The lived experience of health communication professionals during the Covid 19 pandemic.

This article chronicles the approaches to, impacts of and reflections on the Covid 19 pandemic for professional communicators[1] in the English National Health Service (NHS). The research covers the first 90 days of the pandemic, from the beginning of March 2020 to the beginning of June 2020: the period when it was known the pandemic would strike the UK to the point where infections were declining after 'the first wave'.

Three phases of crises frequently cited in the public relations literature (Coombs, 2015) are covered: preparation; initial response and emerging issues from the on-going crisis; and reflection leading to revisions and lessons learned. Crisis management usually entails a fourth and prior element: prevention (Coombs, 2019), but given the pandemic was already unfolding and probably unpreventable, this is not within the scope of this article.

The research contributes insight in three areas: first, the challenges of scale and integration that the first truly global health pandemic poses for communicators working in a national, local, and individual organisational context. Second, it examines strategic and tactical approaches that optimise stakeholder impact. Third, it identifies the centrality of and proposes recommendations for public relations practitioners in situations of civil national emergency in the future.

Context

Since its inception over 70 years ago, the UK National Health Service (NHS) has become the largest publicly-funded health system and, with 1.5 million staff, the fifth largest employer in the world (Nuffield Trust, 2020). It is largely funded via general taxation (Powell, 2020), provides comprehensive care for all citizens and is free of charge based on clinical need. The system is complex. Health service responsibilities in the UK are devolved to the four nations, with the English NHS, the largest of these services, being the subject of this research. In 2019, it employed 1.2 million people and had an annual budget of £138 billion (Harker, 2019). Funded by the Department of Health and Social Care (DH&SC), commissioning of primary and secondary health services is overseen by NHS England. Primary care is the frontline of the NHS and the first point of contact for most people, for example, General Practitioners (GPs), dentists, optometrists and pharmacists.

Secondary or acute care, can be either elective (i.e. planned, such as surgery) or emergency care. Most secondary care is provided through hospitals, specialist care and mental health trusts. There are over 1700 hospitals and specialist care centres grouped in to approximately 223 Trusts (Kings Fund, 2020a). In total there are 27,000 qualified GPs, 117,000 hospital-based doctors and 319,000 nurses, midwives and health visitors (Barker, 2020) in England. Emergency vehicles, mainly ambulances, are also provided by the NHS.

There are 3000 professional communicators in the NHS, employed in 400 organisations with the most senior holding board level positions. Their range of responsibilities includes internal and external communications including community engagement, public affairs and patient communication.

The NHS is a regulated system with strict and codified measures in place to deal with significant local and national emergencies such as the Covid 19 pandemic. NHS England's *Emergency Preparedness, Resilience and Response Framework* (EPRR) (NHS England, 2020a), first published in 2015 and updated annually, provides guidance for the whole system. In it, actions are proscribed, responsibilities set and standards laid down concerning such matters as governance, duty to risk assess, command and control, training and cooperation (NHS England, 2020b). The framework was invoked during this crisis.

Following news of the initial Covid 19 outbreak in Wuhan, China at the end of December 2019, WHO declared a pandemic on 11th March 2020. The first British death was a passenger on the cruise ship *Diamond Princess* docked in Japan on 28th February 2020, the same date on which the first transmission of the disease within the UK was reported. From thereon, infections and deaths rose rapidly, reaching 144 by 19th March, with 3,269 confirmed cases. On 23rd March the Prime Minister announced the country was to be placed under 'lock down' and the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (UK Government, 2020) came into full effect from March 26th 2020. The peak of pandemic occurred throughout April with the highest number of registered deaths (2234) where corona virus was mentioned on the death certificate recorded on 15th April (ONS, 2020a). The same official source shows that by the 13th May, registered deaths, which had been falling consistently, were below 1000 per day and by 3rd July 2020, below 100 per day.

The research reported here covers the time period March to June 2020.

Literature.

The literature on crisis management in the public relations field is extensive, but this brief overview notes a number of gaps. Manias-Munoz, Jin and Reber (2019) observed in their extensive review, that although crisis communication is ranked third among emerging research areas in public relations, there are issues. They identify its organisation-centricity and summarise the view of respondents to their Delphi survey as being that scholars should know the public relations practitioner community better, try to bridge the gap between academia and practice and use 'variables other than reputation or image repair …. in future theoretical and methodological developments'. Many of the more influential books (Coombs, 2019; Fink, 2013; Coombs and Holiday, 2010; Fearn-Banks, 2007; Mitroff, 1996) which are reference works, are again organisation-centric and reputation preservation and repair focussed.

There are instances of research that is not organisation-centric, including Stromback and Nord's (2006) consideration of government communication concerning the 2004 tsunami which affected Thailand and Indonesia. There are a few instances where

public health crises are discussed, for example, Park, Boatwright and Avery (2019) who consider Zika, and government's handling of SARS and MERS is reviewed by Lee (20090, Zhang & Benoit (2009) and Menon & Goh (2005).

Outside the public relations field there is significantly more literature on pandemic communication with a number of reviews (Loud & Simpson, 2017; Infanti el al, 2013; Savoia, Lin & Viswanath, 2013; Fisher et al, 2011) and models and recommendations for effectiveness (Staupe-Delgado & Kruke, 2018; Amirkhani et al., 2016; Cairns et al, 2013; Crouse-Quinn, 2008). Much of this mirrors the main principles outlined in the public relations crisis literature on the importance and nature of dialogue (Taylor & Kent, 2014) and involving stakeholders (Coombs, 2019; Heath, 2010). Characteristic of the literature is the emphasis on whole-system and organisational preparedness and response. Pandemic outbreak communication does not focus on reputation preservation as a priority, but on 'public information….. primarily transferral (broadcasting or exchange) of information before, during and after an outbreak' (Loud & Simpson, 2017, p.10). The main purpose of pandemic outbreak communication is to influence behaviours at scale in order to affect health outcomes positively.

Pandemic communication is founded on a number of well-established health-behaviour models (ISS TELL ME, 2013; Manika & Gregory-Smith, 2017) and good communication is proven, among other factors, to be an antecedent of clinical outcomes (Nichols, 2019). One of the most influential models for pandemic communication is the Extended Parallel Process Model (EPPM) developed by Witte (1992) and explicated in detail in the seminal text by Witte, Mayer and Martell (2001). It describes how to stimulate desired population behaviours by inducing a calibrated fear response, generated by trusted institutions. This and other health pandemic texts are focussed on the *targets* of communication campaigns and how *structures* can be put in place to handle pandemics.

