, we could go back to business as usual."*

In addition, they noted that the most effective approaches to wellbeing happen at a local level, and are based on human relationships. While remaining positive about the national narrative and focus on wellbeing, some questioned the way that it was being operationalised. Rather than looking for formal, one-size-fits-all solutions, there is a need to create the space and flexibility for kindness to happen between individuals and teams, informally, intuitively and often in the margins (a flexibility that demands shifting control away from the centre).

> *"Big organisations perhaps struggle to think about people at a human level [and] there is a tendency to look for a centralised solution, which just doesn't work. We don't operate at a health board level. You only really know what works for your little bit of it, and in the end nothing really substitutes for individual, human action based on understanding of a person – you can't mandate or scale that."*

Personal impact. By the summer, this conversation about wellbeing felt especially important because of the mounting personal and emotional toll of COVID-19 on the healthcare workforce. Reflecting on both personal experience and perceptions of the healthcare community in general, people spoke of "weariness, fatigue and anxiety about what the future may hold." It was suggested that this might be particularly the case for colleagues in ICUs, sustaining high workloads and experiencing the human impact of COVID on a daily basis. But it also felt important to recognise that the pandemic was affecting *everyone*, regardless of decision-making responsibilities or workload intensity.

> *"It's been quite tough emotionally, even though there hasn't been the influx of patients we expected. Personally [and also] at work: the constant awareness of your own space, walking down the corridor, being afraid of being too close to others…"*

In this context, several participants felt a need to pause and reflect with colleagues – not about the practicalities of work, but about "how we all are". They observed the challenge of creating space to do this, and the importance of leadership in ensuring that there is time to prioritise the needs of staff and teams, especially when workload pressure makes this difficult (a theme that should inform organisations' and teams' approaches to staff wellbeing).

> *"It's also important to have these catch ups on a pastoral level: putting everything else to one side, how are you feeling about all this? It feels like this is missing. There are meetings, but they are specifically about the rotas. We know there are colleagues who are worried about a whole range of things, and this can impact how they are at work."*

Change & uncertainty. While acknowledging the necessity and inevitability of evolving measures to control the virus, the resulting "constant flux and change" emerged as a key theme. People spoke openly about the implications of test and trace: not as a critique of infection control measures, but as a recognition of their impact on staff. In some settings this meant putting measures in place that introduced further barriers to human connection; in others, the challenge of adapting systems to manage increasing numbers of patients with reduced spatial capacity.

> *"In practice, we have to see patients within 15 minutes, and at least 2 metres apart […] This means putting more barriers in place to ensure it stays in control, making interactions much quicker. It feels very sterile at the moment because all the focus is on controlling infection – and none of the healing things. We don't really know what the repercussions of this will be. But two months into it and there's a sense that people are starting to flag."*

Alongside practical implications, there was a sense of change fatigue as participants began to talk about how hard it was to keep up with a situation that "changes every week", and to voice their anxiety about all the unknowns associated with COVID-19.

> *"Activity is still way down on normal, and we're wondering what is happening, and where the patients are […] There is uncertainty about the people we're not seeing, what we might be missing, what is the impact of what we're not doing. That uncertainty is hard to manage."*

Listening & being heard. As people reflected on the impact of change and uncertainty, they noticed that the way they felt about change was affected by the extent of their involvement in decisions. At a local level, conversations highlighted the importance of communication and transparency, so that staff understand *why* changes are happening and *how* their feedback has been considered. Among the wider clinical community, there was a sense that they were listened to during the acute phase, and felt empowered as a result; but a worry that things were "slipping back into old ways" as priorities began to change.

> *"It's important to have everyone involved in how they think things could work. People get grumpy when you ask them to change if they don't understand why you're asking them to do that."*

Common purpose. Although the unity and collaboration that everyone noticed in May remained, there was a sense that it was beginning to dissipate as plans for remobilisation opened up new priorities. One indication was that the regular communication across different departments – on which the initial response was built – was being rolled back, as people's focus shifted.

"The shared sense of purpose is still there, but with less intensity. The common goal is changing, because it's opening up different priorities. And the pressure from above to return to normality is intensifying."

