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THE IMPACT OF COVID-19 PANDEMIC ON HEALTHCARE WORKERS IN THE UK

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ABSTRACT

Objectives: To explore the challenges faced and physical, psychological, social and professional impact of COVID-19 on HCWs. factors influencing HCW's willingness to report to work during the crisis. To determine the factors influencing HCW's willingness to report to work during the crisis and effect of community, organisational and government's support on the well-being of HCWs. **Method:** This quantitative research used an online survey tool, posted on social media platforms. Data analysis was retrieved from the built-in online survey software and SPSS was used to generate p-value to ascertain statistical significance between variables using Chi-square tests in regression analysis. **Results:** 152 HCWs were included in this study, 118 were female and 34 male. There was a strong association between willingness to work and fear of acquiring infection (p-value < 0.0043 at 95% CI). 65% of HCWs felt that their friends or family avoided them from fear of getting infected with COVID-19. There was a significant statistical association between anxiety and depression (p-value < 0.001 at 95% CI). **Conclusion:** The most significant impacts of COVID-19 were social, professional, and psychological. HCWs suffered from anxiety, depression, Post Traumatic Stress Disorder (PTSD), moral injury and feeling of desolation. These feelings arose from unsafe work environment, fear of infection and transmission to loved ones, unsupportive workplace and added workload. Professionally, some HCWs felt that they lost skills or confidence in their work and their job role became irrelevant/ secondary. Also, of significance was lack of support from the employers, management, or supervisors.

KEYWORDS: Healthcare workers, COVID,19, well-being, Burnout, perceived barriers.

INTRODUCTION AND BACKGROUND

The world has seen several viral outbreaks in the last two decades including SARS-CoV[1], MERS-CoV[2] in 2012, H1N1 pmd09[3] and Ebola virus epidemic.[4] Despite the high incidence, morbidity and mortality rates associated with the previous outbreaks, none have paralleled the destruction and havoc caused by Corona-virus in 2020. The World Health Organisation declared it a Public Health Emergency of International Concern (PHEIC)[5] on 30th January 2020.

In a public emergency, effective and efficient response may be delayed or limited depending upon the preparedness of the healthcare systems and the workforce. Risk perception theory reveals the multifaceted phenomenon of actual risk faced by frontline workers in addition to independent peripheral influences that may play a role in limiting response and modifying behaviours.[6] These perceived risks can manifest as outrage or dread, stemming from the fear of unknown and, uncertainty about manageability of the threat. Based on the actual risk and perceived risk theory, major barriers to an effective healthcare workforce response to a public health emergency can be physical or circumstantial, affecting the readiness and ability of frontline Healthcare workers (HCWs) to report to work during a crisis.[7]

Absenteeism of staff may arise due to illness[8], fear of interpersonal isolation and quarantine.[9] According to a study by Ehrenstein et al., 28% of HCWs may abandon work in favour of protection of self and family's health or childcaring responsibilities.[10] Other barriers include feeling of unpreparedness to the emergency, apprehension about working environment and safety, ambiguity over role specific expectations, stress management and vague or inadequate information.[11] Factors contributing to willingness to work are also related to gender, sociodemographic background, organisation or institution culture and support as well as knowledge and awareness of the physical or emotional consequences.[12] Age of the HCWs has a paradoxical relation to willingness to work.

In the study by Gottberg et al., older staff members reported that they feel their role as less important as compared to younger staff members but felt more responsible and competent to perform their tasks

during the crisis.[13] Moreover, Koh et al., reported that greater work experience was linked to greater adherence to preventive measures.[14]

Staff shortages may be a pressing issue and a severely limiting factor over the availability of care, medications or equipment.[15] Overcrowding, insufficient workspace and environmental contamination can contribute to transmission of infection and spread amongst HCWs.[16] However, frontline workers may be subjected to increased pressure because of the nature and demand of work. Subsequently, they are at a higher risk to burnout, which may affect the quality of care provided.[17,18] Burnout amongst HCWs may be contributed not only by caring for the rapidly increasing number of infected patients but also by HCWs themselves falling ill; requiring self-isolation and treatment[19,20], adding workload on other HCWs who have to substitute for their colleagues. Ackerman and Benzuidenhout reported that unequal work distribution and flexi-time system, unavailability of supplies and insufficient number of staff reporting to work creates dissatisfaction and bitterness amongst those reporting to work.[21]

Frontline HCWs have 11.6 times greater risk of infection as compared to the general population and 23% higher risk of infection due to the unavailability or inadequate quality of PPE.[22] Furthermore, clinical HCWs are 5 times more likely to acquire the infection (even with adequate PPE) as compared to non-clinical HCWs. Willingness to report to work is associated with the perception of work role relevance, competence, importance, self-efficacy expectations to the role and a sense of duty to the profession.[23] Seale et al., have suggested that some HCWs adjust their availability and readiness to report to work based on the severity or proximity to the pandemic threat.[24] This correlates to the perception of importance of one's role during the response. Amongst clinical staff, doctors and first responders are more willing to work as compared to nurses and other ancillary staff.[25,26]

Although HCWs braved out the situation of constantly living in the fear of being exposed to infection, the long-term effect of this fear and stress may result in depression, anxiety or Post traumatic Stress Disorder (PTSD) due to an increase in workload, burnout, moral injury, difficult decision making and feeling of helplessness.[27,28]

However, some HCWs responded differently to the challenges faced and instead of developing mental health difficulties, they might experience growth exhibiting gratification, resilience, confidence, elevated self-esteem and a positive outlook.[29] In some regions, HCWs were socially and psychologically impacted by facing stigmatisation and ostracism from the public.[30]

The rationale behind conducting this research was to explore the personal, social, professional or psychological impact of COVID-19 pandemic on HCWs as frontline defence against the pandemic. The purpose of this research was to investigate HCWs willingness to work, factors influencing absenteeism, job satisfaction and the effect of changing work pattern on their professional careers. The results generated from this research may help in devising strategies and measures that can be taken to support the HCWs through the challenges they face during the COVID-19 pandemic.

STUDY OBJECTIVES

To explore the challenges faced and physical, psychological, social and professional impact of COVID-19 on HCWs. factors influencing HCW's willingness to report to work during the crisis.

To determine the factors influencing HCW's willingness to report to work during the crisis and effect of community, organisational and government's support on the well-being of HCWs.