In addition to the academic literature, there are guidance documents including those from the World Health Organisation (WHO, 2005), the US government (US Center for Disease Control, 2018), European Commission (European Centre for Disease Prevention and Control (ECDC), 2015) and in the UK (NHS England, 2020a). This latter requires that there is

> "……effective communications [to] ensure that patients and the wider public are well informed about NHS service in their local area and what is expected of them" (p.29)

Again there is a focus on communication with populations and on structural and procedural matters, with little guidance on strategic approaches or operational practices in communication.

In sum, public relations literature describes and theorises organisational crises communication, but little on pandemics and the literature outside the field advises on processes and structures for dealing with a pandemic, including the need to obtain population wide supportive behaviour. However, there is a gap in all these literatures about the lived experience of communicators going through a pandemic and their

communicative response to it. Therefore, a number of research gaps are addressed in this article. First, the Covid 19 pandemic is of such a scale and intensity that it provides the most significant opportunity to date to identify and report on emerging (possibly best) communication practices at national level. Second, it identifies contemporary tools and the mix of those tools that governments and health organisations worldwide can use in order to be effective with a range of stakeholders. Third, the pandemic communication literature, which deals with the topic most comprehensively, tends to treat communicators as peripheral actors, but this study identifies them as major players who have a central and vital role to play.

Methodology and Method

To examine the gaps indicated above, four time periods are investigated. First, the period before the pandemic struck when communicators were preparing for the inevitable (between February and beginning March 2020). Second, the point at which cases began to emerge (11th to 22nd March). Third, the period when lockdown was announced, hospital admissions and mortality reached their peak and ongoing communication about the pandemic was unfolding (23rd March and through April 2020). Fourth, when the 'first wave' of the pandemic began to subside (late May, early June 2020), a time when communicators could reflect on the initial outbreak.

Given the work pressure and additional commitments that communication practitioners have when working in crisis, the researchers chose the survey method to obtain data. A mixed methods quantitative and qualitative research instrument was developed. Quantitative data was essential to discover the type and frequency of activities, while qualitative data was required to discover explanations of opinions and behaviours.

A self-completion questionnaire was developed with assistance from NHS Providers (representing providers of urgent and planned secondary care) and the NHS Confederation (representing organisations that plan, commission and provide services). It consisted of 47 items with 19 items introducing putative moderators and a 10 item classificatory variable matrix. It was pre-tested with an advisory group consisting of representatives of all the organisational types to be surveyed..

The survey comprised five parts, a classification section which also acted as filters for the analysis. Section two covered crisis preparedness, section three stakeholders; channels, tools and tactics; and prioritisation of work. The fourth section covered resources, processes and systems, effects and efficiency, and the final section elicited open comments about change and challenge. Ten themes were explored within the survey and wherever appropriate, respondents were asked to take a perspective from a typical week from *before* and *during* the pandemic.

The total sample universe was the 3000 professional communicators across England with a convenience sample of 1900 being mailed the electronic survey instrument on 20th May which remained open until 3rd June 2020.

Results

The survey yielded a total of 166 usable returns (5.53% of the total population, 8.74% of the surveyed population). While this may seem low given the sample was not randomised, the NHS is not a single state corporation, therefore, as a sample of approximately 150 of 400 entities in a loose federation, the size of the return can be viewed more positively. The returns were analysed by IBM SPSS 25 using correlation, multiple regression and exploratory factor analysis. Content and thematic analysis was conducted on the qualitative aspects of the survey (Vaismoradi, Turunen & Bondas, 2013)

Respondents were 24.7% male, 75.3% female. All staff grades were represented with 8.4 % respondents being the most junior (Band 1 – 5 NHS grades), 59.7 % in the Communication Manager/Head of Communication grades (Bands 6-8b), 19.2% at Associate Director level (Band 8c – 8d) and 12.6% at Board Director level (Band 9 – Very Senior Manager). These percentages represent the profile of communicators across the NHS in England.

Regional representativeness was confirmed by cross-referencing respondents to residential populations (ONS, 2020b). All categories of organisation from national and regional, providers (acute, mental health, community, ambulance trusts) and commissioners responded and in line with the national percentages for each segment.

The results are provided in chronological form, following the unfolding of the crisis as it was experienced by health communication practitioners. Within the four stages previously identified, the ten themes are presented as follows:

Stage 1: crisis preparedness (February and beginning March 2020): results for questions addressing the theme of crisis readiness

Stage 2: 'crossing the line' into the pandemic (11th to 22nd March): results covering three themes: priorities, stakeholder prioritisation, and, work and time.

Stage 3: pandemic peak (23rd March and through April 2020): results for five themes: channels and tactics, national communication leadership, local senior management, relationships and personal factors.

Stage 4: subsidence of the first wave (late May, early June 2020). The last theme addresses reflections on the outcomes of the first wave.

The authors deem it more helpful (and less repetitious) to partially discuss the ten themes alongside the results for the sake of clarity, but an overall discussion section expands on some themes and draws them together.

Stage 1. Before the pandemic struck

Theme 1: crisis preparedness

The survey investigated six areas of preparedness: rigour of processes, role-allocation, level of contact maintenance, advance training/rehearsal, acuity of

horizon scanning and capabilities. Figure 1 below shows the results based on a five part Likert scale and are mean scores.