These observations were pointed: participants emphasised that it was this common purpose, cohesion and strength of relationships that had allowed health and social care in Scotland to achieve so much at such space. They spoke of a desire to "keep it alive" and hold onto the sense of a common goal as conversations turned towards remobilisation and recovery.

Pressure & urgency. As people noticed subtle shifts in language and approach, the conversations felt more urgent. People recognised the critical need to resume services that had been put on hold, and felt the pressure of "ambulances stacked up at the door". Yet, at the same time they worried that the emphasis on remobilisation might indicate a desire to return to normal, and diminish the possibilities for building a different future.

"What is increasing is the pressure to restart services without enough consideration. I really don't know where that impetus to get back to some degree of normality is coming from – does it mean just going back to the way we were before?"

There was a feeling – among participants themselves and their perception of the wider clinical community – that so much had been achieved *because* dialling down targets had enabled different ways of working. And there was a level of fear in the way that they spoke of the system as "a juggernaut revving up", which might instigate a return to the way things were before.

"…turning off targets has allowed different ways of working and [staff] don't want to go back to a target culture […] to unsafe levels of crowding, neglect of staff wellbeing, systemic failure to meet 95% targets." [9]

Opportunity to grasp change. Running alongside these pressures, was a sense of opportunity to hold onto the things that COVID-19 had made possible: to build on technology and community solutions; to (not) focus on things that (don't) offer value to patients; to revolutionise A&E so that it is a "safety net for the patient, not for the system". That optimism was present, in part, because of a feeling that resource scarcity will demand moving "from high volume to high value" healthcare – and that returning to a system that was unsustainable before COVID-19 is not a viable option.

But people also recognised that this is "complete institutional change" which would require communication with everyone involved and, above all, time and space to move beyond health and social care silos, and sustain and develop a common purpose. To grasp these changes, there is "a need to slow down a bit".

"There is potential to revolutionise the way we do things. […] We need to use what's happened now as momentum to implement these kind of changes – but we need board support for that. This is complete institutional change, and so it needs communication with everyone involved, so it's not about people jumping in with their own agenda."

9 LDP Standard: 95% of patients to wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment (Health Performance & Delivery Directorate, 2019).

Collaborative leadership. Woven throughout this second phase of conversations was a sense of people and a system being pulled in different directions: between human relationships and infection control; between valuing the workforce and struggling to carve out time for wellbeing; between remobilising and holding the space for a conversation about what a different health service would look like. Another tension was between the centre and the local. Here participants spoke about the importance of listening, engaging and embracing a truly collaborative approach, so that leaders at all levels have a voice and feel part of what 'the new' looks like.

"After all the plaudits that workers in health and social care have received, that trust and respect must continue. How can we capture that expertise and deliver something that's new and different? That will take brave leadership from politicians and government."

Phase three: remobilising (August-September)

On Tuesday 1st September, the cohort came together for an online session to share what they had noticed, and reflect collectively on what that might mean for recovery and renewal. Structuring the conversation in this way elicited insights reflecting back on the experience of the last two months, and perceptions looking forward to the future, identifying positive changes that need to be sustained beyond the crisis. Phase three of the project came at a time when case numbers were relatively low, and there was still an appetite for discussions about 'getting back to normal' or 'building back better' across society. And yet, despite this, there was a palpable sense of tension, and of people holding conflicting pressures and emotions – the energy and optimism about possibilities for renewal, with tiredness and anxiety about preparing for winter – often at the same time.

Reflecting back

Personal impact. Even in a group setting, the personal and emotional impact was palpable. At times the conversation was animated and energised about the possibility of change; in other places there was a sense of exhaustion and anxiety, particularly about the prospect of winter which people already recognised as "a huge challenge". These conflicting emotions were often expressed by the same people at different times, something that felt particularly pronounced for those who were involved in planning and preparation.

> *"There's an urgency to be ready for winter. For me and the teams trying to get people into a place where they can be prepared, it is taking a lot of emotional energy in terms of being able to support officers, and drive the things that we are being asked whilst getting ready for a second peak and winter."*

Here, it felt like the cumulative effect of being asked to respond, remobilise, adapt and prepare – all while trying to maintain the level of optimism required to drive change – was becoming unsustainable and might be having a real impact on individual wellbeing.

