Maternity Service Changes during Covid-19: Staff Perspectives

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Key Points from Staff Survey

- 186 healthcare professionals completed the survey. Most respondents were from London and Wales and 50% of respondents were midwives or student midwives.

- 93% of the healthcare professionals surveyed reported changes to maternity choices in their area due to Covid-19.

- The main reason selected for changes to maternity choices was safety for mother and baby.

- 45% of staff who reported changes to maternity choices in their practice selected 'Lack of Staff' to be one of the key reasons for these changes.

- Healthcare professionals from London were more likely to report a lack of staff as contributing to changes to maternity choices. Whereas healthcare workers from Wales were less likely to report a lack of staff.

- Midwives were more likely to report 'safety of staff' as a key reason for changes to maternity choices compared to other healthcare professions.

- 49% of healthcare professionals surveyed reported that the only emotional support they have received during the Covid-19 crisis has been in the form of peer support from colleagues.
    - *'We should be acknowledging the impact of this trauma on our staff, whatever their role as it doesn't just affect those providing direct care'*

- A further 31% of healthcare professionals reported that they have not received any emotional support.
    - *'I've never wanted to leave the profession more'*

- There does not appear to be many differences between regions of the UK, yet this could be due to the relatively small numbers of respondents in some regions.

Introduction

During the first wave of the Covid-19 pandemic there were a number of changes made to maternity services, in order to minimise the spread of the virus, and manage the pressure on services. Some of these changes included: a reduction in face-to-face antenatal appointments; no home birth/midwife-led unit provision; redeployment of maternity staff; and birthing partners not being able to attend antenatal appointments or offer support until labour had progressed (Relph, Jardine, Magee, et al., 2020; Rimmer, Wattar, Members, 2020). At that time little was known about the impact of Covid-19 on pregnant women. However, research has emerged which indicates that compared to non-pregnant women, there is no greater risk of severe illness from Covid-19 for pregnant women, although there might be an increased risk for them requiring admission to intensive care (Knight, Bunch, Vousden, et al., 2020; Allotey, Stallings, Bonet, et al., 2020; Williamson, Walker, Bhaskaran, et al., 2020; MBRRACE, 2020).

As the widespread of the virus reduced, Covid related restrictions eased in response, and for a short period many people began to slowly return to their normal way of life. Despite the government encouraging maternity services to resume as usual, many Trusts continue to restrict birthing partner's access to antenatal appointments/early labour, and limit the birthplace provision. In our previous report which surveyed 485 women, the psychological impact these changes have had on them, and their birth partners has been significant (Baptie, Baddeley, Smith, 2020). For some maternity services, their staffing levels haven't returned to usual, and so they have been unable to provide what they typically would. This has been further impacted by delays in accessing tests (and receiving results) for staff or their family members who display Covid symptoms. Also, as children have returned to education and there have been outbreaks there, staff have had to be with their children as they self-isolate.

Before the pandemic hit, the UK midwifery workforce reported high levels of anxiety, depression, stress and burnout (Hunter, Fenwick, Sidebotham, et al., 2019), particularly in younger, more recently qualified midwives, and those self-reported as having a disability. For obstetricians, 2 in 3 have reported experiencing a traumatic work-related event, out of 728 clinicians (Slade, Balling, Sheen et al., 2020). Given the radical changes maternity services have faced, it is likely that mental wellbeing has further deteriorated for many staff.

The aim of this survey was to better understand the changes maternity services had undertaken during Covid-19, and its impact on women, from staff perspectives. Also, the emotional impact these changes have had on staff, and the support they received to manage this effectively.