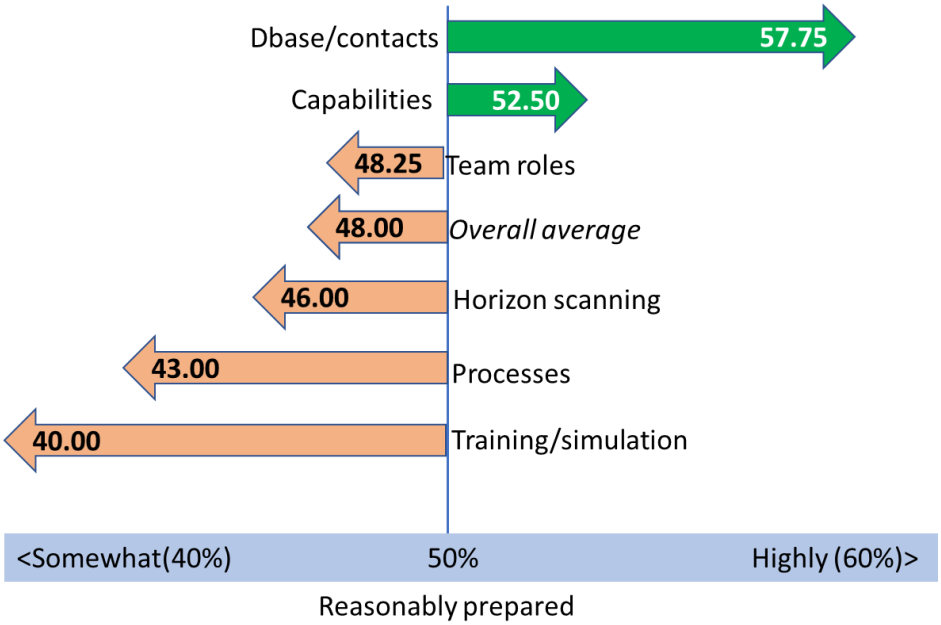

Figure 1. Crisis preparedness

Most NHS professional communicators considered themselves to be reasonably well prepared for the pandemic but there are significant variation between the ways in which they were prepared. 40% of respondents felt they were either “highly prepared” or “completely prepared” (including 12.1% in the latter category) in having an up-to-date contacts database, compared with 18% who felt they were “somewhat prepared” or “not all prepared” (including 2.4% in the latter category) . This contrasts with 18% felt they were “highly prepared” or “completely prepared” (including 1.8% in the letter category) with regards to training or rehearsing compared with 44% who felt they were only “somewhat prepared” or “not all prepared” (15.3% in the latter category).

NHS communicators felt they were under-prepared when it came to horizon scanning for issues and in having documented, clear processes for decision-making. This may not be particularly surprising. Pandemics are not unknown in the UK, but the last such event was in 2009, H1N1 influenza (so-called “swine flu”) which featured far lower mortality rates and had a vaccine available after six months.

Stage 2: ‘crossing the line’

Theme two: setting communication priorities. The available guidance to practitioners (US Center for Disease Control, 2018; NHS England, 2020b) encourages the development, coordination and dissemination of public information, alerts and warnings. The questions in the survey covered five areas of prioritisation and the shift from before to after the commencement of the pandemic are shown in Figure 2.

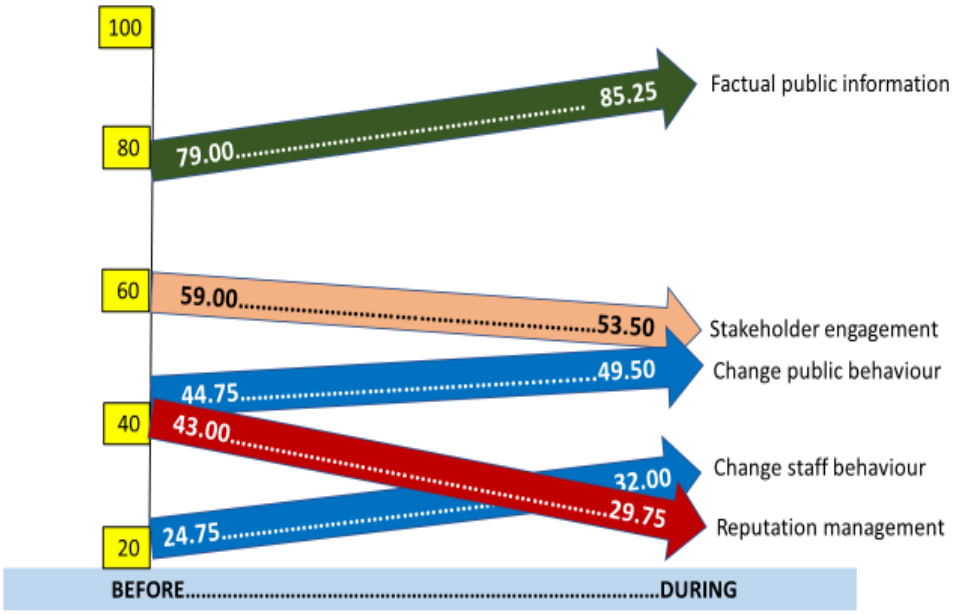

Figure 2. Adjusting priorities before and during the pandemic

The primacy of factual public information was re-enforced during the pandemic. Behaviour change was prioritized to the point where it almost overtook stakeholder engagement and indeed did so for 'systems' respondents (that is, those larger collectives of health organisations, often locality wide and which include all services). Staff behaviour change took on the steepest change, overtaking reputation management. The qualitative comments confirmed that communicators did not have to defend the reputation of the NHS since the media and the general public were very supportive of it as an institution.

Theme 3: stakeholder prioritisation. Despite the overall increased hours devoted to communication during the pandemic, it does not appear that communicators make major 'during' the pandemic stakeholder targeting adjustments. However, breaking this down by organisational type reveals significant differences as Figure 3 shows.