> *"My soul feels anxious, and I am not normally like this. I am optimistic. But now less so."*

Connection & loss. Alongside uncertainty about the future, the group reflected on the present reality of clinical practice. Perhaps reinforced by the validation of shared experience, the sense of loss which had been present throughout the pandemic felt stronger than before. In some cases, somewhat contrary to the idea that technology would bring ease and efficiency, people spoke about how tiring they found back-to-back telephone calls. But most of all they spoke about missing "the things that happen in the appointment" that can't be replicated through technology.

> *"It feels very transactional rather than holistic. You listen to a problem on the telephone and that's what you manage – you don't look at it in the whole."*

There was no critique of the approach being taken to control infection – and indeed elsewhere people spoke about the possibilities that technology presented. However, it did feel like people valued the space simply to recognise that working in this way, feeling disconnected and not being able to provide the care that you would otherwise is emotionally hard.

Values & culture. These discussions about how people were feeling, led to a conversation about wellbeing at work that questioned whether the values that were being expressed publicly were truly reflected in their experience. As in previous phases of the project, there was a consensus that staff wellbeing was "really prevalent" in conversations across the service; and that people had been "humbled that the values of the NHS were being celebrated" at a national level. Yet, people wondered whether this translated into reality, and articulated the challenges of maintaining the space for wellbeing and driving culture change.

"From being involved in various things to do with wellbeing and culture, one of the challenges is to identify what you can actually do. People are well intentioned and try to do the right things, but it always somehow ends up getting sucked into discussions about process and targets."

Renewing & remobilising. At the heart of all of these discussions was a feeling of tension between the hopes of renewal and the pressures of remobilisation. Participants felt the sense of common purpose dissipating, as people started "going back to different parts of the system", their focus returning to more narrow departmental and organisational priorities. While some of this was inevitable, or at least anticipated, people voiced concerns about the focus on "getting back to normal" without knowing what it was that they were aiming for. There was a feeling that this would risk reconstructing how things were – "targets by another name" – rather than something based on the voice and relationships that had been at the heart of so much of what was strong in the pandemic response.

"There are concerns from everyone. There was a pause and we hoped it would be an opportunity to re-evaluate. But now there's this focus on bureaucracy and returning to normal, and I'm not sure how we create the common purpose and align our activity with it. I'm not sure that cultural shift within the NHS will ever happen…"

Public expectations. As well as the top-down pressure to remobilise, people also felt the weight of public perception that the NHS is open. There was recognition that there had been huge adherence and compliance with the restrictions and guidance across society, but now there was a weariness about living with COVID, and a growing expectation around access to healthcare, which the service was not always in a position to provide.

"In general practice, the doors are shut, and people are starting to get frustrated and angry."

Beyond the immediate concern, participants worried that there simply would not be the resources to create the systems that the public would like to see, and predicted that it could be "pretty dire in terms of waiting times and elective surgeries". In this context, they spoke of the need for an "honest conversation" with the public, one which would aim to embed the ethos of realistic medicine; but noted that this type of conversation would require a fundamentally different relationship between politics, policy making and the media.

Looking forward

"Changes are not necessarily bad, but we need to acknowledge what has shifted and what that means."

Bringing everyone together in September felt like a different type of conversation: partly because of the group dynamic, but perhaps more because of the shifting pressures across the health service, which caused people to wonder whether the possibilities for change that felt so powerful at the start of the pandemic would be realised. This felt urgent, and as the conversation turned towards the future, participants identified a set of principles that might help sustain the positives.

- **Communication.** In reflecting on what was valued and prioritised at the beginning of the pandemic, people spoke about the strength of communication across departments as the cornerstone of an

effective response. In places, they had perceived this beginning to slip back, as services felt the pressure to remobilise "based on the experience of what was, not what might be". But there was a clear sense that openness and communication – both horizontal and vertical – would be at the heart of sustaining a holistic approach to health and wellbeing beyond the COVID response.