METHODOLOGY

This research adopted a quantitative method and deductive approach, using an online survey instrument. The study used an online questionnaire **(Appendix A)**. The target population were clinical and non-clinical HCWs in UK. The questionnaire link was posted on social media platforms (Facebook, twitter, and LinkedIn) to reach out to a wide cohort of HCWs from a variety of different disciplines. Data was collected using an online software (SmartSurvey), with anonymity of participants ensured and consent requested before starting the questionnaire **(Appendix B).** Data was analysed automatically and cross tabulated, presented as simple frequency and percentages,which were presented as graphs, charts or tables. Pearson's correlation coefficient measures were employed to determine the strength and direction of the relationships between variables. SPSS statistics was used to generate p-value to ascertain statistical significance between variables using Chi-square tests in linear regression analysis. Descriptive text was generated for those participants who wanted to elaborate more **(Appendix C).**

RESULTS

A total of 182 questionnaires were submitted, out of which 30 were partial responses and were excluded. The remaining 152 responses were analysed using simple frequency charts, cross tabulations, and regression analysis. Amongst the respondents, 118 (77.6%) were females while 34 (22.4%) were males. Amongst the 129 clinical staff, majority of the respondents were nurses (56), followed by doctors (33) and dentists (19), healthcare assistants (9) and pharmacists (7), all currently practicing in the UK. The remaining 5 respondents were radiologists, physiologist. Majority of the non-clinical respondents who participated in the

study belonged to administration and management (17).

As shown in table 1, dentists amongst all other HCWs feel their job roles have become unclear (63%) and secondary during the crisis (58%). While doctors (82%) and pharmacists (100%), amongst the study participants, feel that their role is crucial during the crisis the most. 65% of the HCWs from administration and management staff feel they are required to perform tasks that they normally do not have to. Lastly, most doctors (70%) feel they have gained new skills during the pandemic.

Table 1: Shows different HCWs perception about their job tasks during COVID-19 pandemic.

	Doctors	Dentists	Nurses	HCAs	Pharmacist	Admin
Your job role and responsibilities have become unclear?	30%	63%	43%	33%	57%	53%
Are you required to perform tasks that you normally do not have to?	45%	47%	55%	55%	57%	65%
Do you feel your job role has become secondary/ irrelevant?	6%	58%	36%	33%	29%	19%
Do you feel your job role is crucial in the emergency response to the crisis?	82%	68%	68%	56%	100%	41%
Did you develop new skills during the pandemic (due to deployment/ change in job roles)	70%	53%	55%	44%	57%	53%

118 (77%) participants of the study reported not to have taken time off from work during the pandemic. 58 (38%) respondents stated that the pandemic affected their willingness to report to work while 94 (62%) stated that it did not. Overall, the most prevalent factor affecting HCWs willing to work was the fear of acquiring infection and transmitting it to their family, staff shortages (leading to excessive workload and burnout) and personal health or family issues, as shown in figure 1. Unsafe public transport, insufficient workspace and other HCWs not adhering to cross infection control protocols were other areas of concern.

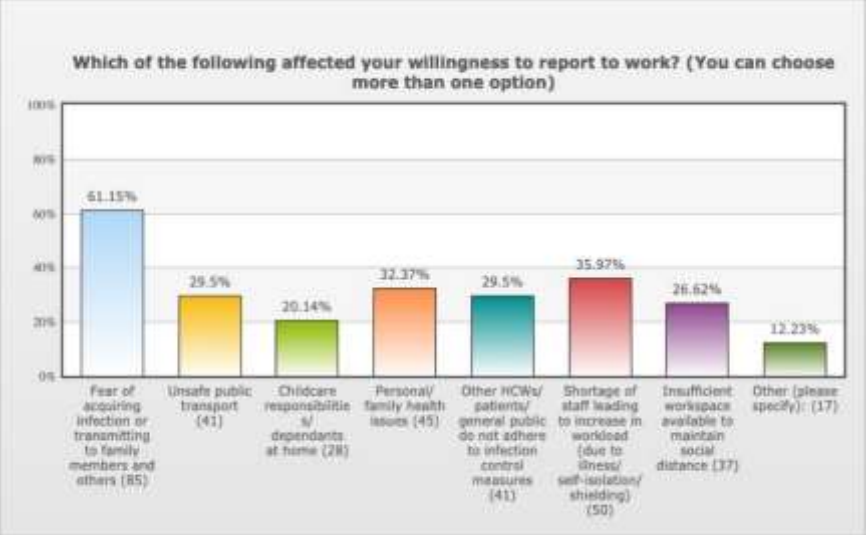

Figure 1: shows the factors affecting willing to work.

There was no correlation between gender and the willingness to work (p-value 0.722, 95% CI). However, most female HCWs (82%) reported that childcare responsibilities and dependants at home were factors affecting their willingness to report to work as compared to 18% of males. The only statistically significant factors showing association between willingness to work were fear of acquiring infection (p-value <0.0001 at 95% CI), unsafe public transport (p value 0.009 at 95% CI) and insufficient workspace availability (p-value 0.000015 at 95% CI).

There was no statistical significance in the difference between motivation factors between both the genders (p- value 0.4379 at 95% CI).

Clinical HCWs considered their job roles to be crucial in the emergency response to the pandemic as compared to the non-clinical staff (p-value 0.0048 at 95% CI). However, this did not affect the willingness to report to work in either group (p-value 0.1456 at 95% CI). Collectively, those who considered their job roles to be crucial during the emergency response reported willingness to report to duty (p-value 0.0493 at 95% CI), as shown in figure 2.

