Policy Brief: Rapidly formed Covid-19 teams in the NHS: implications for leadership, team-working, career intentions and individual mental health.

The large-scale expansion of NHS acute and intensive care capacity during the Covid-19 pandemic has provided the opportunity to examine how improvised inter-professional (IP) teams of varied experience and occupational training best work together. The implications for healthcare practice and NHS policy include:

- During crisis IP teams need to invest in regular team debriefs, challenge pre-existing hierarchies, and focus on modelling mental health awareness by leaders.
- NHS trusts should optimise communal spaces for IP teams and invest in – regularly reviewed – mental health support services at the team level.
- The NHS should standardise IP team guidance to allow quick utilisation by trusts during crisis and promote IP training and education for junior leaders.

Summary of problem

A key component of the NHS (and global) response to the Covid-19 pandemic was the large-scale expansion of acute and intensive care capacity. The urgent need for skilled staff, led to a rapid expansion of capacity across Emergency Departments, Intensive Care, Infectious Disease, and High Dependency Units, with nurses, physicians, allied health professionals (AHPs) from non-intensive care backgrounds being deployed into such wards. Many Covid wards were, therefore, characterised by improvised, fluid, inter-professional (IP) teams with many deployed personnel not adequately prepared or trained for working in such a high-risk environment.

Much of the contemporary research on IP teams, has been focused on either simulated training scenarios or on permanent teams with common training or preparation and work experience as a team. Rapidly formed, improvised IP teams during crisis often have none of these advantages and may have a varied mix of personnel that need to perform well from the start. New research, funded by the UKRI/ ESRC, has been carried out jointly by Oxford Brookes, King's College London, and Robert Gordon Universities, to address this lack of evidence. This project, taking data from a wide number of different Trusts, addresses a gap in current research by examining the impact of Covid-19 deployment on IP team members' abilities to effectively work together and develop cooperative communication processes. The impact of teamwork, leadership and communication in rapidly formed teams, and the interaction between Covid experiences, mental health outcomes and career intentions is also investigated.

The study consisted of two phases. Phase 1 entailed 75 cross-sectional interviews (completed in November 2021), with nurses, doctors, allied health professionals, healthcare assistants as well as hospital directors and senior managers. Mental health, work life balance, and social identification were assessed, and the interview focused on team bonding, teamwork, leadership, as well as mental health, career intentions and family. Phase 2 of the study (conducted in January to March 2022) involves a confirmatory online survey, in collaboration with 10 NHS hospital trusts from across the UK. The survey aims to assess the impact of team bonding, teamwork, and communication and the relationship between Covid experiences and mental health and career outcomes. The following recommendations are based on evaluation of four targeted themes in the Phase 1 Interviews, regarding the impact of Covid work on individuals, teams, leadership, and workforce support.

Policy recommendations

Recommendations for IP Teams and Wards

- **Team leaders need to invest in regular team-wide debriefs during crisis**. Debriefs (informal or formal) allow staff to share and make sense of their experiences, create commonality, and create a socially supportive network with colleagues across the occupational spectrum. This need is particularly strong for personnel who have re-deployed out of Covid wards, and thus feel isolated from those that 'were there with them'.

- **During crisis, IP teams require leaders to be present, support the team, and model good mental health awareness.** Considering that leadership in crisis depends on presence on the wards, experience in direct patient contact, and supporting staff with clinical issues mental health concerns, leaders play a crucial role in developing good mental health behaviours and a socially supportive network. If responsibilities are clearly assigned, IP teams may even benefit from shared leadership between clinical and managerial leads.

- **Team leaders need to be willing to challenge pre-existing hierarchies and power-dynamics, while emphasising the occupational value of team-members.** Medical hierarchies and occupational power dynamics tend to be key barriers to IP teamwork, which can be overcome by frequent information exchange, inclusive meetings, and development of team-wide goals, emphasising the occupational value of individual team-members to the team.