- **Innovation.** Participants recognised that the pandemic had triggered a "discovery that there are some things we could have done differently", implementing practical change at speed, particularly through embracing technology. These innovations held the potential for delivering a much more person-centred approach to healthcare delivery; but there were also "tensions between old and new", and uncertainty about who decides what to keep, and where the permission comes from.
- **Collective leadership.** There was a sense that the early days of the COVID response might offer a framework for navigating this change and innovation. People recognised an enabling environment – borne out of necessity – that had allowed teams "to get on with it" and unleashed the potential of a more collective leadership. This was described in terms of "letting the leadership and knowledge come from where it needs to", rather than a top-down, command and control approach.
- **Spaces for listening.** Yet, alongside what might be considered more strategic considerations, perhaps the most powerful message to come through these conversations was the importance of providing spaces for listening.[10] The series of conversations captured some of the physical and emotional burden that people are carrying; and those involved spoke about how they valued the opportunity to pause and reflect as part of the project. In this regard, the recent focus on staff wellbeing is therefore welcome; the experience of this group suggests that it could be improved by ensuring that people have protected space to be listened to, and heard.

"I'm noticing the importance of stopping and taking time to reflect, because the feelings of loss and change have been significant, and the way we've been practising has altered dramatically […] I see people exhausted. I think there's something about how we support each other."

10 This theme is discussed elsewhere (West & Coia, 2019), but the term itself is borrowed from Brigid Russell and Charlie Jones, who developed the concept and practice of #SpacesForListening over the course of 2020 (Jones & Russell, 2020).

Discussion

This is not the only report to document the experiences of those working in the health service and the changes that have been brought about by COVID-19, nor is it the most representative. It does, however, offer a perspective – one that is valuable *because of* the project's more intimate, relational approach, which brought a depth in reflection that can complement and enrich more quantitative interpretations. The reflective conversations enabled a level of openness and honesty that went beyond what people are often comfortable and willing to report in staff or membership body surveys. This human and emotional understanding of the impact of COVID-19, as well as the professional, has to form part of the conversations about how to build cultures that bring out the best for both patients and staff.

In addition, the group's collective insights reflect and reinforce both the Trust's longer-term evidence base on kindness in public policy (Unwin, 2018), and the conversations we have had with public sector leaders during the COVID-19 crisis (Coutts et al., 2020; Thurman, 2020). In the coming months, it will be critical to find ways to listen to the diversity of experience across health and social care in Scotland, and to build this knowledge and understanding into decisions that are made about renewal. But the five voices that have been heard in this report have already laid down a challenge. Their reflections act as a reminder of how difficult it can be to work in certain parts of the NHS, and that the solutions are not about wellbeing programmes or overtly valuing healthcare workers – welcome though these are. The solutions require radical, systemic change.

When the final group conversation was held in September, the discussion about change and renewal felt a live one. Although people voiced real concerns about the winter, and anticipated that remobilisation might be stymied by rising caseloads, a second wave was very much on the horizon. At the time of publication, this is now the reality. And so it feels important to acknowledge the rising number of cases and deaths, the growing waiting lists, the reduced capacity due to infection control, the general public fatigue about ongoing and fluctuating restrictions; and to recognise the impact that this might be having on staff. This is a workforce that has been under constant stress, having gone from crisis, to remobilisation, and back into a second wave, with no respite; and now managing a COVID winter without the same visible level of public goodwill valuing the NHS that was so present in the spring.

In this context, it might feel like a strange time to reflect on the learning from the healthcare response to COVID-19, and what this might mean for the future. But what has been heard in these conversations is that creating the space for a conversation about kindness is never more important than when systems are under most pressure, and workforce wellbeing is most affected.

Alongside this, the themes emerging from this project have re-emphasised the relevance of the Sturrock Review. These are not pandemic, but systemic issues that were around long before COVID-19, and there is work to be done to create cultures and leadership with kindness at the centre. The current context provides an opportunity to take stock what is being valued in the health service in Scotland.

A culture of kindness

Although they reflected shifting dynamics, pressures and emotions, the three phases of conversations present a clear focus on what is important, and an indication of what should be valued and prioritised in health and social care renewal, in order to build a system that looks after the wellbeing of patients and staff.