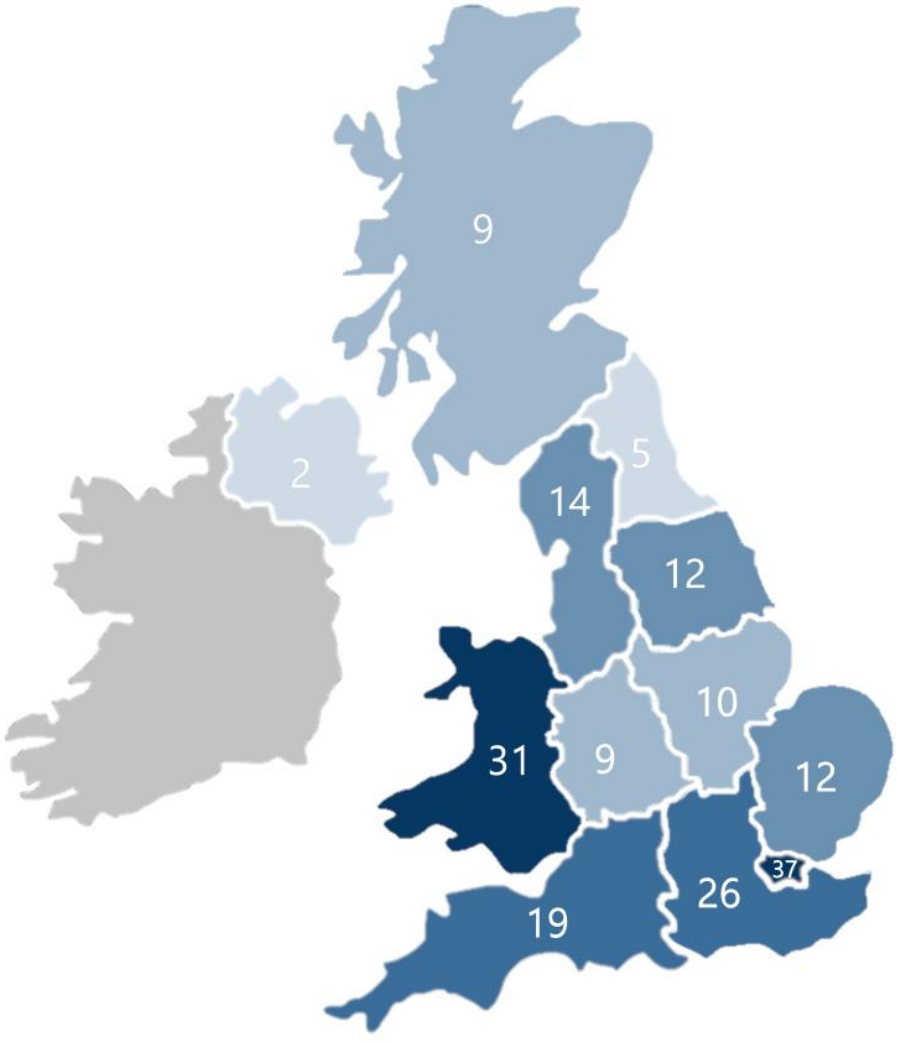
The Survey

The Staff Maternity Choices Survey was completed online by 186 healthcare professionals across the UK. The survey consisted of eight questions regarding changes to maternity choices during the Covid-19 health crisis. Survey responses were collected from the 8th of April 2020 until the 6th of July 2020. The survey consisted of both multiple-choice questions and free-text responses. The average time taken to complete the survey was 6minutes 12seconds.

The following report contains initial data analysis of the responses to this survey separated by question.

1.1. Demographic Information of respondents.

Healthcare professionals were asked to select which region of the UK they work in. This information is presented in *Figure 1.* The majority of respondents came from London, Wales and the South East. The regions with the lowest number of respondents were Northern Ireland and the North East.



UK Region	Number of Respondents
London	37
Wales	31
South East	26
South West	19
North West	14
East of England	12
Yorkshire and the Humber	12
East Midlands	10
Scotland	9
West Midlands	9
North East	5
Northern Ireland	2
TOTAL	**186**

Figure 1. Map of the UK presenting number of survey respondents from each UK region.

1.2. Profession of respondents

Respondents were asked to state their profession in a free-text response box. Approximately half of all respondents stated that they were either a midwife *(n=82),* specialist midwife *(n=6)* or student midwife *(n=4).* There were 15 doulas who completed the survey and 13 psychologists or psychotherapists. Thirty respondents left this field blank and so these were classified as 'unspecified'. The relative proportions of healthcare professions reported by respondents are presented in *Figure 2.*