Recommendations for NHS Trusts and Healthcare Organisations

- **NHS trusts should optimise communal spaces for IP teamwork and collaboration.** Co-location of staff is an important factor in maintaining professional and personal familiarity and increasing cohesion and social support. As such, IP teams require both shared clinical spaces to discuss patients and shared communal break rooms to retreat and recharge (e.g., 'wobble rooms').

- **NHS trusts are advised to develop and routinely review occupational and mental health support services.** Besides reduction of stigma and positive modelling of mental health awareness through colleagues and leaders, mental health utilisation requires access and adaptation of occupational health and mental health support services. These need to be routinely reviewed to fit the schedules and requirements of those most in need of them. For example, meetings or classes during lunch hours are likely inaccessible to frontline staff.

Recommendations for Policy Makers

- **NHS Trusts would benefit from standardised NHS workforce guidance for IP Leadership and Teamwork during crisis.** Much training occurs during mono-professional education and training. Consequently, IP teamwork, team integration, and leadership is often neglected. Standardised guidance for NHS trusts on how to

structure, lead, and support IP teams during crisis can reduce many of the risks undermining teamwork, collaboration, and innovation in IP teams (e.g., overlapping management structures, ambiguous communication processes, and reliance on occupational hierarchies)

- **Health Education should encompass psychosocial training and IP team training in real world situations.** As common stereotypes about other professional groups and occupational hierarchies can limit collaboration and team cohesion, the successful utilisation of IP teams demands that junior leaders (e.g., Band 6 nurses and AHPs, junior doctors) receive IP training in real world situations rather than simulations, equipping them with the psycho-social skills to work effectively with colleagues from different backgrounds.

Summary of evidence

The following section will provide a short, prelusive overview of four important themes from the study's exploratory interviews. Further in-depth thematic analysis of the data is currently ongoing, aimed at constructing in-vivo themes, identify cross-sectional distinctions (i.e., how personnel from different occupational backgrounds experienced their Covid work) and pinpoint lessons learned from their experience.

Individual Impact and Mental Health

Frontline personnel frequently reported emotional distress caused by the Covid work environment. Overall, a total of 27% of participants met the cut-off score for probable common mental disorders (as measured by GHQ-12 (Goldberg & Hillier, 1979)). Simultaneously, 51% of participants experienced impaired work life balance on two or more days per week (as measured by WLB Scale (Schwartz et al., 2019; Sexton et al., 2017)), with nutrition, coming home late from work, and difficulty sleeping showing the highest scores. The interviews identified that across the occupational spectrum, participants highlighted a range of explicit challenges: (1) the uncertainty and hardship of working on Covid wards; (2) struggles with unforeseen levels of patient mortality and inexperience with end-of-life care; (3) communication difficulties (e.g., due to PPE (Personal Protective Equipment), noise levels, lack of meetings); (4) restrictions on communal space due to social distancing; and lastly (5) lack of training, preparation, and direction prior to working on Covid wards.

For many, the work on the wards lead to self-doubt, moral ambiguity, guilt, and anxiety, with some participants describing their experiences as traumatic. Interestingly, almost all participants discussed the inability to prepare for the psychological aspects of Covid work. However, personnel with no infectious disease or intensive care experience (e.g., day surgery nurses, physiotherapists, dieticians, health care assistants) connected lack of preparation for psychological issues with their technical inexperience in the skills required (e.g., "*read blood gases", "prepare medication").* Lastly, younger, and less experienced staff worried about lack of professional development, while female participants often discussed the impact on family members, their care responsibilities and infecting family members. Despite the challenges, many interviewees offered detailed descriptions of personal resources and support arrangements, including self-care activities (e.g., *spending time outdoors, sport, contact family members*) or help-seeking behaviours (e.g., *access workplace*

mental health support, seek professional help). The interviews highlighted the cumulative effect of working on Covid wards for individuals' well-being and their team's resilience.