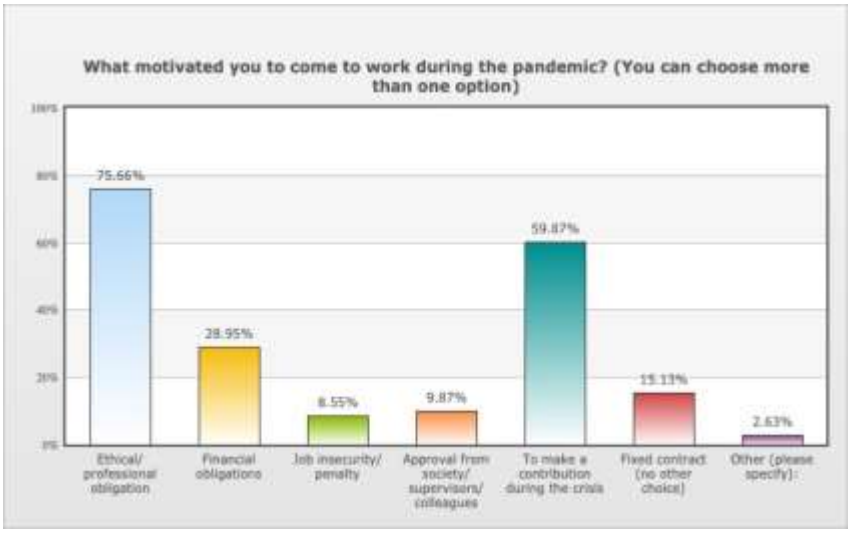

Figure 2: Motivators for reporting to work during COVID-19 pandemic.

Over a half of respondents (58.6%) stated that they gained new skills during the COVID-19 pandemic due to redeployment to other areas. Majority of changes to work pattern were fewer face to face consultations, as shown in figure 3.

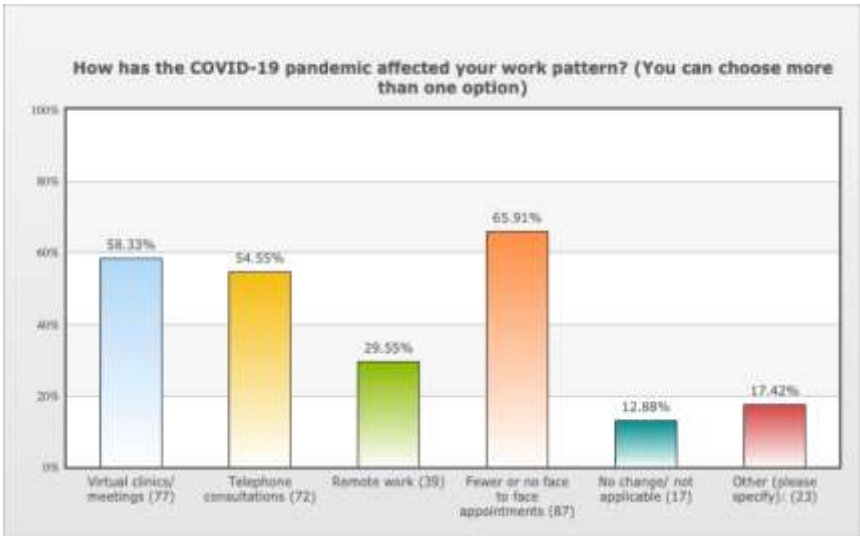

Figure 3: Changes in workload.

16.5% of the respondents felt they did not have enough support from supervisors or managers while 39.5% of the responders considered always well supported during the pandemic. There was no difference amongst clinical and non-clinical HCWs about the support from supervisors or organisation (p-value 0.956 at 95% CI). 37.5% HCWs in this study stated that there was no difference in colleagues' behaviour during the crisis. However, 62.5% of the study participants felt that the pandemic has created an excusable environment for colleagues to not contribute to work efficiently, voicing out feelings of resentment and hostility. However, attitudes and behaviours of colleagues did not affect the willingness to report to work (p-value 0.1714 at 95% CI).

There was no statistically significant association between job role and loss of confidence in skills (p-value 0.846 at 95% CI). Approximately 67% of respondents expressed anxiety and depression. Amongst HCWs, females feel more anxious and depressed than males (p-value 0.0043 at 95% CI). A third of respondents stated that they were losing their skills while 36.9% felt less confident in themselves or their work. Almost 68% of respondents reported feeling overwhelmed during the crisis. 40.1% of respondents stated that they were able to enjoy day to day activities while 82 (53.9%) stated that they could not enjoy day to day activities.

Additionally, the well-being services specifically aimed for well-being of HCWs did not show to be effective in abating HCWs anxiety and depression (p-value 0.846 at 95% CI). As shown in Table 2, almost a half of respondents felt appreciated in the society (51%) and by friends or family (43%), whereas a minority reported that they are much less appreciated. Almost 40% of respondents believed that there was no change in

appreciation from the public before and after the COVID-19 outbreak. However, 65% of respondents felt that their friends or family avoided them from fear of getting infected with COVID-19.

Table 2: Explores the psychological impacts of COVID-19 on HCWs.

	Much lessthan usual	Same as usual	More than usual	Much morethan usual	Response (Total)
Felt overwhelmed	3.9% (6)	28.3% (43)	48.7% (74)	19.1% (29)	152
Felt anxious or depressed	5.3% (8)	27.6% (42)	45.5% (69)	21.7% (33)	152
Felt like you were losing yourskills	15.8% (24)	53.9% (82)	25.7% (39)	4.6% (7)	152
Felt less self-confident inyourself or in your work	13.8% (21)	49.3% (75)	28.3% (43)	8.6% (13)	152
Felt appreciated by thesociety/ public	7.9% (12)	40.8% (62)	39.5% (60)	11.8% (18)	152
Felt appreciated by family andfriends	3.9% (6)	52% (79)	32.9% (50)	11.2% (17)	152
Been able to enjoy your normal day-to-day activities and feeling reasonably happy,all things considered?	53.9% (82)	40.1% (61)	3.3% (5)	2.6% (4)	152

DISCUSSION

HCWs have a pivotal role to play in containing and minimizing the risk of spread of infection during a public health emergency. As an occupational health risk, HCWs are routinely exposed to COVID-19 but also can be a source of transmission of this highly transmissible infection.

Amongst respondents belonging to both genders, a vast majority indicated that the pandemic did not influence their willingness to work during the crisis. However, these findings contradict findings from the study by Gottberg et al.,[13] which suggest that males are more likely to report to work as compared to females. Nevertheless, there are similarities in some findings from both the studies indicating age and experience of HCWs influence willingness to work, as more experienced HCWs are readily willing to work during the crisis despite the risks involved and experienced HCWs may exhibit more confidence and competence in providing emergency care.