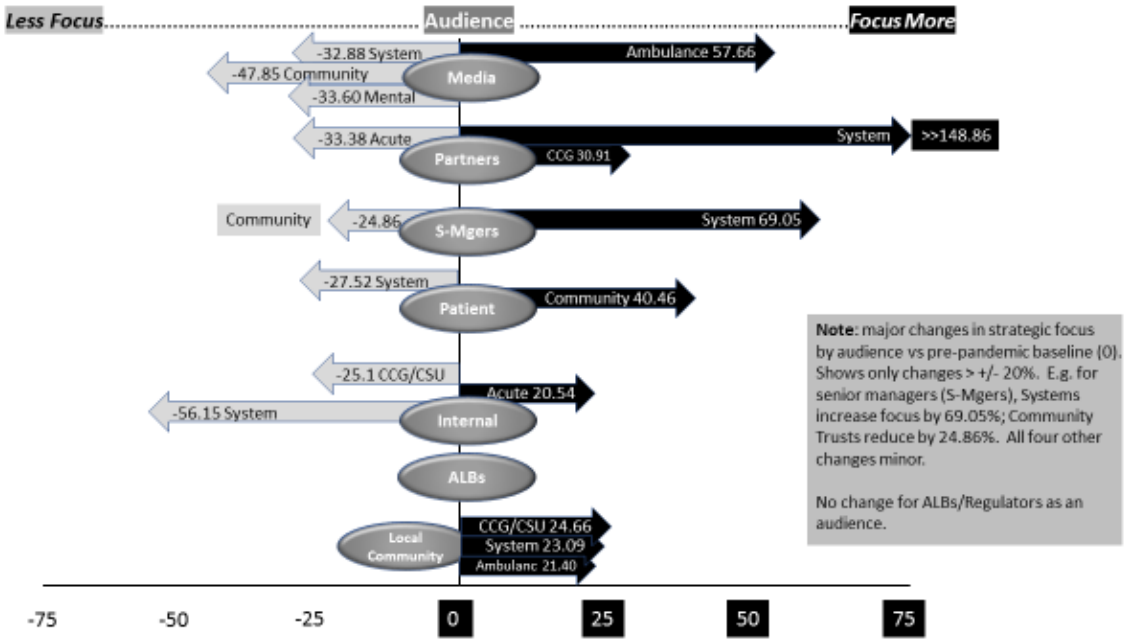

Figure 4. Comparison of stakeholder focus during crisis

The striking features here are that communication with central organisations (Arms Length Bodies (ALBs)[2] and Regulators) experience no change and that ambulance service communicators significantly increased the amount of time communicating with the media whereas others decreased their contact or it remained the same. The outlier is the more than doubling of 'system' communication with partners, indicative of the fact that communication is centralised during a pandemic (NHS England 2020a).

Theme four: work and time. In common with other NHS workers, communicators worked longer hours than they typically worked before the pandemic. Overall working hours increased by about 25% rising from an average of just over 41 hours a week to just over 51 hours a week. The most affected, Band 8d, worked almost 40% more hours increasing from 43.46 to 60.71 per week. This last group of staff are often regarded as 'the engine room' of communication and operate at Associate Director level. At the most senior levels (Band 9 and Very Senior Manager (VSM)), the percentage increase dropped to around 20-25%. However, it should be noted that these senior staff were working the longest hours before the pandemic and therefore their total 'load' was high.

There was a significant switch from on-site working to homeworking and a move to seven day working rosters to facilitate unbroken coverage. On average communicators spent three and a half days working at home with two days at their place of work with one and a half days off-duty each week. For many this work transition has been a large and positive step forward. Respondents to the survey referenced reduced commuting time and more family time as good reasons for home working. However, for others home working has not been as successful. They cited personal isolation, a loss of work-life balance, a negative impact on family life and a

tendency towards an unhealthy, sedentary, desk-based lifestyle. One wrote of the "complete blurring of any lines between weekday/weekend, day/night, at work/not at work."

Stage 3: Pandemic peak

As the pandemic reached its peak at the end of March 2020 there were significant changes.

Theme five: channels and tactics. Some change was predictable and driven by risk and legal restraints, such as the constraints on face to face meetings, but other changes were less so. Figure 5 benchmarks each communication channel at 50 (pre-pandemic levels) and shows the comparative increase and decrease in use.

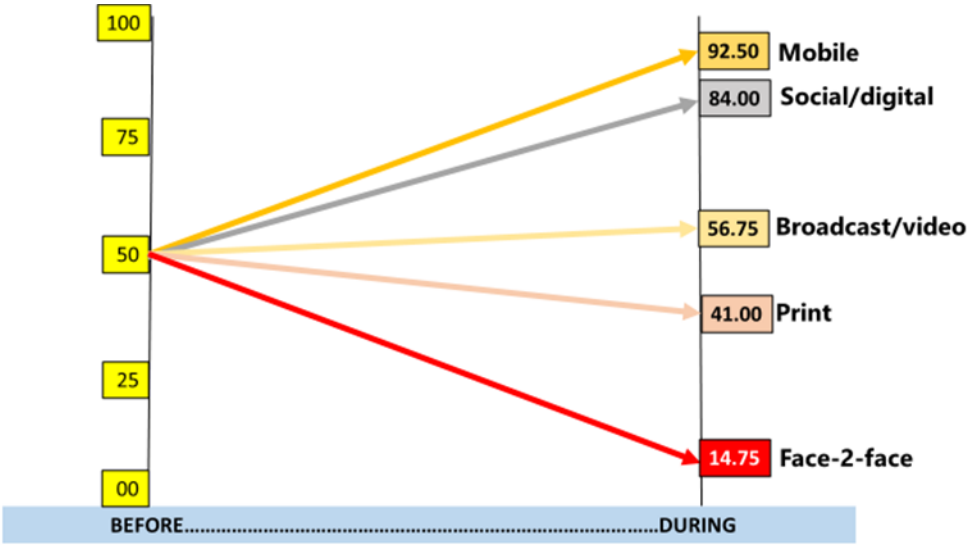

Figure 5. Channel use before and during the pandemic

The use of mobile communication - text messaging, audio and video calling and conferencing - almost doubled, rising from the "pre-pandemic" benchmark of 50 to a "during-pandemic" rating of 92.5. Other digital communication, including web, intranet and social media also saw significant increases whereas print decreased from 50 to 41.

Respondents were asked which single communication tool and tactic they thought were most and least effective during the pandemic: this was deliberately unprompted in order to capture 'top of mind' responses. Most effective tools mentioned were: social media, predominantly Facebook (mentioned by 17.9% of respondents), increased use of virtual meeting technology such as video conferencing (mentioned by 14.3%) and daily staff communication bulletins and regular briefings from a visible chief executive (mentioned by 13.6%). The proliferation of new, closed staff

Facebook groups was commented on by many respondents and was widely deemed to be very effective.

> "We have been trying to get a staff Facebook page off the ground for ages and it has now become a really effective comms tool, particularly for clinical staff."

Other effective tools included: webinars, virtual engagement meetings to replace traditional face-to-face engagement with staff and stakeholders, the use of explanatory videos to save staff and others from reading lengthy documents and, the establishment of a daily "battle rhythm" that gave structure and predictability to communication activities during the height of the pandemic.

More 'traditional' tools and tactics were regarded as being least effective. Face to face communication was mentioned by almost 20% of respondents, traditional media briefings were deemed ineffective by 17.8% of respondents and posters and pop-up banners by almost 10% of respondents, in part because the key messages were changing very rapidly.

A significant number of respondents thought all-user electronic briefings were very effective, whereas a similarly significant number felt all-user emails were not. The explanation here may be that short, sharp, well-written and well-presented electronic briefings have great impact while lengthy and often dull all-user emails are rarely read. NHS communicators increasingly recognised that busy staff were more likely to watch short video "explainers" than to read lengthy documents.