1. **A meaningful conversation about wellbeing**
   That each section of this report opened with participants' reflections on the personal impact of the COVID-19 response is intentional, highlighting the strength of the message about the need to create time and space to attend to how people are feeling. Too often the individual can be overlooked in conversations about the system; add to this the context of COVID-19 and the sheer exhaustion that is being felt across the health service, and staff wellbeing becomes ever more important. The commitments in the Programme for Government (Scottish Government, 2020) around mental health and wellbeing support are welcome, and the engagement with the National Wellbeing Hub[11] over the past six months only serves to underline this point. However, the conversations also spoke about creating spaces at a local level that are more relational and more human, and how competing pressures and priorities make it hard to carve out time to prioritise this.

> *"We're trying to create those reflective spaces within teams [and] we need to make a conscious effort to create and value those spaces. But that permission to recharge and recap needs to be given, especially from SG [Scottish Government]."*

2. **Sustaining a common purpose.**
   Especially in the immediate, crisis response, there was a clear message about how much could be achieved at pace when people were united by a common purpose. The clear focus on COVID-19 demanded and enabled a more relational approach: people noticed that improved communication had unlocked effective partnership working; that innovation and changes in practice were directed at achieving the best possible outcomes for patients; and, more widely, that kindness had become a feature of interactions among staff and leadership. But they also recognised that this was only possible because the NHS stopped doing so much. As participants felt competing priorities and behaviours beginning to return, there was a desire to find ways to retain the common purpose, and for renewal to build on the partnerships and relationships that were at the heart of an effective pandemic response.

> *"There is a common purpose […] and everyone wants to feed in and have shared ownership of it. It's silly really, because that purpose was always there, but somehow it got lost."*

3. **Shifting the emphasis on targets**
   Alongside the common purpose, people reflected on what was possible when the pressure of the pre-existing performance management system was relaxed. Throughout the conversations there was regular acknowledgement of the good that targets have done, and of their ongoing role in ensuring that the NHS is able to deliver certain evidence-based standards. Yet, there was also a recognition of the negative impact of an overbearing target culture. People spoke about the language of 'breaches' and a sometimes-punitive response to missing targets, which can encourage the sorts of behaviours that were reported in NHS Highland. They also noted

11 See https://www.promis.scot/.

how too great an emphasis on outputs can inadvertently lead to 'gaming', with staff incentivised to focus on the needs of a service rather than the needs of the patient, in a way that cuts across both collaboration and person-centred care. Recognising that there are no easy answers, the hope was that the experience of COVID-19 would open up a much wider conversation about how best to fit targets to a system in a way that delivers the best for both patients and staff.

A new conversation

Given the nature of this reflective listening project, it is not appropriate to end with a set of recommendations. What feels important, is to set the tone for a different type of conversation, one that creates space to listen to the full range of voices in health and social care in Scotland. Having observed the way that authority – and pressure – filters down through the system, the permission for this may need to start at the top.

Before the pandemic, the Carnegie UK Trust had begun to explore the role of a media-politics-government axis in driving the culture and behaviours within the system. The evidence shows that there is widespread public support for the NHS (Reid, Montagu, & Scholes, 2020), and that trust in practitioners is high; but this is not the narrative that is carried forward in the way that leaders are publicly held to account. The current levels of scrutiny over resources and waiting times have contributed to a highly pressurised political environment, which influences both behaviour and decision-making.

This observation echoes what has been found across the public sector, where leaders struggle to create the space for transformational change while at the same time remaining accountable for targets and performance indicators that are increasingly hard to deliver (Wallace, 2019). In the health service in Scotland, directors and chief officers in the Scottish Government are under pressure to deliver, which means that the Chairs and Chief Executives of health boards are too. Ultimately the media scrutiny of Ministers just shifts pressure to other places in the system, inevitably from those making decisions to those working in patient-facing roles.

The Trust's interest in securing the role of kindness in healthcare is in delivering better outcomes and improving societal wellbeing. This conversation about the pressures within the healthcare system matters for two reasons. First, because the purpose of performance management should be to improve health outcomes. If at times this leads to processes that are "in the interest of the system, not the patient", or if it squeezes the space for human relationships which are at the heart of better health outcomes, then there is a need to challenge the assumptions on which decisions are being made, and the targets and indicators to which health boards are held accountable. But it also matters because it is both unkind and unsustainable to demand that these pressures and tensions are held by those charged with caring for patients on a day-to-day basis. The levels of sickness and absence across NHS Scotland were unsustainable before COVID-19 (Health Performance & Delivery Directorate, 2019), and this will only become more acute as the workforce begins to feel the long-term impact of the pandemic response. There is an urgent need to ease some of the pressure in the system in order to safeguard the wellbeing of staff, which is intimately connected with the wellbeing of the patients they care for.