Majority of the respondents of this study did not take time off from work during the crisis. Similar to findings from other studies, the main motivators for HCWs to report to work were ethical or professional obligations and a sense of duty towards the patients, considering it unethical to abandon their professional duty in the face of a crisis.[23,24,25,26] These findings reflect intrinsic motivations to be strong drivers for willingness to work during a crisis, overpowering the extrinsic motivations of financial incentives or promotion. Financial obligations and fixed contract were reported by some respondents, while for some approval from society, peers and colleagues were the main influencing factors to report to work. Some respondents in this study showed apprehension about job and financial insecurity during the pandemic resonating with results from other studies. One respondent reported work was an avenue for social contact and helped in uplifting morale and mood. Results of this study are also comparable to those from previous researches which state that importance of job role is an important motivator in willingness to work during a crisis.

Interestingly, respondents belonging to high risk of acquiring COVID-19 showed greater willingness to work as compared to those with minimal or low risk. This correlates with the results from various other studies which established an association between willingness to work with perceived threat and risk of acquiring infection.[11,21]

The results from the current study parallel those from other studies[24,29,30] which concluded that concerns for transmission of infection to family and loved ones was a major source of concern for HCWs as compared to risk of infection to themselves. Other factors affecting wiliness to work were unsafe public transport, insufficient workspace and childcare responsibilities as HCWs had to work while all schools and childcare facilities were closed during the lockdown. Another significant finding from this study was the workforce shortage affecting willingness to work during the crisis, which correlates with findings from literature[19,18,27,28] which concludes that there is added pressure on HCWs from increased treatment needs, colleagues' absenteeism and role delegation or substitution can result in burnout and suboptimal quality of care. Added workload may be a burden on those who are reporting to work dueto colleagues who were self-isolating, shielding, unwell or working remotely. This may also contribute to development of feelings of bitterness and resentment[18,21,23], which has also been reported by respondents in this study. Findings from this study also reveal that HCWs were apprehensive about unsafe work environment and the use of PPE. Many participants find the usage of PPE affecting their work, as extensively reported in literature.[5,6,14,15] The main challenges faced by HCWs were time consumption, limitation in visibility, difficult in communication with patients, restricted mobility and steaming up of goggles or visors.

Participants in this study have been redeployed from

one department to another, other parts of the hospitals or support team. Although a few have taken this to be a constructive learning experience in their careers, others have been resentful because this was a decision imposed on them. The results of this study demonstrate that 44% of the HCWs reported that their job roles have become unclear, while more than half were required to perform tasks that they were not used to or that was not in their job plan prior to the pandemic outbreak. Redeployment, reconfiguration and task delegation or substitution can bring opportunities in refreshing knowledge, enhancing and developing new skills. The results of this study coincide with evidence from several studies[15] which suggested redistributing or delegating tasks can aid in development of new skill set or enhancement of current skills. The participants of this study reported development of skills in IT, spreadsheets, meeting handover and assessments, development of new services and educational system, developing telephone and video consultation skills in 111 telephone triage, learning skills from redeployment in different wards (COVID-19 hot-zone wards) and updating knowledge and skills for retired healthcare contributing to the pandemic by returning to work.

The findings of this study correlate with findings from previous studies[19,20,21,23,17,28] which reported that HCWs may be stigmatized or ostracized by public or friends and family because of their profession. There is a statistically significant link between avoidance from family and friends with feeling of anxiety and depression amongst HCWs in this study. More than half the participants in this study (63%) felt that their friends or family avoid them from fear of acquiring the infection through them. On the other hand, most respondents felt generally appreciated by the society (51%) and friends and family (44%) during the crisis. These findings are contradictory in a sense that although the public appreciated the role of HCWs during the COVID-19 pandemic, they still face apprehension in sharing physical space with them, fearing transmission of infection as healthcare facilities have the highest risk of infection transmission.[29,30] Findings from this study also complement the results of other studies[5,9,14] which suggested that female HCWs felt more anxious, overwhelmed and depressed than males, which may have a background of childcare responsibilities, emotional vulnerability to avoidance from friends and family as their professional and personal life is heavily intermingled as compared to male HCWs.

Almost one third of the participants in this study reported that they were losing their skills in work and their self confidence in work was lower than usual, two thirds reported that their skills and confidence remained the same. These findings are comparable to those by Koh et al.[14] which suggested that during a crisis, some HCWs may feel their skills have enhanced or refined, while some feel that they are losing skills. For some HCWs, working during the crisis in an emergency situation might bolster their confidence and self-esteem, it may be the opposite for others. More than half of the respondents stated that they felt despondent in the face of the pandemic and were unable to enjoy day to day activities. This feeling of despondency may arise from chronic stress, anxiety, depression, working in a high-pressure setting fuelled by uncertainty and helplessness, working in an unsupported environment, living in a threat for self and loved ones, as supported by various studies.

The lessons learnt from past public health emergencies should have equipped healthcare systems across the world to be better prepared to cope with an unexpected pandemic. Although UK has by large and far implemented many policies and protocols to manage the crisis, contain the spread and support the healthcare staff during the crisis, HCWs and public were not entirely satisfied with the swiftness of the response or how it has been managed. HCWs have shown equanimity, fortitude and courage in the face of a crisis caused by an unknown and lethal entity but due to the uncertainty and novelty of the virus and disease, they have been subjected to various forms of stress. In order to maintain the functioning of a burdened healthcare system and to prepare for a second wave, a strong healthcare workforce is essential. Which is why there is an urgent need to address the challenges faced by HCWs during the pandemic so they can be supported economically, socially and professionally.

CONCLUSIONS

The physical impact of COVID-19 has not been burdensome on HCWs as the findings of this study indicate that HCWs workers have not been required to work longer or extra shifts during the pandemic. However, this cannot be generalised across the entire UK healthcare workforce. . Healthcare wellbeing policies have integrated measures like frequent breaks during shifts and prophylactic absenteeism to maintain a steady reservoir of HCWs without affecting the normal workflow. The most significant impact of COVID-19 was on social, professional and psychological aspects. COVID-19 pandemic impacted HCWs socially where they feel ostracised or avoided by public, friends and family. Although this is very diluted in the UK as compared to other countries in the world where the reaction of the public to HCWs is disheartening, HCWs still felt apprehension about the attitude of the public towards them. The psychological impact of COVID-19 was substantial. HCWs fear for their own health and the health of their families and friends. HCWs suffered from anxiety, depression, PTSD, moral injury and feeling of desolation due to the crisis. These feelings arose from unsafe work environment, fear of infection and transmission to loved ones, unsupported workplace and added workload. Although the government, employers and the public have appreciated HCWs for their valiant efforts during the pandemic, they still felt unappreciated. Most respondents reported that well-being

