“See us as humans. Speak to us with respect. Listen to us.” A qualitative study on UK ambulance staff requirements of leadership while working during the COVID-19 pandemic

Peter James Eaton-Williams, Julia Williams

ABSTRACT
Background The COVID-19 Ambulance Response Assessment (CARA) study aimed to enable the experiences of UK frontline ambulance staff working during the first wave of the pandemic to be heard. Specifically, CARA aimed to assess feelings of preparedness and well-being and to collect suggestions for beneficial leadership support.

Methods Three online surveys were sequentially presented between April and October 2020. Overall, 18 questions elicited free-text responses that were analysed qualitatively using an inductive thematic approach.

Findings Analysis of 14,237 responses revealed participants’ goals and their requirements of leadership to enable those goals to be achieved. A large number of participants expressed low confidence and anxiety resulting from disagreement, inconsistency and an absence of transparency related to policy implementation. Some staff struggled with large quantities of written correspondence and many desired more face-to-face training and an opportunity to communicate with policymakers. Suggestions were made on how best to allocate resources to reduce operational demands and maintain service delivery, and a need to learn from current events in order to plan for the future was stressed. To further support well-being, staff wanted leadership to understand and empathise with their working conditions, to work to reduce the risks and if required, to facilitate access to appropriate therapeutic interventions.

Conclusions This study demonstrates that ambulance staff desire both inclusive and compassionate leadership. Leadership should aim to engage in honest dialogue and attentive listening. Resultant learning can then inform policy development and resource allocation to effectively support both service delivery and staff well-being.

INTRODUCTION
Leadership is a critical factor for the UK’s National Health Service (NHS) to deliver continually improving, high-quality healthcare and the outbreak of the COVID-19 pandemic in 2020 undoubtedly represented a huge challenge to its leaders. NHS ambulance trusts continued to deliver remote and face-to-face patient care as the first wave spread across the country. Their staff had to adapt to new working practices while caring for patients with a disease that was still poorly understood and while other health and social care providers experienced reductions in capacity.

Inclusive leadership, where staff are actively listened to and encouraged to contribute, benefits the positive development of organisational culture and consequently its care provision to patients. In that spirit, following outbreak of the pandemic, the College of Paramedics, in association with the National Ambulance Research Steering Group and the South East Coast Ambulance Service NHS Foundation Trust, initiated a prospective series of three online surveys to enable UK ambulance staff to have their experiences heard, of working during those exceptional times. The COVID-19 Ambulance Response Assessment (CARA) study specifically aimed to evaluate perceptions of preparedness and well-being, and to collect staff suggestions of how leadership could most effectively support working practices and conditions.

METHODS
The surveys took place in April, May and September/October 2020, approximating to the acceleration, peak and deceleration phases of COVID-19’s first wave. CARA was open to ambulance staff delivering either remote or face-to-face patient care and also to paramedics working in other clinical environments. A total of 3717 participants completed phase I and subsequently received invitations to complete phases II (n=2709) and III (n=2159). Most participants (83%, n=3078) identified a UK NHS ambulance service trust as their primary employer, 82% (n=3055) reported a patient-facing role and at least 65% (n=2399) were registered paramedics. Surveys included questions...
FINDINGS
Figure 1 shows a thematic framework derived during analysis of phase I that maintained a strong relevance for the free-text questions throughout all three phases of CARA. Participants expressed three overarching goals to work towards:

- To reduce risk to staff, patients and loved ones by optimising infection prevention and control (IPC) practices.
- To enable staff to maintain effective clinical service delivery.
- To recognise and work to diminish pressures at work and provide support for staff mental and physical well-being.

To achieve these goals, participants described elements of leadership that they believed would enable them (enablers). In this paper, we focus on those enabler features of leadership identified, and particularly on how they relate to both service delivery and staff well-being goals. A separate qualitative paper, specifically reporting on the goal to minimise infection risk and experiences of IPC practices has been submitted elsewhere.

