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Arrest to Recovery

Pandemic Observations and Reflections in response to
Quality Governance- What Happens when the Dust Settles'?

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When a person stops breathing; when their heart stops; they are in cardiac arrest. The healthcare team steps up and steps in, functioning as one. To the observer it can be a brutal, intense dance with the enemy. An apparently detached, coordinated assault to restore an individual's humanity.

But in the depths of cardiac arrest, there is an element of control. There isn't anything we can do to make it worse; there is everything we can do to make it better.

The challenge is peri-arrest. Whether it is before: when the numbers on the charts are going the wrong way or clinical instinct telling you something bad is going to happen. Or whether it is after: the split second of relief you allow yourself when someone on the team checks for a pulse and it is there, breathing returns and with it the possibility of the individual in front of you.
But only if you don't succumb to the belief that you have won, only if you don't allow relief to paralyse you. That time is the most critical. It requires the most thought, the most investment from the team.

COVID-19 was portrayed to the nation as a cardiac arrest for healthcare. The UK tried to ready itself for a pervasive unseen attack. With hospitals built in days to serve the needs of thousands, care delivered by self-sacrificing staff, amidst the legacy of decades of decisions made to deliver different goals and to fulfil different agendas.

There have been cardiac arrests, tens of thousands, and we are not through it yet. The trauma will live on for decades.

As the number of people admitted to hospital with COVID-19 reduces and the numbers of daily deaths decrease, the NHS faces even greater challenges.

Our healthcare system is now peri-arrest.

Senior medics have publically shared concerns over non-COVID related deaths due to delayed or absent healthcare. As a result, junior medical staff are learning to treat complications from heart attacks that we have rarely seen in the last decade because our systems were so good before lockdown.

How do we begin to recover and build the new normal?

Now more than ever we should know that healthcare is delivered by people for people. Recovery begins and continues with open honest communication with people.

The importance of the motivation and engagement of staff, who have overwhelmingly answered the call of the nation to keep it safe, needs to be at the centre of decision-making. The discussion with patients and the public must be paramount, just as the intention of clap for carers and front line staff and the good will and outpouring of support for those who have fought the good fight could very quickly and easily be lost or redirected.

Boards need to ask the views of those delivering services and patients accessing services. Not in a questionnaire in six months time but here and now to be able to act upon their answers swiftly, with transparency and agility.

Clinical Governance provides the value base that should shape and inform the approach and conduct of relationships with partner organisations and how local populations, staff, patients and their relatives are listened to. The values of respect and trust that underpin clinical governance should characterise these relationships.

Organisations facing this challenge must remember that the quality and governance frameworks in place before COVID-19 are still there and have been throughout. It is what we do within them that can change and improve as well as responding in a timely way so as not to hinder new ways of working.

Clinical and care teams on the front line are very used to ensuring the quality of care for patients within their professional regulatory frameworks, but Boards have responsibility for both successful delivery and failures in the quality of care. There is no doubt that everyone is working to deliver the best care possible and do the right thing in circumstances that we have never seen before. However, these actions will be judged and scrutinised at a later date; it will **not** be enough to rely on ***'oh, that was during the Pandemic'***.

Each organisation has a duty to reflect on what they have done and how they did it. In the rush to reduce and cease services, were actions considered and documented? Was a pathway developed that can now be used to open services back up? The corporate memory needs to be recalled and examined.

Is it a hazy memory held by a few who had socially distanced corridor conversations or late night phone calls and a few scribbled notes? Or is it the documented outputs of purposeful, frequent Board meetings that critically question an organisation's priorities at every stage and evaluate implementation of Command structures that previously only existed on paper?

Whilst the NHS may seem to be at its best in a crisis, our health and care organisations must always strive to achieve the best outcomes for patients, on any given day.

On the days that have been, how has this been evaluated for every individual who has accessed healthcare and for every individual who has not? Has the organisation been there for its community? Has it served individual, service-level or national needs?

Who does it serve now?

What does that mean for the patient who waited months for a clinic appointment to see a specialist, only to have it cancelled and is now on a waiting list, with on-going symptoms and progressive underlying disease? What does that mean to the family who ask the organisation in 12 months time why their loved one died on a waiting list?

Does the Board know to how many, in what ways and how quickly they are obligated? How robust is that knowledge?

Is this aligned to their staff skills, expertise and values?

Is there a mechanism to seek the views of staff at all levels? How does a Board know that this is being used and works? Are individuals co-opted into discussions when additional expertise is needed, or is there a reliance on hierarchy? Do staff feel valued and recognised? Does the organisational governance facilitate service delivery at the highest level?

The pressures facing clinical and care teams are not to be underestimated. At every level they are showing the grit, determination and resilience that brought them into their profession. Informed, courageous Boards will facilitate and learn from their questions and challenges, encouraging discussion without fear of reprisal.

A Board that is transparent, questioning and receptive will welcome and reply to the individual who asks ‘am I safe?’ and to the many who ask ‘what now?
Will your Board welcome your question?

What if we asked?

Questions to Board:	Questions from Board:
1. What have you learned in the last 6 months?	Is there a comprehensive communications plan in place for staff and stakeholders? Has it been effective? What else do we need to do?

2. Have you acted appropriately? Have actions been recorded are they accessible?	Is staff welfare being prioritised? Is there adequate succession planning in place for clinical leaders albeit for short-term absence?
3. What has been the quantifiable impact on your pre COVID-19 services?	Are we confident that the reporting to the board is timely and accurate?
4. How do you know what we should be doing next?	Do clinical leaders have plans in place for their services for both escalation and de-escalation? Are they aligned with the local health and care community?
5. How ready are we for the next wave?	How flexible are we at being able to meet the requirements of Covid-19 and non covid-19 patients?

**Box 1: Questions for consideration*