initiatives at workplace helped them cope with the stress from the crisis but some reported that they did not help them at all, which suggests that management support and acknowledgment of their work as individuals is more important to HCWs as compared to generic well-being initiatives and activities. COVID-19 affected HCWs professionally as well where some HCWs felt that they lost skills or confidence in their work, felt their job role became irrelevant or secondary. For some, the increased workload and transformed service and work pattern was a source of fatigue or burnout and affect the quality of care. Some HCWs were redeployed and felt resentment about this imposition while some felt this gave them an opportunity to explore avenues and develop additional skills. Work pattern changed as an emergency response with heavy dependence on IT and digital infrastructure, which was readily accepted and adapted by HCWs. Perhaps the most significant finding of this study was the lack of support from the employers, management or supervisors. HCWs want acknowledgement, better guidance and communication, up to date information, clarity about their job roles and inclusion in decision making. HCWs want to be heard, acknowledged and felt valued. This could be done by listening to the challenges they faced, acknowledging their hardships, giving support in any form, making them feel that their work is contributing towards the crisis management as an equally valuable member of staff.

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APPENDICES
Appendix A – Consent for participants.

Appendix B – Questionnaire for participants.

Barts and The London
Queen Mary's School of Medicine and Dentistry

The Impact of COVID-19 on healthcare workers in the UK

1. Gender?

- ☐ Male
- ☐ Female
- ☐ Prefer not to say

2. Age?

- ☐ Under 20 years
- ☐ 20-29 years
- ☐ 30-39 years
- ☐ 40-49 years
- ☐ 50-59 years
- ☐ 60 +

3. What is your personal experience of COVID-19?

- ☐ No suspected COVID-19 symptoms
- ☐ Suspected COVID-19 symptoms
- ☐ Tested COVID-19 positive
- ☐ Tested COVID-19 negative
- ☐ Hospitalised for COVID-19

4. Have you had the COVID-19 antibody test?

- ☐ No

☐ **If yes,**

- ☐ Tested positive to antibodies
- ☐ Tested negative to antibodies

5. What is your job designation?

☐ **Clinical staff**

- ☐ Doctor
- ☐ Dentist
- ☐ Nurse
- ☐ Physiotherapist
- ☐ Healthcare assistant
- ☐ Occupational health therapist, Speech & language therapist
- ☐ Radiographer & radiologist
- ☐ Pharmacist
- ☐ Dietician/ nutritionist
- ☐ Physiologist
- ☐ Other

☐ **Non-clinical staff**

- ☐ Administration and management
- ☐ Security staff
- ☐ Estates and facilities personnel
- ☐ Switch board operator/ reception
- ☐ IT/ support staff
- ☐ Laboratory technician
- ☐ Research and development
- ☐ Any Other
- ☐ Other (please specify)

6. How has the COVID-19 pandemic affected your work pattern? (You can choose more than one option)

- ☐ Virtual clinics/ meetings
- ☐ Telephone consultations
- ☐ Remote work

- ☐ Fewer or no face to face appointments
- ☐ No change/ not applicable
- ☐ Other (please specify)

7. Are you in one of the groups at higher risk from coronavirus? If you are unsure you can check here https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk-from-coronavirus/whos-at-higher-risk-from-coronavirus/

- ☐ No
- ☐ Yes, in the moderate risk group (clinically vulnerable)
- ☐ Yes, in the high risk group (extremely clinically vulnerable, shielded)

8. At any point, did COVID-19 pandemic affect your willingness to work?

- ☐ Yes
- ☐ No

9. Which of the following affected your willingness to report to work? (You can choose more than one option)

- ☐ Fear of acquiring infection or transmitting to family members and others
- ☐ Unsafe public transport
- ☐ Childcare responsibilities/ dependants at home
- ☐ Personal/ family health issues
- ☐ Other HCWs/ patients/ general public do not adhere to infection control measures
- ☐ Shortage of staff leading to increase in workload (due to illness/ self-isolation/ shielding)
- ☐ Insufficient workspace available to maintain social distance
- ☐ Other (please specify):

10. Did you take off from work during the pandemic due to any of the reasons mentioned above?

- ☐ No

☐ **If yes, how many days?**

- ☐ Less than 1 week
- ☐ 1 week
- ☐ 2 weeks
- ☐ 3 weeks
- ☐ 4 weeks
- ☐ >4 weeks

11. What motivated you to come to work during the pandemic? (You can choose more than one option)

- ☐ Ethical/ professional obligation
- ☐ Financial obligations
- ☐ Job insecurity/ penalty
- ☐ Approval from society/ supervisors/ colleagues
- ☐ To make a contribution during the crisis
- ☐ Fixed contract (no other choice)
- ☐ Other (please specify)

12. How has the pandemic affected your workload?

	Much less than usual	Same as usual	More than usual	Much more than usual
Working hours	☐	☐	☐	☐
Number of shifts	☐	☐	☐	☐
Workload (meetings, clinics, calls, paper work, patient care andcommunication)	☐	☐	☐	☐

Please elaborate (optional)

13. During the Pandemic, has your work role changed/ have you been redeployed?

	Yes	Sometimes	No
Your job role and responsibilities have become unclear?	☐	☐	☐
Are you required to perform tasks that you normally do not have to?	☐	☐	☐
Do you feel your job role has become secondary/ irrelevant?	☐	☐	☐
Do you feel your job role is crucial in the emergency response to the crisis?	☐	☐	☐
Did you develop new skills during the pandemic (due to deployment/ change in job roles)	☐	☐	☐

Please elaborate (optional)

14. This section is about the organisational preparedness, availability of information and resources

	Always	Most of the time	Sometimes	Not at all
Do you feel you have access to clear guidelines and up to date information about COVID-19?	☐	☐	☐	☐
Have the well-being initiatives at your workplace helped you copeduring the crisis?	☐	☐	☐	☐

15. Support from family, friends and colleagues

	Always	Sometimes	Not at all
Do you feel your family members or friends avoid you from fear of gettinginfected?	☐	☐	☐
Do you feel that the pandemic has created an excusable environment for your colleagues to not contribute to work efficiently?	☐	☐	☐
Do you feel you have sufficient support from your supervisors/ managers?	☐	☐	☐

Please elaborate how your supervisors/ managers/ colleagues can support you? (optional)

16. What is the impact of PPE on you or your work comfort (You can choose more than one option)

- ☐ Makes your work difficult
- ☐ Makes you slightly uncomfortable
- ☐ Time consuming
- ☐ Not applicable/ Does not affect yourwork

Please elaborate (optional)

17. We would like to know how you have been feeling over the past few months. Please answer the following questions by ticking the box that best applies to you. Have you recently....