Overall, participants described five features of leadership required, variedly applicable to national and organisational levels. These subthemes were:

- Appropriate and coordinated policy
- Communication and training
- Provision and effective use of resources
- Learn and plan
- Demonstrate empathy and respect

Appropriate and coordinated policy
Throughout all stages of CARA, it was apparent that disagreement among national and international agencies on what constitutes an aerosol-generating procedure (AGP) and on how this influenced related policies governing the use of personal protective equipment (PPE) and procedures such as cardiopulmonary resuscitation, caused significant confusion, anger and distrust.

A definitive decision surrounding what is and isn’t an AGP is required, disagreement between professional organisations is deeply unnerving and counterproductive. C2.Q16a.2201

Similar feelings arose from the inability to coordinate procedures and policies across ambulance trusts and the hospitals that they work with. Variations in PPE use and in handover procedures added extra demands on ambulance clinicians and damaged confidence in their own practices.

There should be a nationwide plan of action. Every area has different policies/procedures making clinical decision making difficult and confusing. C1.Q46.2668

In A&E and ITU all staff wear full length gowns when in direct patient contact. I genuinely look on with anguish when I compare their kit to our flimsy apron. C1.Q46.0770

Witnessing such disparity of procedure contributed to calls for transparency regarding policy implementation. Participants wanted to see the evidence supporting changes to policy and wanted the opportunity to engage in dialogue concerning those changes.

It would be nice to receive evidence and references for some of the constant changes. C3.Q26a.1690

Meetings on hubs with senior management to discuss concerns. Or at least someone to take concerns to the managers. C1.Q45.1178

Participants also wanted their employers to introduce policies that they perceived as fair. For example, there were many requests to relax targets on job-cycle times to enable clinicians to manage the extra working demands placed on them by the pandemic. Appropriate absence and return to work policies were also requested.

Clear up at hospital audit time is 10 minutes under normal circumstances. Changing this time to 15 minutes would allow staff extra time to take on fluids and have an interval without wearing a mask… This change in time would show support, increase morale, and prevent fatigue. C3.Q17a.0653

Following the spirit of COVID related medical suspension rather than pressing people back to work or converting their time off to normal sickness in order to activate disciplinary stages. C2.Q43.1656

Communication and training
A significant subtheme of organisational leadership related to the communication of guidance and policy, and to the provision of effective training. In phase I, numerous perceptions of information overload were expressed. Persistent delivery of rapid changes to guidance and information, together with the perceived presence of contradictions, led to confusion.

Lots of emails of policies and procedures which are constantly updated sometimes 4-5 times a day. That in itself is stressful enough,… C1.Q45.2111

…we have constant conflicting advice which is very stressful. C1.Q46.0100
Participants complained that important changes were often hidden within much larger pieces of information delivered repeatedly, making them difficult to identify. They stressed the need for guidance to be succinct and relevant to their particular role. A ‘need to know’ approach.

Bullet point board with daily updates. The emails are so vast and constantly changing it’s hard to keep up. C1.Q45.2305
I would prefer to only be notified when there are changes to practice or guidelines. C3.Q26a.1310

Contrastingly, there were other participants who recognised that they were in a rapidly changing situation with new knowledge emerging constantly and who welcomed as much dissemination of information as possible.

Information was always changing and the trust did what they could to keep us up to date. C3.Q26a.0832

Progressing through the phases of CARA, some perceptions of information overload persisted and were accompanied by expressions of disengagement or ‘information fatigue’. However, many other participants perceived the initial overload had been replaced by a level of communication that was now ‘just right’, or that was now actually insufficient.

We’ve gone from daily (sometimes multiple per day) updates with little change to weekly if not less frequent. There must be an infrequent! C3.Q26a.0318

Examples of both good and poor methods of communication were provided but a consistent complaint was an overreliance on written material. Copious comments highlighted the perceived benefits of face-to-face instruction and practical simulation. The former permitting questions to be addressed as they arise and the latter providing an opportunity to gain experience and familiarity.

It would be better if it was face to face and talked through. C3.Q26a.1472
Scenario training which I know is difficult under these pressures but to release hundreds of emails daily with updates which people don’t have the time/interest in reading isn’t helpful. C1.Q45.0235

Provision and effective use of resources
There were numerous calls to maximise available resources and for these resources to be employed effectively. Related to national leadership, comments focused on PPE supply, public education in self-management and on restoring a primary care capacity that was perceived to have diminished significantly. Increased demand for ambulance services and reduced options for patient management alternative to hospital emergency department assessment were consequences attributed to this lost capacity.