Figure 6 below shows those channels and tools that were categorised as being in the top five for most effective, least effective and most innovative.

	Most Effective	**%**	**Least Effective**	**%**	**Most Innovative**	**%**
1	Social media in general	17.9	Face-2-Face in general	19.4	Videoconferencing/ MS Teams	33.3
2	Video-conferencing (e.g. Teams)	14.2	PR/Press/media briefings	17.8	Facebook Staff CUG	11.3
3	Bespoke e-briefings	13.6	Global emails	14.7	Other video/virtual meetings	09.3
4	Facebook (Staff CUGs)	09.9	Posters	09.3	WhatsApp	06.6
5	'All Hands' Emails	08.6	Staff Intranet	03.9	Webinars	04.7
	Total Top Five	**64.2**	**Total Top Five**	**65.1**	**Total Top Five**	**65.2**
	Response (162/166)	*64.2*	*Response (129/166)*		*Response (150/166)*	

Figure 6. Most and least effective and most innovative channels and tools for communication during the pandemic

The other three themes under Stage 3 can be categorised as key influencing factors during the pandemic.

Theme six: national communication leadership. NHS professional communicators were asked a) if nationally provided communication content had been valuable, b) the national coronavirus communication strategy had been effective c) national command and control of communications strategy had been appropriate and d) the national control of local messaging had been acceptable

50% of respondents felt the nationally provided NHS content and messaging provided during the pandemic was valuable compared with 13% who felt it was not. The most senior communication leaders (Band 9 and VSM) were more inclined (39%) to think this content was not valuable and there was some criticism that national messaging and content was not always timely.

> "One of the biggest challenges we continue to face is the lack of notice we receive for big announcements"

On the national communications strategy, opinions were more evenly balanced, with 35% of respondents agreeing that it had been effective while 38% disagreed. However, the percentage of respondents who felt the national strategy had NOT been effective jumped to 57% among the most senior communicators (Band 9 and VSM). While it might be thought that that these most senior managers might be involved in developing this strategy, as has been explained earlier, the NHS consists of 400 semi-autonomous organisations in a loose federation. Under the powers given to NHS England in an emergency, the centralised approach debars senior communicators in other parts of the system from being involved in strategy development.

> "The biggest challenges, and there have been many, throughout this process have been around changing guidance and facts, or a need to communicate processes which everyone knows will change in a day or two".

The issue that generated most discussion was centralised "command and control" of NHS communication. NHS England announced in early March 2020 that coronavirus had been declared a level four national emergency and under the NHS England Emergency Framework (NHS England, 2020a) NHS England (national) can take command of all NHS resources across England and that this will be actioned through regional teams.

The purpose of command and control is to ensure consistency of message, unity of voice and that the duty under the Civil Contingencies Act to warn and inform the public is fulfilled. 41% of respondents felt the application of national command and control of communication strategy and activities had not been appropriate, but almost the same percentage (37%) felt the reverse. Once again, the most senior professional communicators (Band 9 and VSM) were more inclined (57%) to the negative view. Additionally, the weight of detailed comment was clearly troubled by the *way* command and control had been applied.

> "Biggest challenge NHS communicators face at Foundation Trust level is the misuse of 'command and control' from the centre".

Others offered a more nuanced response which recognised the need for command and control, but raised questions about its application.

Front line NHS communicators often found it took an excessive amount of time to sign off a proposed local communication initiative.

> "I think NHS England/Improvement have to think about their role in NHS communications. We found them really hard to deal with and their sign off process far too slow,"

There were, however, some strong counter views including:

> "I do find the criticism of national NHS/Government communications - particularly from provider communication leads - a bit over the top. The criticism comes with hindsight - and, speaking as a communications lead for a large London hospital, the pressures/demands on me are no way near what they are at a national level."

On the question of whether the national control of local messaging had been appropriate, 50% of survey's respondents felt not, while 29% felt it had been. Among the most senior communicators, the percentage rose significantly to 71%.

> "It did not help that NHS England / the Department of Health and Social Care felt that they knew better than us HOW to do OUR jobs locally."

Theme seven: local senior management teams. In contrast with the linkages with national communication bodies,

> "communications has been more appreciated by (local) senior leaders over the last few months and they have looked to us more frequently for assistance and advice."

Specifically, local senior management teams demonstrate: a) more active communications involvement (78.00%); b) faster decision-making (80.75%); and c) faster approvals (72.50%).

A part-explanation for senior teams' changed behaviour lies in increased communicator influence (77.5%) at the top table. It associates positively, for example, with speed of approvals. Where influence and/or active board involvement are less, approvals are slower. Most importantly, influence and involvement shape beneficial outcomes. Communicator influence, for example, alone explains: 16.70% of campaign effectiveness and 27.90% of communication results; and, combined with 'speed-of-approvals', 28% of efficiency.

Theme eight: other relationships. The pandemic appears to have driven a notable improvement in relationships between NHS communicators and the professional groups with whom they interact, see Figure 7.

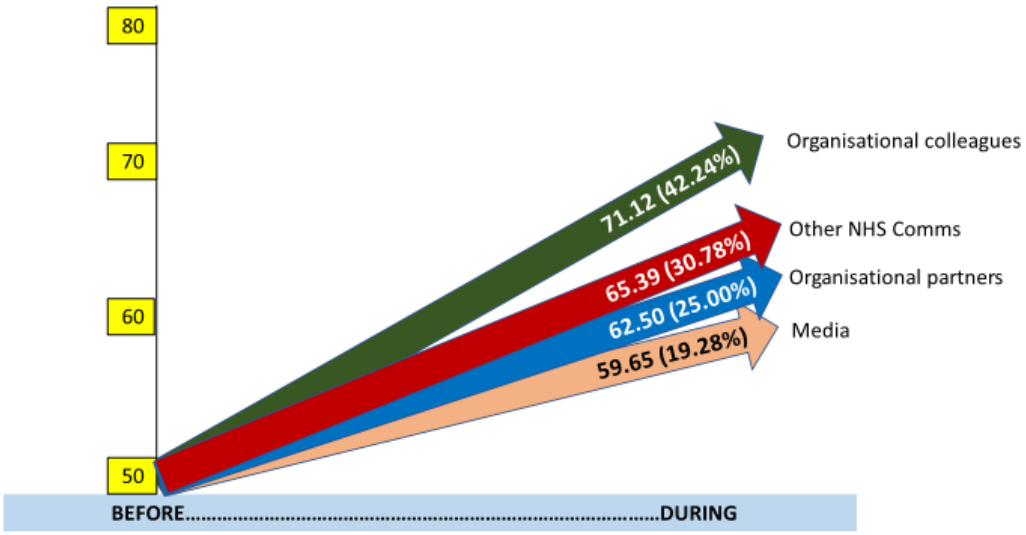

Figure 7. Improvements in relationships during the pandemic

Relationships appeared to improve most in organisations that were relatively well prepared for the pandemic crisis and there was an alignment with higher levels of job satisfaction: those who reported higher levels of job satisfaction also reported improved relationships.