	Much less than usual	Same as usual	More than usual	Much more than usual
Felt overwhelmed	☐	☐	☐	☐
Felt anxious or depressed	☐	☐	☐	☐
Felt like you were losing yourskills	☐	☐	☐	☐
Felt less self-confident inyourself or in your work	☐	☐	☐	☐
Felt appreciated by the society/ public	☐	☐	☐	☐
Felt appreciated by family and friends	☐	☐	☐	☐
Been able to enjoy your normal day-to-day activities and feeling reasonably happy, all things considered?	☐	☐	☐	☐

Comments:

Appendix C - Descriptive answers

DESCRIPTIVE ANSWERS

AnswerText: 3. Which of the following affected your willingness to report to work? (You can choose morethan one option)
Unable to do my job as I used to and giving advice over the phone did not feel right.
Stress of change in work patterns and workload
Lack of appointment time and nurse assistance
No cover available during shortage of staff
none
Shortages of PPE
Multiple colleagues off from work long term and still awaiting occupational health review
Lack of adequate PPE
Long hours in full PPE: constantly feeling unwell- headaches, sinus issues, cystitis symptoms. Constantfatigue, sheer exhaustion.
Not much support from service manager, difficulty procuring scrubs/ PPE, expectation by clinical lead to carry on as usual, being caught between differences between colleagues' approach to the pandemic
My son is shielding and lives with me
I have gone to work every day. When colleagues at the main hospital site were not socially distancing, I refused to attend meetings until eventually they introduced TEAMs to the directorate SMTs. Seeing so manyfriends being able to work from home (or not work at all) has made me quite resentful!!
Being made to work over my normal hours by at least double was difficult but given no choice.
People not working from home when they could have done. People working across 2 sites. My suggestions not being discussed/adopted
Bullying
Lack of PPE

AnswerText: 2. Question: How has the pandemic affected your workload?
Same conversation with two different parents on ward as both can't come in; additional time pressures due to PPE and notes not being allowed in rooms
Longer appointments for f2f because of cleaning and PPE, feels like continuous clinical work, whether phone consultations or f2f
A lot more notes to be written, screenings to be done, PPE to be worn making the day extremely difficult.
The workload in cancer management initially significantly decreased due to the uncertainty of the expected duration of pandemic and the reactive public aversion to healthcare environments. Now that it is much clearer

that this pandemic will be long lasting, patients are presenting to hospitals and being late diagnosed with more
advanced cancers, resulting in significantly higher healthcare resource requirements and huge increase in workloads for our services which is likely to be very long lasting
Amount of reading to understand pandemic. Extra note taking and communication with patients to explain things.
Same workload but content of work very different - shift rather than routine duties, much more remote work, more meetings, less face to face patient contact.
Nobody was there to cover me and clinics. Everything had to be fixed within the working hours.
Special focus has been noted on meetings/projects to increase compliance/safety once things return to normal.
this pandemic has made the workload excessive which is putting a lot pressure of us to get the work done.
Concerned patient phone calls enquiring about clinic attendance, where they can go to have a test done.
I have changed my contracts four times and had to complete more admin to get resources to and from clients.
Finding telephone consultations take longer than face to face appointments, also did extra telephone 111 shifts.
I work in SRH. I set up an early abortion clinic at the end of April. This has hugely increased my workloadwith no funding or extra pay
Set up new abortion service in NI
Initially much reduced f2f but now a lot busier, appointments full but gaps between for changing PPE and cleaning between.
We have had to embrace a Different way of working. All patients are telephone triaged then have possiblyvideo or face to face review if needed. Tel consults are time consuming as need to assess whether risk of seeing face to face is justified and will change management.
Redeployed to ITU from community. Usually work with health visitors as community staff nurse. Felt rewarding but exhausting.
Working 60+ hours per week
This is hard to answer. As lead of the service going into lockdown and now easing restrictions workload is phenomenal and I cannot cope especially trying to reconfigure clinics. In the height of lockdown, it was much easier and less busy.
Week on, week off from work in teams to protect staff. To start with, now the workload is increasing but we have started new ways of working to do this, more telephone consulting and less face to face interactions.
Short notice changes from government /Trust
Lots of online meetings
In mental health, our work hasn't slowed down, just got busier
12-hour shifts with only a half hour break Expected to work weekends/Nightshift etc when I would usuallywork Mon-Fri. Haven’t worked on a ward for 15 years. Physically and mentally draining as insufficient training given
Overall hours the same but more antisocial hours-long days/nights to cover rota gaps (more than appropriate LTFT quota)
Had to rewrite whole operational policy for service and update all clinical protocols
More remote consultations and more clinics trying to catch up the lost clinics that were cancelled in the early days
Longer days
As nurse lead for branch surgery, it has been necessary to 'reinvent' clinics to manage patient demands and protect the surgery and staff. Additionally, we have had to recruit locum staff to cover for nurses not doing f2f work.

AnswerText: 6. During the Pandemic, has your work role changed/ have you been redeployed?
Developed use of Lync systems for meetings handover and assessments
Better infection control training. Exposure to different clinical environments and increased interaction withother medical specialities. This effect, however, is not very significant and I do not feel has had a positive impact on my medical career.
Ventilator assistant
Played role in developing trache service, particularly education component for wider team as well ascontributing to performing the actual surgery.
patient communication skills
Learning new programs (zoom, teams, attend anywhere)
No clear instructions as to whether patients should be seen face to face or telephone consultation only. Lots of confusion.
Redeployment to urgent care centre. Increase in computer skills, use of spreadsheets etc