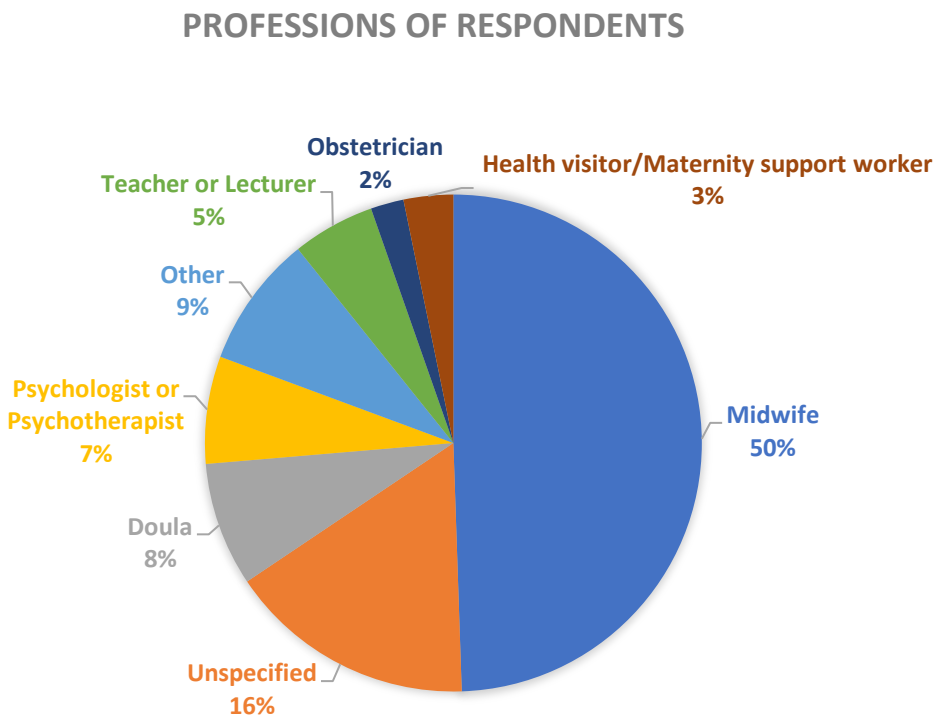


Figure 2. A pie chart representing the proportion of professions reported by healthcare professionals who completed this survey

Changes caused by Covid-19

To gauge the level of disruption to maternity care caused by Covid-19, healthcare professionals were asked whether maternity choices have changed in their area and what the key reasons were for these changes.

2.1. Changes to maternity choices

93% of healthcare professionals who completed the survey reported changes to maternity choices in their area as a result of Covid-19. Only 14 out of the 186 healthcare professionals surveyed reported no changes to maternity choices in their area as a result of Covid-19.

There were no statistically significant differences in reported changes to maternity choices between regions or between job sectors.

The themes reported below were generated from the follow up question, 'how do you feel about these changes?'

Overall theme: Effects of changes on birthing people and their families

Impact on care and patient safety

Staff described many changes to maternity care and were concerned about how these affected the support that families received, including, in particular, the relational aspects of care:

> *'feels really hard showing compassion from behind a mask or over the phone'*

> *'relationship-based care is key to maternity services. I just pray that when the crisis response is over, we are able to return to forward thinking practice'*

They described a reduction in contacts, with less contacts face-to-face – this led to a concern for patient safety, and safeguarding women and children:

> *'the main changes are to the provision of antenatal care, and I'm really worried about patient safety'*

> *'both DV and child abuse are known/speculated to be rising – but how can we pick these up when we have reduced/eliminated all the relational aspects of maternity (eg telephone booking and no face to face apt til 28 weeks!)'*

Some staff were concerned that women may be pushed into freebirthing:

> *'Women are freebirthing who do not wish to. Women are left with minimal care and are having to birth alone'*

They also felt concerned by the reduction in postnatal care:

> *'I am very fearful that women and babies are being forgotten and there will be long term consequences of this. VERY reduced postnatal care (which was already inadequate) makes me feel for the families not getting the support required. Breastfeeding will be badly affected (tongue tie clinic here has been closed until further notice - where does this leave women? No choice but to formula feed...unacceptable if their choice was to breastfeed). Already seeing increase domestic abuse, how many newborns will be affected by this as well?? So many concerns'*

Respondents believed there was likely to be an increase in stress and mental health difficulties for mothers, and an increase in birth trauma:

'I think in few months we will be flooded with postnatal depression and PTSD rise. I am very concerned'

<u>*Choice and consent*</u>

Responses suggested that there were differences in the degree of choice birthing families had available to them. Homebirth was a key issue, and there were differences in responses as to whether homebirth was still available:

'Devastated that women are having the choice of a home birth taken away from them'

'I feel our trust have tried to maintain choices for families such as home birth, water birth and BUs remaining open'

'It's confusing to see various different trusts respond differently eg homebirth cover'

Many described homebirths as preferable in current circumstances, and felt that there were additional risks attached to hospital births, and the potential for birth to be more medicalised, with more interventions:

'I fail to see the logic behind directing healthy pregnant women, who wanted to birth in stand-alone MLU's or at home, into hospitals that have confirmed cases of COVID-19'

'Can't understand the Homebirth decision when it seems safer all round […] Hospital births without partner or doula in these circumstances will mean more anxiety, more adrenalin, leading to more intervention, more c-sections - both of which require many more staff'

A number described feeling that blanket policies were being used which challenged person-centred care and impacted birthing people's rights:

'I feel they are restricting mother's choices and negatively affecting their birth experiences. Some restrictions could be overcome but blanket policies are being applied and women's individual needs not being considered'

'Angry, women's rights not being respected. Blanket policy is not in the best interests of women'

They described a focus only on Covid-19, to the exclusion of women's needs:

'I feel anxious, I feel scared and I feel my colleagues are being too over the top and not really thinking about the birthing woman, only thinking about covid and how it affects them'

Some felt that there was also an impact on consent:

'I worry that trusts are using Covid-19 to restrict birth choices unnecessarily. Pushing birthing people into choices about their births from a place of fear not informed consent'

'Furious. The rights of women and birthing people are being taken away and other avenues aren't being fully explored'

And questioned the legitimacy of the changes:

'I'm not confident that the current situation warrants changes as significant as have been implemented. I am concerned that we are not justified (at present) or in fact 'allowed' to withdraw/ limit services as we have done'

Others responded with their concerns around power and potential abuses of power

'Whilst they are understandable, these changes disempower women at a time when they so need to feel as in control as they can be'

'There are being some abuses of power when women are without their birth partners'

<u>*People who may need additional support*</u>

Respondents described there were some groups of people who were more likely to be impacted by the changes to maternity choices, who may need additional support/consideration. This included people from ethnic minorities, people who had experienced birth trauma, or had a history of past trauma, people with mental health difficulties, and parents who are separated from their child after birth for any reason.

'I think cancelled C sections and limited opportunity to supported and accompanied by a birthing partner (at scans, at birth) has provoked a great deal of fear and anxiety particularly those women with MH difficulties, histories of birth trauma or vulnerable to past trauma triggered at appointments of birth without a containing supportive other with them'

'They will impact the BAME community most heavily as they are already struggling in a system and structure based in racism'

<u>*Positives*</u>

A number of potential positives to the changes were described – these included that women may be able to take control and trust their 'inner voice' more (p145); positive environment on postnatal wards; increased efficiency in maternity services; or more creativity in maternity services:

'Birthing women I hope will trust their inner voice / their intuition more and tap into their inner strengths at this time... and be heard. It's time'

'The postnatal ward has been lovely with just the birthing people. It's a very supportive environment where all the people are speaking to each other. They are rested and learning to feed well'

'I'm actually seeing lots of positive birth stories coming out. Perhaps there is a lesson to be learnt in how people approach birth. Also how people talk about it. In my experience people who have had a 'good' experience tend to keep quiet. Now they are sharing their stories to encourage others'

2.2. Key reasons for changes to maternity choices

Respondents were asked to identify the key reasons for the changes to maternity choices in their practice due to Covid-19. As stated above, the vast majority of healthcare professionals reported changes to maternity care, subsequently, only respondents who reported to have experienced changes to maternity choices were included in the following analysis *(n=172).* Key reasons for changes to maternity care are presented in Figure 3.