> "The pandemic has galvanised our partnership approaches"

Respondents also felt the pandemic provided a single focus of activity that created a "sense of one team working together".

> "Having one priority and sufficient resource to do it justice was delightful."

Stage 4: subsidence of the first wave

The survey instrument was administered when the first wave of the pandemic was subsiding and in the last part of the survey, respondents were asked to reflect on the first 90 days of the pandemic. Two themes were covered.

Theme nine: personal effects relating to stress and job satisfaction. In comparison with pre-pandemic levels, both stress (29.70%) and job-satisfaction (30.36%) increased during the pandemic. There is no clear relationship between these figures.

On job-satisfaction, there are limited, but significant associations between seniority and job-satisfaction (the more senior the individual the higher the level of increased job satisfaction). The effect, however, is individually contingent with homeworking impacting negatively on job satisfaction directly by a moderate association. There are also indirect effects via weakened relationships with both colleagues and other NHS communicators caused by issues such as the intensity, immediacy and volume of work.

Job stress increases by seniority in the grades below Band 9 (37%); and by organisational-type, among commissioners/regulators (40%+, both cases). For levels of stress, there are linkages with national strategy; command-and-control and local message-control and associations with increased community stakeholder contact over these issues, and working-time during the pandemic.

Theme ten: outcomes - performance and its enablers. NHS communicators believe their activities have achieved positive outcomes. Procedural components such as tools, channels and technologies and creative execution marginally out-perform hard outcomes such as stakeholder access and communication results. Notably, there is broad consensus that, during-pandemic, communications teams have performed both more efficiently and more effectively. (Nearly 80% somewhat/strongly agree both cases).

In the free comment section, respondents were asked to review whatever aspect of the pandemic they wished, but specifically what changed over the 90 days. The results are categorised by changes for individuals, organisations and the NHS system as a whole with the top five for each provided in Figure 8. The profundity of change is summarised by this quote:

> "Everything! Moving from a focus on our financial problems and need for a future in a hospital chain to focus on a nimble response to system needs, treating cancer patients, moving just about every clinical service to a different location on site to separate screened and unscreened patients."

	Personal	**%**	**Organisational**	**%**	**Wider NHS**	**%**
1	Homeworking	31.4	Homeworking (joint first)	14.7	NHS value	15.8
2	Intensity/ impact	11.4	Technology (joint first)	14.7	Agile working	11.6
3	Span: ops involvement	11.4	New modes of service delivery (joint third)	11.5	Technology	09.6
4	Homeworking issues	07.2	Agile working (joint third)	11.5	Partnership working	07.5
5	Appreciation of comms value	07.2	Culture (joint fifth)	06.1	National command and control	05.5
5=			Productivity (joint fifth)	06.1		
	Total Top Five	**68.6**	**Total Top Five**	**64.6**	**Total Top Five**	**50.0**
	Response (166/166)		*Response (164/166)*		*Response (146/166)*	

Figure 8. Top five changes during the pandemic

For individuals the most significant change, to home-working, was for some a benefit, but it brought significant issues (fourth ranked). The second ranked change, intensity, includes a complex, individually contingent value-equation. For some it has

been a generative experience “I feel more prepared and able than ever to do my job”, for others, change has lost its initial energising rush: “work is overwhelming and whilst incredibly rewarding at the outset of COVID, less so as the daily grind returns”.

For organisations homeworking and technology are ranked as the joint top changes with video-conferencing featuring most often. Joint third, new modes of service delivery and new-modes of working indicates the pandemic’s transformative and ‘disrupter’ effects which had many positive effects, but also brought adverse consequences such as de-prioritisation of many services and projects, including elective surgery, which has emerged as a major issue.

For the wider NHS, its perceived value has increased, but this hides both positive and negative connotations. Without doubt, “the pandemic has strengthened the reputation of the NHS (which is) more respected… the public values the NHS more… broader appreciation and gratitude.” Characterised by “almost a feeling of reverence”, the NHS has been pedestalised in national esteem.

Communicator-optimists hope this exalted status lays foundations for “better public understanding of the complexities of delivering modern healthcare.” However, pessimists see it as risk-laden: “the public has reminded itself why it loves the NHS – presenting a longer-term problem for anyone who wants to change things.” It also impacts on the expectations placed on the NHS which have been heightened, potentially dangerously so in terms of service provision and quality.

The free comment section also encouraged observations on innovations during the pandemic, how communicators will change their leadership/management and delivery of communication as a result, and on the next big challenge for the NHS.

The results can be summarised as providing four agendas for action. First, the *immediate* requirement to remain on full crisis communication alert for future COVID waves and a much-heightened ‘winter impact’ among susceptible groups.

Second, a *risk* agenda which includes a) winning public consent for the ‘new normal’ of a ‘very different post-pandemic NHS’. b) crafting and investing in strong ‘public health messaging’ to manage an anticipated demand surge (many services, for instance elective surgery, will play ‘catch-up’ while others, for example, mental health, will be required to address on-going pandemic consequences; c) expectation management to retain public confidence and protect reputation. Put succinctly, “the media and public will start turning on the NHS as we are unable to meet expectations of restoring services and seeing people as quickly as they hope.”

Third, a *continuous change* agenda which involves; engaging and sustaining commitment among an ‘exhausted workforce’; sustaining innovation in the face of ‘increasing governance’ and the ‘digital equalities gap’; promoting and embedding agile and flexible working in teams and in cross-organisational collaboration; reduced administration (‘biggest change = reduction in meetings’); and accelerated digital technology adoption.