A non-clinical role was switch to 111 telephone triage. Have gained new skills in telephone consultations and video consultations (would not normally do video consults).
Telephone triage, video consultations.
New early medical abortion service developed
Usual role less contact but much more service and reshaping of services which is interesting.
Doing shared phone calls meant dealing with things I have not managed for years.
Wearing PPE, using video conferencing
Embracing technology, I had never used video consults before, now regularly use them, using technology to allow patients to send photos.
Redeployed from community staff nurse (health visiting) to ITU
Underwent some medical training in preparation for redeployment
Ability to assess patients via phone consultations- checking confidently, accepting loss of nonverbal clues
Not crucial to tackling corona - but crucial to patients ongoing health
Figuring out new ways to do things to keep everyone as safe as possible
Use of entonox in department, dealing with trauma
I faced the pandemic as if in military mode, but my employers were not used to this approach from me and hada more liaise faire response & awaited government advice/guidance
Adapting to communication without face to face contact whilst maintaining safe practice and managing risk.
Pulled to 100% clinical from 50/50 academic. More focus on clinical care.
Impact on education, fewer parental interactions
Recognising/ working with COVID patients in Hot Zone. Different ways of delivering Oxygen/ respiratory medication to limit Aerosols.
Video consulting Using new ways of consulting remotely such as AskmyGP
Did some policy review, National guidance contribution, CQC review
Redeployed to adult ITU
Telephone and remote consultations that I hadn't done before really. Plus being redeployed to other areas ofthe hospital for occasional shifts and support of teams
After 20 years out of Obs and Gynae I returned. I learned to do manual vacuum aspiration for miscarriagesand initiated contraception on the wards, so that this is now becoming almost normal (midwives realised wewere not overdosing their women with hormones in contraception) but sparing them being one of the 200.000+ abortions per year!
As an ANP my job changed overnight. I was needed to cover for practice nurse colleagues who were no longer seeing patients f2f. Telephone work changed from basic triage to total triage. Plus, management of nurse clinics and access to appointments plus PPE considerations added significant pressure.
Assertiveness
Redeployed to manage two COVID wards

Answer Text: 7. Please elaborate how your supervisors/ managers/ colleagues can support you? (optional)
More guidance and better communication
Clear instructions that do not change every 5mins!
By providing safe work environment. As work is overloaded atm they can offer help to share duties notmaking staff multitask.
Allow more control at various levels in a flexible way rather than top down approaches which may be invalid
To push for better testing of staff and their family members. The initial and recent guidelines for testing are an obvious attempt to reduce staff eligibility for testing, thus saving resources which is understandable but not excusable when applied to an essential workforce. Increase availability of IT equipment to support remote working Increase availability of clinic space and required equipment such as phones to allow telephone consults. Streamline processes around test requests and booking appointments which are highly bureaucratic and have multiple points of failure with no standardisation in conduct between clinicians
Extend appointment time, provide nurse assistance and provide necessary PPE without cost to us.
Frequent calls and updates
Clearer guidance on process of virtual clinics/calls. Clearer idea of what is happening in the future andcurrently in the workplace. better communication with the whole team not just certain people.
People working from home for 3 months or so do not contribute to work and also have less workload. they do not have to answer phone calls. There IS nobody to support me with the added workload and managers do not understand that. They want the job done without understanding the situation we are in. They can appreciate my work and commitment at the least.
Continue to support us by maintaining social distancing and also preventing doctors in scrubs from enteringthe

admin office.
more information about guidelines
Can feel unsupported when working from home and not having regular meetings. Difficult when have to ask my colleagues who are lower risk to see patients on my behalf and they have different thresholds and may not want to see the patients.
I've relied on government and professional guidelines. I've liaised with other colleges outside my practice. I would have liked more podcasts and information that didn't require a huge amount of reading.
Just asking how we are
Managers who are actually trained nurses could actually do clinical work with patients or at least cover so staff can take a 10 minutes break.
The managers should have got in touch and acknowledged that this was a difficult situation for all of us providing a clinical service, asked about well-being of staff, checked whether we had PPE, staffing issues etc. Due to the merging of trusts a while back, the line of management is not clear, and we feel forgotten and left on our own with no support to the service lead consultant who is trying to do the best that can be done
Managers governed from above….
I work in a satellite mental health unit. Nursing concerns have repeatedly been ignored throughout this crisis. Government guidelines have been repeatedly flouted. As a consequence, a patient was admitted whom the consultant/management team were aware was showing symptoms. They would not allow us to isolate him for7 day and withheld the information that he was suspected positive. As a result, 9 other patients and 7 staff developed COVID-19. So, in response to your question, any support would be positive.
I feel the NHS managers have not kept me in the loop sufficiently and now are creating endless recovery documents for me to complete that are not fit for purpose - when I need to get on with the work. It is the usual hindering management bureaucracy.
Good communication, considering people as individuals not just treating everyone the same when we are all different!
Being more involved, being more aware of staff situations, health, home situations.
While support has been offered via links to NHS recommended groups, actual support in response to my comments were not taken on board
Bullying and harassment
Managers have not instilled infection control procedures. Not ensures PPE is worn. The trust has provided all PPE however this has not been used by staff. There has been no social distancing and there are too many people working in close environments.
Sharing their rationale on changes to services so that we could contribute our thoughts on how less emergent workload could be managed during the crisis. Currently everything is just turned off and patients in the community are being left waiting or receiving riskier care (ie: only telephone appointments with limited facility to safely bring someone in to examine them).
Manager didn't call once when I tested COVID positive or complete a return to work interview.
By following guidelines
Communication wasn't great. I was redeployed away from my regular (still vital) role, lack of training provided for the new ward-based role. Luckily, I had worked in similar capacity only 3 years prior, I could dothe job, I resented having no choice, it felt like being parachuted in and told to just get on with it.
Taking time to acknowledge the extra workload with increased antisocial hours, Rota uncertainties and last-minute night shifts, as well as increased pressures at home. Acknowledging and trying to work our solutionsfor lack of rest space due to social distancing and nowhere to do private study or admin work.
My main issue is with CQC as we had just been through a bruising and exhausting 8 months of 4 inspections, jumping through hoops, that it transpired adding nothing to our preparedness for a pandemic. The concern that many of the changes that we had to make to stay safe and maintain our service would not meet the convoluted CQC requirements was overwhelming initially and, in the end, made a mockery of all the work we had engaged in for the preceding 8 months. Also, I and my manager then went into this crisis in a state of near burn out.
Unfortunately, manager was not capable of supporting anyone. Wouldn't listen to anyone else. The fallout inthis particular place of work, because of her, led me to hand in my notice.
No training for holding the risk associated with telephone clinics. No offer of training or even an interest in how to manage patients differently. No interest from the clinical director of the department in engaging with the support offered by the Trust to look at the challenges people have felt during COVID. No engagement withthe feedback mechanism to the Trust for issues by the clinical lead of the dept as felt it was 'unnecessary'. I think the leads were of the opinion that everyone should suck it up and crack on and that those who had to shield were work shy and not pulling their weight (not true at all). I think in these extraordinary times, there should be a responsibility of all to acknowledge that everyone has different struggles and is dealing with so much more outside of work than normal. There was such little grace shown and little compassion to those in the team who

were frightened or anxious. It was quite shocking and an eye opener as to people's true colours. It is very hard to teach this kind of thing or help people see and change their views or that their ways of managing could potentially be hurtful or harmful.
Better/ more comprehensive communication and clearer time scales. More involvement in decision making.