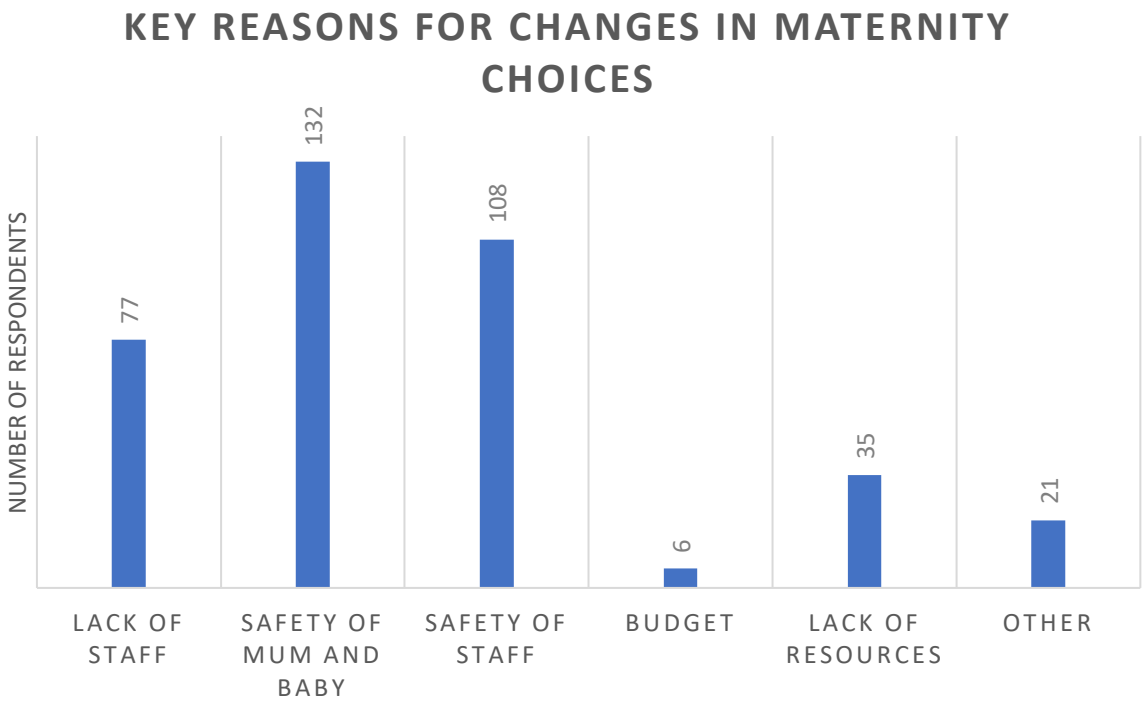


Figure 3. Bar chart to show distribution of responses to the survey question: "What are the key reasons for the changes to maternity choices due to Covid-19?" Only respondents who reported changes to maternity choices were included in analysis *(n=172).*

77% of healthcare professionals reported the key reason for changes to maternity care was to guarantee safety for mothers and their babies. 45% of healthcare professionals reported that a lack of staff was the key reason for changes to maternity choices in light of Covid-19.

21 respondents (8%) selected 'Other' and used a free-text field to type the key reasons they feel to be behind changes to maternity choices in their practice due to Covid-19. Analysis of

the free-text responses revealed three additional key reasons: 12 healthcare professionals reported 'Lack of ambulance services' as a key reason for changes to maternity care; an additional 6 staff reported 'redeployment of staff' and the remaining 5 reported 'in-keeping with government guidelines' as key reasons for changes to maternity care.

Statistical analysis revealed that **midwives were more likely to select the option 'Safety for staff' as one of the key reasons for changes to maternity choices compared to all other professions**, *(χ^2= 6.61, p=.01).* There was some evidence of a difference in responses to whether 'lack of staff' had contributed to the reasons behind changes to maternity choices between UK regions *(χ^2= 18.36, p=.07)*. Post-hoc tests revealed a greater proportion of **staff from London were likely to report 'lack of staff' as contributing to changes to maternity choices. Whereas staff from Wales were less likely to report a lack of staff as a key reason for changes to maternity care**, *(Figure 4).* There were no other statistically significant differences between responses to this question and UK regions or job sector.