Fourth and finally, a communication *functional* agenda which consists of a) re-setting the relationship with 'frustrating, hard to deal with' national communications to ensure best preparation for any future at-scale waves and pandemic events; b) building on the attractions of change to recruit and retain 'high-calibre' communications staff; and c) resisting a return to the 'shadows' via consolidation of communications' hard-won recognition as an 'essential service'.

Discussion

The data gathered provides opportunity for extensive and extended discussion and space limitations demands that this section is necessarily selective. The discussion again follows the four stage chronology picking out a number of topics for further elaboration.

Stage 1: crisis preparedness

The literature (Coombes, 2019; Staupe-Delgado & Kruke, 2018; Amirkhani et al, 2016) and practitioner guidance (WHO, 2005) suggests that risk assessment, resources and preparations that enable optimal performance are crucial in the crisis preparedness phase. The results indicate that the English NHS was reasonably well prepared overall. It is unsurprising that the best scores were associated with up to date contacts/data based and capabilities: partly explained by the fact that the NHS is a bureaucratic and regulated system with administrative processes that are developed and embedded. Relationship links and 'pathways' both within and without the service are generally well-established and processes for communicating with patients and the community formalised. It is clear this served the communication community well and is counter to many anecdotal stories in other kinds of organisations about difficulties in obtaining definitive contact lists and data-bases.

The findings on preparedness capability are also unsurprising. In many sectors, a communication crisis is the exception. In the NHS it can be one emergency call away. It is well used to dealing with death, accidents of scale and service errors that have critical consequences. Crisis prevention and handling is the everyday normal. This may also explain why training and simulation scores the lowest. The NHS is perpetually in training for crises, but, in common with other public services in the UK, although a pandemic had been anticipated in the national emergency plan, its importance had been downgraded and therefore no specific outbreak training had been undertaken and this possibly explains some of the problems with 'command and control'.

Overall, being prepared for the crisis set the campaign 'tone'. Good preparation associates positively with: communicators' ability to influence local organisational boards; better overall campaign efficiency and greater effectiveness. However, those who were 'not at all' prepared were adversely affected by the positives just mentioned.

Stage 2: 'crossing the line'

As the pandemic struck, NHS communicators rapidly had to prioritise their communication goals and stakeholders and restructure working practices.

Loud and Simpson's (2017) review of best practice recommends that during-pandemic communication priorities should be to maintain institutional trust and stimulate uptake of preventative measures as antecedents of outbreak control. This approach appears to be embedded in the UK Government's original messaging: institutional trust + preventative behaviour = outbreak control translated into the three part slogan 'Protect the NHS (a trusted institution), Stay at home, Save lives'.

Seven different types of organisations were surveyed and normally they have different communication priorities. However, on the whole, during-pandemic NHS communicators increase emphasis on both public information and behaviour-change. This is very much in line with NHS England's (2020a) injunction and is facilitated via the command and control structure: local communicators were not only compliant with command and control directives on priorities, they were supportive of them. There was little objection to the overall direction set centrally, the discontent, especially among the most senior communicators in local organisations, was around not recognising the importance and relevance of local knowledge, cumbersome processes and poor timing.

Concerning stakeholder selection and targeting, the literature and guidance on pandemic health communication is conflicted. For example, in the US, Crisis and Emergency Risk Communication (Hewitt et al, 2008) recommends a standard approach to public communication. Others, (Loud & Simpson, 2017; Crouse-Quinn, 2008) recommend a differentiated and tailored approach. As already shown, this debate is played out in the issues around NHS national level control of local messaging. The results show there were significant differences in shifts in stakeholder selection and targeting based on organisational imperatives, but they do not show any shift to accommodate minority challenges. This is borne out by UK media reports at the end of April that "people from a BAME[3] background make up about 13% of the UK population, but account for one-third of patients admitted to hospital critical care units" (Cookson & Milne, 2020). A fact encapsulated in what has become a popular aphorism about the differential impacts of Covid 19 in the UK, "we may all be in the same storm, but we are not all in the same boat".

On the theme of work and time, it is noteworthy that the hardest pressed group in terms of increased hours is at Band 8d: Associate Directors. It is at this point where national policy and Board decisions are operationalised. Even though the 'load' is shared by already hard-pressed Band 9 and VSMs, as directives are received (sometimes at very short-notice and often in the form of lengthy and complex documents), the risk potential in getting the operationalisation wrong are significant. Operationalisation entails extensive and extended communication and this group of professionals are the pivotal point in the chain. The pressure is increased by the switch to tele or home working and to seven day rotas.

Operationally, the combined effects of long hours, switch to tele- or home working and seven day shifts are equivocal. Nonetheless, failure to evidence positive associations for homeworking, seven-day working, and longer hours is striking and could be gendered.

Stage 3: Pandemic peak

During the pandemic peak a range of new channels and tactics were used and a strong wave of transformative innovation across the NHS was triggered. The findings answer calls in the literature for 'tools and tactics' guidance and they also highlight two opportunities for communicators to own, shape and lead.

First, video conferencing's potency, as pandemic communication technology-enabler, extends beyond home working and internal audiences. For example

> "patient communication is the biggest innovation - the move to telephone/video conferencing has been a challenge for years and now within weeks it is commonplace."

Assuming it becomes the norm, video-conferencing offers a platform for many new public facing applications.

Second, effective innovation may be low-cost and incremental. COVID-specific closed-user groups (CUGs) on the Facebook platform achieved top-five 'nominations' for both effectiveness and innovation. Similarly, intranets: the fully collaborative, productivity-focused 4th-generation versions elicits support during-pandemic and offers significant collaborative potential.

However, there is a caveat to be added to technological transformation: it is not a universal panacea. It

> "disassociates communication from face to face contact and relationship-building with staff and presents huge barriers to gathering strong messages… The result is less rich and powerful communication."

On the *national communication leadership* theme, the lack of input to and influence over communication strategy by local and individual organisations is concerning. This is important because it suggests that national policy- and strategy-formulation neither secured shared goals with local teams nor harnessed the potency of a 3000-strong communications field-force. At a tactical level, while content and messaging was regarded as valuable, the timing issues betray a lack of understanding of the needs and operational realities of those at the local and organisational level 'sharp end'. In addition, the application of command and control and the implied 'we know best' and 'do as you are told' overtones did much to depress morale and alienate a skilled, dedicated and knowledgeable communication workforce to the extent that relationships have to be re-built.