I feel many services such as GPs have reduced face to face contact with patients but the ambulance service is expected to fill this gap. C3.Q46.2968

At an organisational level, comments focused on a number of different areas. Increasing the number of ambulances available was a familiar call and effective use of specialist units, students and external personnel was also the subject of many suggestions. A substantial number of participants advocated using more clinicians within the triage process to benefit remote treatment rates and reduce demand for ambulance attendance.

Better triage of calls, increase clinical assessment of calls, reduce dispatch of ambulances to calls where we offer little to patients other than help to book a GP appointment. C3.Q46.0855

Many other participants highlighted the benefits of access to on scene collaborative decision-making support provided by general practitioners (GPs) or advanced/specialised paramedics.

Doctor support in EOC [Emergency Operations Centre] for ‘No decision in isolation’ decision making support when deciding to convey/not convey patients—particularly with comorbidities and expected poor outcome. C1.Q45.1662

Various suggestions to commit resources towards improving IPC practices at work and to reduce the likelihood of transmission returning home were also submitted.

A team to restock and clean vehicles ready for operational crews. C2.Q43.2031
Uniform washing services. C3.Q46.1495

Learn and plan
Many participants perceived that leadership had demonstrated a reactive response to the outbreak of the pandemic in the UK rather than a proactive one to the initial outbreak in China.

Why did we not learn from what came before us in China, and elsewhere in Europe? Will the NHS and ambulance services STOP being reactive and instead turn proactive? C1.Q46.0092

There was surprise expressed that plans did not appear to be in place for this contingency, despite long-term investment in emergency preparedness, resilience and response. Inadequate availability of PPE, an absence of prior training and poor coordination of organisations were viewed as consequences of this perceived failure to plan.

I feel we were extremely unprepared for this scenario. I don’t think we have ever covered the possibility of a pandemic within our core skill refreshers or major incident training. C1.Q46.1444

Accordingly, others emphasised the need to learn from the current situation and to make plans for future eventualities.

Hindsight is a wonderful thing so we MUST learn from this pandemic. C1.Q46.2705
I am amazed there has been no debrief or any sort of review for lessons learned. No senior clinicians have been asked for any input or feedback for potential changes for the second wave. C3.Q47.0372

Other participants praised their employers’ response to the situation, in what they viewed were unprecedented and unforeseeable circumstances.

I think the response from my employer has been innovative and adapting. C1.Q46.2901

Demonstrate empathy and respect
Interpretative analysis of responses in CARA revealed strong feelings of isolation and vulnerability, with many participants employing the phrase or sentiment of being ‘cannon fodder’.

I’ve never felt more isolated and unappreciated in twenty years ambulance than I do now, and for the first time I genuinely feel our lives are at risk and absolutely no one cares. Are we expendable? C1.Q46.0168

Associated with these feelings were calls for leadership to ‘walk in my shoes’, to understand and have empathy with the demands placed on staff. In addition, leadership needed to be visible, approachable and responsive to staff concerns, treating staff with respect and dignity.
Management rolling their sleeves up and working on the shop floor. Our current systems of work are very different to usual ways of working and management need to understand that. C2.Q46.0248 Be more visible. And even if you cannot solve our problem, at least be there to listen. C3.Q46.0622

Unfortunately, many participants reported the absence of such leadership, perceiving a withdrawal of management away from staff interaction. An accusation particularly levelled at more senior management. Some recounted dictatorial and threatening management, accusing them of putting targets before concerns for both staff and patients.

Senior management nowhere to be seen. They have let the front line down badly. C1.Q46.1722 I feel that management have prioritised figures and appearances over staff welfare. C3.Q47.0917

However, there were also many examples provided of supportive management and some participants recognised that managers had experienced pressures related to the pandemic similarly to themselves.

I believe managers of all areas have tried their best to offer thanks, support and advice considering they are also new to this pandemic. C1.Q45.1750

Supporting the physical and mental well-being of staff was a goal identified in the thematic framework (figure 1). Suggestions included provision of refreshments, frequent rest breaks, shorter shifts, ‘kinder’ rotas and break periods away from frontline clinical interaction. They also included regular welfare checks, screening for mental health problems and access to appropriate therapy for those in need.