Team Bonding, Teamwork

Participants reported concerns around inter-personal difficulties while working in teams, which were often couched in occupational differences and medical hierarchies. Participants who were re-deployed from the Covid ward to their old position or rotated to a new position discussed feelings of being ostracised and isolated upon leaving the Covid team and being unable to discuss events with "*those that were there* with us". Despite these concerns, 78% of participants in the study reported a moderate to high level of identification with their rapidly formed Covid team (as measured by the SISI (Postmes et al., 2012)). Consequently, many participants discussed issues around team bonding (e.g., *"going through the same hardship"* and *"having been there"*) as well as teamwork (e.g., *"having our back", "everybody pulling together"*), with teamwork being related to the value of the professional skills individuals brought to the team.

Simultaneously, staff repeatedly discussed that colleagues were one of the biggest providers of social support in making sense of the situation – especially for younger, and less experienced personnel. Regular information exchange, inclusive meetings, and co-location on the same ward reportedly benefitted the development of teamwork and increased feelings of inclusion. For example, deployed AHPs reported higher identification with colleagues – and were more likely to aid in patient care responsibilities – if they were incorporated into the bedside rounds and located in the same area as nurses.

Leadership

Leadership was crucial for the establishment of effective teamwork and team cohesion. However, due to social distancing, leadership appeared more localised to the wards, with most frontline staff attributing leadership to "*those on the shop floor"* (i.e., band 6 & 7 nurses and AHPs, registrars). Consequently, the interviews emphasised the emergence of "natural leaders" who took on responsibilities beyond their assigned occupational role. Interestingly, many senior leaders (e.g., matrons, deputy medical and nursing directors) chose to be directly involved on Covid wards aiding with patient care, family liaison, or supporting healthcare staff with mental health support. As such, Leadership was routinely attributed with presence on the wards and experience in direct patient contact, as well as checking on people, listening to staff concerns and solving problems.

Simultaneously, team leaders or more experienced team members explained that they felt the responsibility to reassure less experienced team members that they share their anxieties and aid in making sense of difficult situations and decisions. As such the interviews highlighted the importance of leaders championing and raising mental health awareness, reducing stigma, and creating a socially supportive work environment. Importantly, while participants described leadership during the first and second wave as resulting in "*flat hierarchies*," which benefitted teamwork, during latter

waves participants reported a gradual return of medical hierarchies and occupational differences.

Workplace Support:

For many participants workplace support was an important discussion point, with three themes regularly occurring in the interviews: (1) concerns and confusion around technical equipment and health and safety protocols; (2) access to mental health support systems; and (3) concerns around workload and staffing. Reminiscent of reports highlighting the low mental health utilisation among healthcare staff during the pandemic, the interviews suggest that a lot of staff may not take up support opportunities provided because of stigma or unease; with participants arguing that what they experienced "*isn't too bad*", or that "*they don't deserve to take up space from people that are really unwell*". This implies that mental health awareness may be central in assessing and offering appropriate support to team members that could be struggling. Consequently, interviewees' most frequently reported source of support was colleagues and impromptu debriefs with colleagues and leaders aimed at sharing and making sense of experiences.

These findings highlight the need for staff to make sense of their experience and find closure, resulting in many participants requesting group debriefs with their colleagues to share and reflect upon their experiences. Lastly, a frequently raised intervention was the introduction of communal spaces aimed at providing staff with opportunity to retreat, and recharge after particular difficult situations (e.g., *"wobble rooms")*. This was often discussed as preferential over some mental and occupational health support (e.g., Yoga classes, drop-in mental health support groups) which were described as useful and well-meaning but for many frontline staff inaccessible due to workload and schedules during the pandemic.

Phase 2 of the study is currently underway with first results expected in April/ May 2022. The project will conclude in summer 2022 with final findings published in healthcare and academic journals and disseminated at conferences. Reports and findings will also be publicly accessible on our webpage at: https://www.brookes.ac.uk/research/units/hls/projects/rapidly-formed-Covid-19-teams-in-the-nhs

Sources and further reading

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