AnswerText: 8. What is the impact of PPE on you or your work comfort (You can choose more than one option)
More than slightly uncomfortable
Depending what masks to wear, my line of sight can be impaired. It's slightly uncomfortable but not a major problem. Main problem is time. In addition, there's a further cost incurred to launder everything separately.
Unable to deal with telephone work and distressed patients. Humidity, Temperature and confined space makes work and social distancing difficult.
Very uncomfortable, difficult to wear in hot weather
Frequent changes in PPE policy - what required lower level PPE one week requires full PPE the next day. Mask brand and type changed frequently (often years past use by date - one brand expired 2016) so caution required to ensure elastic does not snap. Very challenging to communicate, particularly when trying to clearareas to allow x-ray exposure. Delays work significantly
Goggles / visors steam up
It get too warm and glasses steam up
work in a prison. Prison currently states we should not wear masks
We got our own PPE as what was provided was inadequate
Makes some procedures more technically challenging e.g. Poor visibility through face shields. Does takemore time to see patients but this is necessary to try and reduce risk of spread.
Feel hot Glasses steam up But appreciate need to wear it and that it's available
Not enough time allocated for donning and disposal of PPE and cleaning work area between patients
And ineffective
Had my fist needle-stick for over 30 years Can't think properly as concentrating on my steamed-up glasses. Taken the naturalness out of F2F consultations
Visors and mask wearing steam up glasses at times ..depend on which brand PPE available
Trust provide all necessary PPE however there is no adherence to the use of PPE where I work by my colleagues.
They are horrible to wear when it's hot, and I don't see the point in aprons and gloves which we are being provided for
Having to factor time in my week to physically collect the PPE from 1 particular health centre.
I changed from FFP Mask and visor to hood with ventilation. Game Changer (better communication /massive difference in personal comfort)
Difficult to communicate sensitively with families at a stressful time. Difficult to hear colleagues/ be heard properly
As a doctor with a significant hearing problem masks present a particular difficulty as I rely significantly on lip reading. It would be helpful if decent window masks for patient use in clinical settings were available. I am using the equipment I have available, but it remains more exhausting than it was. Video is also more tiring especially teams' meetings though this is better than just audio
esp. because have asthma
One of the worst things about an adult COVID, it was PPE, impacting physically but also psychologically as it impedes communication
The worst is not being able to reassure the women during a procedure with my facial expressions. All women have been very grateful, so the discomfort doesn't matter.

AnswerText: General well-being and mental health
On a general level the pandemic has been tough on my colleagues and equally on me. The single biggest source of stress and depression for me has been the conduct of the Home Office which has announced extension of visas for NHS workers publicly. However, in reality there are a large number of specific guidelines which excludes a significant portion of NHS staff from these benefits including myself which has resulted in all the same financial pressure on me as usual but an increased amount of stress due to the Home office not performing their duties for many months, stopping their priority service resulting in all members ofsociety requiring their services to suffer including NHS workers.
Having worked for 27 years in dentistry to suddenly have 3 months at home to myself to suddenly be going back with increased health risk, no extra help to do what is already a stressful job, dealing with a general public

who are now freaking out about a pandemic and attending a place they don't like to be at the best of time. Under these conditions is so stressful I'm thinking that I can't cope, I'm going to have to sell my houseand the few minor assets I've worked incredibly hard for all of my life since school, so I will have to changemy entire lifestyle to one that is affordable on far less money.
Feeling of anxiety - Not knowing if you are positive or negative until you get tested. Queueing up at shops for hours just to purchase one item. Colleagues self-isolating causing strain on workload.
Lack of communication. No new policies issued. Told to use own initiative No rota to minimise number ofstaff in practice at any one time, Staff suffering from fatigue. If time taken off it was unpaid or had to use holiday. Management should address all these.
Reduced time with my kids, both also NHS workers and mixed race so we have kept apart as I am worried thatI might pass it to them should I contract COVID and they could be more seriously affected than me. This has been the hardest part for me.
Difficult times
During the height of lockdown, I was able to learn new skills e.g. not work related ... now I am about to have a breakdown - I am completely worn out and cannot see an end to this.
Enjoy day to day activities as husband at home, I work part time as so we have had more time to enjoy.
Due to the trauma of my redeployment, lack of support and training. Issues with PPE/Policies etc I experienced my first panic attack at work on the ward which has led to Anxiety and Depression. I have recently had Rapid Intervention for suicidal thoughts. I am recovering but strongly feel let down by the trust. Ihave 25yrs of nursing experience and I have never felt like this or experienced any Mental Health Issue. My redeployment was forced upon me. The lack of training and support is a major factor to my traumatic experience, and I feel could of been avoided. I will never let this happen to me again
I recognise that I remain close to burn out despite actively managing this, but this is largely due to coming into the pandemic in that state because of CQC in the run up.
Missed exercise as gym closed. This helps me unwind from work. Very limited options available at the start of pandemic due to increased hours of work
More emotional burden both in and out of work has taken a toll. Work colleagues becoming more and more stressed has also become more difficult in the workplace. Moral injury is high - the feeling of not being able to do the best job possible because of all the constraints is a heavy burden to carry.
Covid-19 and its management has left me feeling miserable, stressed, frustrated, irritable and angry both in my personal and professional life. I have no fear or worries about contracting the illness. I feel the handling of the crisis has been appalling and has left us with years of potential misery. I am disappointed with colleagues who have been, and continue to be, reluctant to see patients f2f despite high levels of COVID security in primary care but seem happy to watch other members of their team shoulder the burden. The potential long-term impact of COVID-19 on how I manage personal life makes me feel miserable.