Feed us, give us welfare checks, get off our backs about meeting time targets, protect our finish times. C2.Q43.1514 The need for leadership to provide this support became more predominantly expressed as the study progressed. Analysis of phase III reflected the effects of prolonged exposure to pandemic working conditions by identifying a new interpretative subtheme of ‘be kind to staff’ and by outlining participants’ experiences so far as both experiences of frustration and experiences of harmful consequences.

I have developed significant mental health ill health. C3.Q47.1962 I resigned from frontline ambulance work as we weren’t ‘all in it together’. C3.Q47.0328 Sometimes it feels utterly overwhelming. C3.Q47.1036

See us as humans. Speak to us with respect. Listen to us. C3.Q46.0242

**DISCUSSION**

Our findings indicate that UK ambulance staff perceived certain requirements of leadership could attain their goals of reducing COVID-19 infection risk, maintaining service delivery and protecting their own well-being. Those enabler themes were to provide appropriate, coordinated policy, to enable effective communication and training, to demonstrate planning and effective use of resources and to engage with staff exhibiting empathy and respect. Some of these goals and enablers identified by CARA participants (figure 1) are shared with other healthcare workers (HCWs) working in a variety of environments during this pandemic and during previous epidemics. Developing policies with clear evidence supporting them and applying them consistently will reduce anxiety and improve confidence in their validity.6–10 Unfortunately, important policies relying on the efficacy of PPE and the definition of AGPs had supporting evidence of low certainty.11–12 Additionally, initial complex PPE guidance and a struggling supply chain resulted in variations of PPE use across differing clinical environments.13–15 Together with repeated revisions to guidance,16 this adversely affected staff’s confidence in PPE-related policy in particular. Nordby17 highlighted that paramedics value transparency associated with policy implementation and desire the opportunity to engage in dialogue.17 Enabling these might increase the trust that staff place in their leaders18 and permit evaluation of how implementation is proceeding in the field.9 Additionally, to sustain trust, our participants called for policies they perceived as fair and respectful of their professionalism.19

However, communicating with a widespread, mobile workforce such as that which predominantly exists in the ambulance service presents considerable challenges.20 Reliance on written electronic communications during a rapidly changing situation produced an overload of information as perceived by many of our participants. Succinct, relevant information was desired, delivered via a variety of media, although calls for face-to-face training and briefing predominated. But at a time when operational demand remained high2 and when social distancing was procedure, the delivery of training was logistically problematic. Perhaps some preparedness, especially related to familiarity with PPE, could have been achieved from prior annual mandatory training,21 as suggested by some participants.

Ambulance service leadership must demonstrate effective use of limited resources2 and many suggestions were received on how best to do this. Appeals to improve the availability of PPE and operational ambulances, together with comments on how best to use student paramedics, personnel from other services and support staff were commonplace. During the period covered by phases I and II, the ‘see and treat’ rate, where ambulance clinicians physically attend patients without subsequent transport to hospital, saw an increase of >10%.22 These figures explain repeated calls for public education programmes and improved triage processes. Participants perceived that many incidents could be dealt with remotely, reducing clinician exposure to possible infection and enabling maintenance of service delivery to patients that required an ambulance attendance. This is a view endorsed by the strategic planning of both the Association of Ambulance Chief Executives and the UK Parliament.23 24 When attending patients, it is unsurprising that participants also wanted access to clinical guidance and decision-making support for a novel disease with elusive diagnosis,25 uncertain prognosis26 and when pathways of care provision demonstrated limited capacity.9 24

Ahern and Loh suggest that demonstrating preparedness and planning creates trust in leadership during times of exceptional uncertainty.28 Many of our participants questioned the extent to which these qualities had been exhibited. It may be that countries who had experienced more recent viral epidemics, such as Hong Kong and South Korea were more prepared to react to the COVID-19 pandemic.27 However, other participants perceived a good response from UK ambulance services and it appears that relevant agencies are demonstrating a commitment to learn from events and to maintain the positive innovations made.24 28 29