As far as *relationships with others* theme is concerned, the results indicate that relationships emerge as a 'nexus' running throughout the crisis' constitutive fabric from its antecedents through to its diminution. The results demonstrate communicators' willingness and ability to embrace change and to see it as a positive. Given the inertia that characterises the NHS, institutionalised through its structures, the power of professional interests and regulatory systems, this zest for change is relatively rare. At all levels, communicators celebrated the "tearing down of barriers", a reduction in bureaucracy and the development of streamlined local approvals processes both intra and inter organisation during the pandemic with 82% feeling that management decision-making was generally faster. It is clear many viewed this as a unique opportunity to instigate rapid change and to embed some of the positive transformations that have emerged. Communicators emerged as catalysts for change and modelled that change in their own quickly re-engineered working practices. There was, however, a fear that positive, innovative change could easily be forgotten and the NHS could fall back into old, bureaucratic behaviours.

Stage 4; reflection on outcomes – performance and its enablers.

With regards to *personal effects*, it has passed into the practitioner mythology that communicators thrive on deadlines and crises. The results show that job-satisfaction increased during the pandemic, despite respondents rating communication among the most stressful occupations. It is plausible to deduce from this that stress and job satisfaction can be positively correlated - the satisfaction that comes with doing something important and difficult, and doing it well. At the end of the pandemic they were left feeling "exhausted….tired and drained' and some, as noted earlier were ambivalent about prolonged home or tele-working. Interestingly the 'intangibles' of working under 'normal' conditions came out strongly as missing factors that affected them most when working at home: the incidental conversations, the water cooler moments when there was break from the pressure to chat about other things, the feeling of being connected, all came over as being more than 'hygiene' factors. They are part of the business of being a professional communicator, who, to be functionally expert, needs to be embedded into the materiality of the organisation and its relationships.

Closely linked to the theme of job-satisfaction, reflection identified that during-pandemic, communication teams had performed efficiently and effectivity despite a lack of resources, mainly human, with some technology gaps. These communicators appeared to believe they had made a breakthrough in terms of being respected, included and regarded as trusted advisers by senior managers and of gaining the level of influence to be able to cut through cumbersome and obstructive decision-making and hierarchical processes. Their own self-respect and confidence has also received a boost. The pride in the quality of their work and the outcomes achieved despite the challenges, is palpable.

Focussing in more detail on the final area of the research, the free comment section, the views of communicators can be summarised under five words:

Cohesion: 'one clear focus' enabling staff "in the main to pull together".

Commitment: 'staff empowerment' and matching heightened 'morale', normalisation of 'flexible working' and 'staff redeployment'.

Congruence: greater 'system-' and 'partnership-working' and 'in the quiet spaces of …empty wards'.

Creativity: 'rethinking' of future delivery including online ('video/telephony'), 'reconfiguration of entire hospital services' supporting "health and social care providers to deliver services in different and new ways";

Communication: breaking new ground 'across organisations, partners, stakeholders' and 'across traditional boundaries.'

Communicators also had a very clear view on the various agendas for the future as outlined in the results.

Conclusions and recommendations.

This article identifies a number of gaps which are addressed in this research. First, at the national level, there are pointers towards best practice in pandemic communication which are generalisable. Five stand out as being of note: the importance of rehearsal and training in pandemic preparedness; the prioritisation of honest, informative public information which in turn encourages changes in behaviour that assists in public protection; differentiated communication for different stakeholder groups; streamlined, de-bureaucratised and collaborative approaches to communication between national and local; support for 'engine room' communicators who bear the brunt of operationalising policy into communication products, and the importance of strong and extended formal and informal relationships being built before crises.

Second, the research has identified contemporary tools and the mix of those tools that health organisations need in order to serve their organisational and stakeholder needs, with mobile and digital coming to the fore, but also a recognition that minority communities have particular information needs which, if not satisfied lead to disproportionate health vulnerabilities.

Finally, this research has addressed the gap in the pandemic communication literature that treat communicators as peripheral actors. This study confirms them as major players, central in organisational decision-making and pivotal in generating health outcomes. Furthermore, it has provided a rare perspective of professional communicators *in* crises seldom captured and assessed.

The research provides the basis for a number of recommendations which are applicable not only to health, but to other sectors, especially those in public services structured into national, local and organisational levels.

During the pandemic, communicators were disempowered and frustrated by embedded systems, processes and practices such as cumbersome command and control processes and over-hierarchical internal approvals practices. It is recommended that these ‘pathways’ be reviewed and revised to be ‘fit for purpose’ and tested in national planning and rehearsal exercises.

A national information deficit has been identified with minority communities which has contributed (but is not solely responsible) to the pandemic impacts being more severe for them. This is reflected elsewhere in the world where disadvantaged communities appear to have suffered disproportionately. In future pandemic communication planning, it is recommended that additional consideration be given to the needs of minority communities and strategies and tactics developed to address them.

It is clear that the personal work and stress impacts on communicators of working through a pandemic has been particularly acute for those working at senior levels in ‘the engine room’, where policy is operationalised. This represents a significant risk to organisations, the system and the population. It is therefore recommended that additional resources at this level are built into emergency plans.

As part of what is called in the vernacular ‘the new normal’ there are some calls among communicators and organisational leaders to move to more on-line and home working, but there is ambivalence about this. It is recommended that a full review of the psychological and unintended consequences of this, such as communicators being unwoven from the fabric of their organisations, well as the efficiency and effectiveness impacts be undertaken before such a move is institutionalised.

This research also provides a platform and incentive for further work to aid theoretical and practical development. The following two lines of enquiry are suggested as being urgent, although many more could be recommended.

a) To investigate the ‘communication entropy’ that was observable where initial communication was seen to be impactful and effective initially, but less so as the pandemic progressed. Research on antecedents and remedies is required.
b) To investigate further the personal impacts of prolonged crises on professional communicators in order to identify the barriers and opportunities for optimal performance.

In the longer term research in other sectors that are under attack, for example, primary extraction industries or the financial services sector during a recession could form the basis for a meta-study that could reach generalized conclusions about the actual experience of practitioners in a crisis of prolonged duration.

Notes

1. Public relations practitioners are known as communicators/communication professionals in the UK public service and the terms should be regarded a synonymous.
2. Arms Length Bodies are non-ministerial organisations attached to the DH&SC such as NHS England and Public Health England.
3. BAME is the UK accepted short-form for Black, Asian and Minority Ethnic communities

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