COVID-19 has shone a light on all of this, and also shown that it is possible to work in a different way. In doing so, it has opened up an opportunity to rethink and reform the health service in a way that builds on the strength of what has been seen in 2020. But translating this into lasting change will require open and honest dialogue with people right across the sector; and this must happen now.

In publishing this report, the hope is that it is the approach, as much as its content, that influences what happens next. Because it is only by listening deep and wide, and by embracing the vast collective knowledge within the health service, that it will be possible to truly recover and renew.

"We still have the kindness in the way we communicate with each other; but it can be eroded when we're under pressure, and we just try to switch to command and control. It's a constant balance between emotions, the needs of the service, your resilience, your kindness."

Bibliography

Ballatt, J., & Campling, P. (2011). *Intelligent Kindness: Reforming the Culture of Healthcare.* London: RCPsych Publications.

Copeland, A. (2019, October 01). *NHS sickness and absence: let's talk about mental health.* Retrieved from The King's Fund: https://www.kingsfund.org.uk/blog/2019/10/nhs-sickness-absence

Coutts, P., Bowyer, G., Heydecker, R., Ormston, H., Pennycook, L., Thurman, B., & Wallace, J. (2020). *COVID-19 and Communities Listening Project: A Shared Response*. Dunfermline: Carnegie UK Trust.

Health Performance & Delivery Directorate. (2019, December 18). *NHS Scotland performance against LDP standards.* Retrieved from The Scottish Government: https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/

Irvine, G., White, D., & Diffley, M. (2018). *Measuring Good Work: The final report of the Measuring Job Quality Working Group.* Dunfermline: Carnegie UK Trust.

Jones, C., & Russell, B. (2020, November 2). *Spaces for Listening.* Retrieved from https://brigidrussell43.medium.com/spaces-for-listening-8c597c1f52a2

Jones, C., & Seager, M. (2019, March/April). Humanising the 'Machinery' of Care. *Resurgence & Ecologist (*313).

NHS Education for Scotland. (2020, October 20). *Values Based Reflective Practice.* Retrieved from The Knowledge Network: http://www.knowledge.scot.nhs.uk/vbrp/vbrp-in-detail/what-is-vbrp.aspx

Reid, S., Montagu, I., & Scholes, A. (2020). *Scotish Social Attitudes Survey 2019: Attitudes to government, the economy and the health service, and political engagement in Scotland.* Edinburgh: ScotCen Social Research.

Scottish Government. (2018). *National Performance Framework.* Retrieved from The Scottish Government: https://nationalperformance.gov.scot/

Scottish Government. (2019). *The Scottish Government Response to the Sturrock Review.* Edinburgh: The Scottish Government.

Scottish Government. (2020). *Protecting Scotland, Renewing Scotland: The Government's Programme for Scotland 2020-2021.* Edinburgh: The Scottish Government.

Sturrock, J. (2019). *Report to the Cabinet Secretary for Health and Sport into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland.* Edinburgh: The Scottish Government.

Thurman, B. (2020). *North Ayrshire: A case study on kindness.* Dunfermline: Carnegie UK Trust.

Unwin, J. (2018). *Kindness, emotions and human Relationships: The blind spot in public policy.* Dunfermline: Carnegie UK Trust.

Wallace, J. (2019, July 17). *Kindness in Public Policy: The importance of leadership.* Retrieved from Solace: https://solace.org.uk/kindness-in-public-policy-the-importance-of-leadership/

West, M., & Coia, D. (2019). *Caring for doctors Caring for patients: How to transform UK healthcare environments to support doctors and medical students to care for patients.* Manchester: The General Medical Council.

West, M., Eckert, R., Collins, B., & Chowla, R. (2017). *Caring to change: How compasionate leadership can stimulate innovation in healthcare.* London: The King's Fund.

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