Compassionate leadership is advocated to enable an innovative and adaptive NHS and its constituent components closely mirror desires expressed by participants in CARA.3 4 Participants wanted leadership to attend, or listen to their concerns, to understand the demands placed on them, to empathise with these and to help where possible. Visible leadership ‘in the field’ facilitates achieving these goals and is also valued by
paramedics. With regard to well-being, in their meta-analysis of the psychological impact of virus outbreaks on HCWs, Kisely et al concluded that good communications, training and supply of PPE effectively reduced the risk to staff, and these are all enabler subthemes of leadership already discussed. Other effective measures, identified by both our participants and Kisely et al were practical steps to ensure staff take adequate sustenance and rest, and providing them with access to appropriate psychological interventions. A combination of both preventative and curative measures tailored to the individual similar to that described in guidance to healthcare leaders published at the time.

Finally, it is important to state that our purpose is to benefit leadership development, not to negatively reflect on those acting with best intentions and we would highlight that, alongside calls for improvement, many comments were collected praising examples of leaders demonstrating the requirements we have identified. Similarly, qualitative analysis will always contain an element of subjectivity and it is not possible to represent all individual viewpoints from such a rich and diverse dataset.

CONCLUSIONS
Qualitative analysis of free-text questions in the CARA study revealed many opinions and aspirations held by UK front-line ambulance staff working throughout the first wave of the COVID-19 pandemic. It appears that ambulance staff will accept policies that they identify as fair, evidence-based and applied consistently. However, they require leaders to communicate changes to practice effectively and to subsequently listen and react to their experiences of enacting those policies. Enabling dialogue is problematic, but over-reliance on written correspondence can lead to confusion and anxiety. Ambulance service leaders can gain their staff’s trust by providing and using resources astutely and by demonstrating that they are learning and planning for the future. Leadership displaying empathy and respect for staff may benefit their psychological well-being, but additional preventative and therapeutic well-being support should also be provided where practical and appropriate. Overall, coordination, inclusion, efficiency, planning and compassion were all identified by our participants as critical elements of leadership that will support ambulance staff well-being and service delivery during pandemic conditions.

Twitter Peter James Eaton-Williams @PeterEatonWill

Acknowledgements The CARA study would like to thank the Trainee Emergency Research Network (TERN) for sharing resources while developing a similar study and GL Assessment for donating use of the GHQ-12 within the study.

Contributors PJE-W contributed to survey design and qualitative analysis of results. He drafted, revised and approved the submitted paper for publication and agreed to be accountable for it. JW contributed to survey design and qualitative analysis of results. She reviewed, revised and approved the submitted paper for publication and agreed to be accountable for it. No other individuals satisfy all four ICMJE criteria. PJE-W will act as the guarantor.

Funding This study was funded by the College of Paramedics, a unique grant awarded in response to exceptional circumstances.

Competing interests JW is Head of Research for the College of Paramedics and additionally for the South East Coast Ambulance Service NHS Foundation Trust.

Patient consent for publication Not applicable.

Ethics approval The study was approved by the Health Research Authority (HRA) (IRAS 282314). The HRA confirmed that the study did not require NHS Research Ethics Committee review as it was a survey of staff. Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available on reasonable request. De-identified participant data held by the sponsor will be made available if a reasonable request is submitted to the authors.

Supplemental material This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by BMJ. BMJ disclaims all liability and responsibility arising from any reliance placed on the content. Where the content includes any translated material, BMJ does not warrant the accuracy and reliability of the translations (including but not limited to local regulations, clinical guidelines, terminology, drug names and drug dosages), and is not responsible for any error and/or omissions arising from translation and adaptation or otherwise.

This article is made freely available for personal use in accordance with BMJ’s website terms and conditions for the duration of the covid-19 pandemic or until otherwise determined by BMJ. You may download and print the article for any lawful, non-commercial purpose (including text and data mining) provided that all copyright notices and trade marks are retained.

ORCID iDs
Peter James Eaton-Williams http://orcid.org/0000-0001-5664-3329
Julia Williams http://orcid.org/0000-0003-0796-5465

REFERENCES
Patient safety in ambulance services: a scoping review. 


---