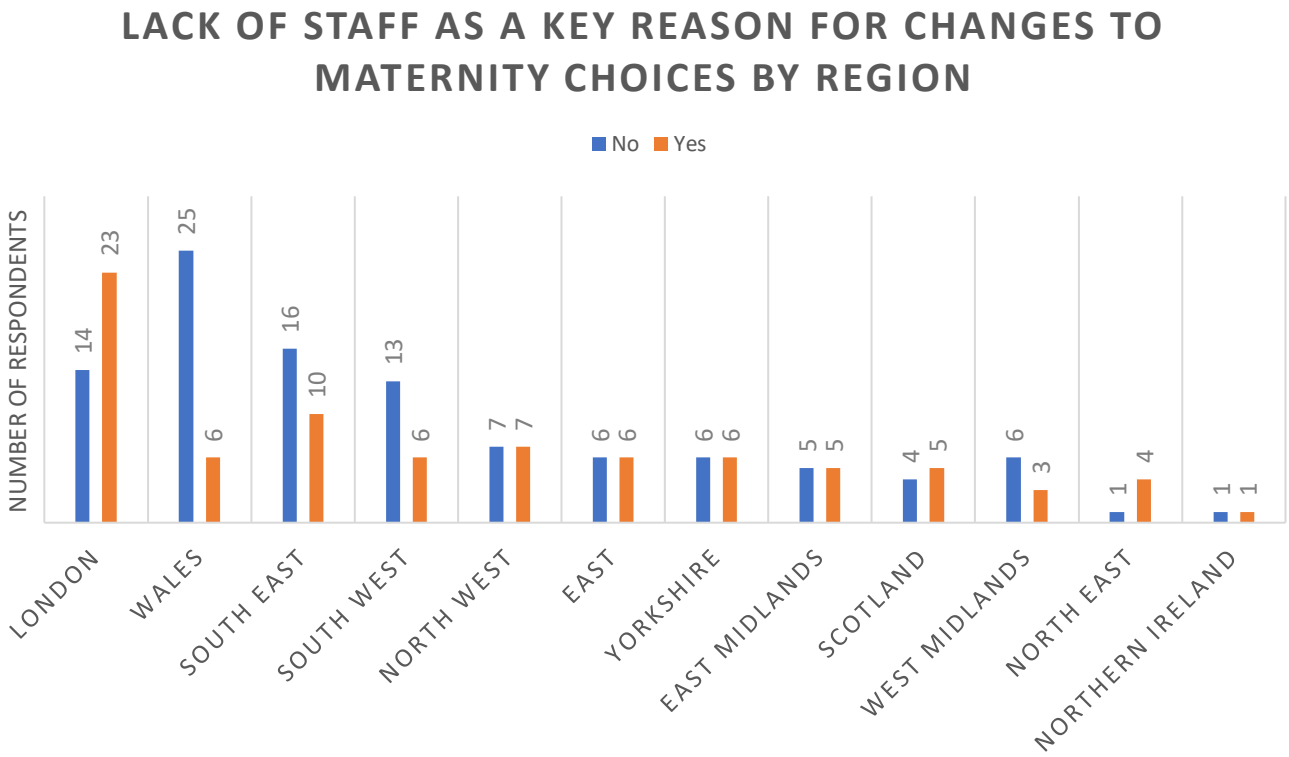


Figure 4. Bar chart to show the proportion of respondents who selected 'Lack of Staff' as a key reason for changes to maternity choices by UK region.

Staff were then asked a follow up question, 'how do you feel about these changes?' and answered were thematically analysed.

Overall theme: Is this fair? Differing views about the effects of changes on practice

Disagreement with changes

Respondents questioned how well thought through the changes to maternity choices were. They questioned their safety, and appeared to be concerned about the basis on which they were made.

> *'There is a lack of joined up (eg, in the case of the service I work in, pan London) decision making about how to restructure services to ensure both a safe and efficacious service for all'*

> *'decisions do not seem to be evidence based or best for anyone. Seems to be fear driven'*

They noted existing resource issues prior to Covid-19 meaning that staff were already 'overstretched'. Several responses conveyed a sense that more could be done to support staff, and additional resources re-allocated, including a number who felt independent midwives may have an important role to play.

> *'this is a very challenging time for midwives working in what was already an overstretched system'*

> *'Independent midwives are in great need by women now. But NHS is not relying on these midwives to offer support and we are perfectly able to support'*

Staff were concerned that the changes may not be regularly reviewed, and were worried that the changes may be permanent.

> *'Frustrated as not being reviewed often enough as circumstances change'*

> *'Worry that care will not return to the level it was not it is more 'efficient'*

'Doing what we have to do' – changes as reasonable and necessary

Other respondents acknowledged the emotional weight of the changes but felt that they were reasonable and necessary in the context of safety.

> *'Think they are important, fewer people entering and leaving our department should reduce the spread and protect women, babies, families and staff and their families'*

> *'sad, but the measures are essential'*

Responses appeared to weigh up different risks (e.g. risks to staff vs risks to birthing women), and described a need to focus on the *'bigger picture of society as a whole'* in order to contextualise the changes against the backdrop of a global pandemic.

'As a member of the homebirth team, it has been stressful but understandable. It is hard to get a balance between our rights as staff to safe working environments and women's rights to safety and care'

Some staff described believing the changes were justified, and in line with policy and professional guidance.

'We are doing what we have to do & continue to give care as per RCOG & NICE guidance'

'Sinister roots' – scepticism and lack of trust

The extent and speed by which changes were made appeared to lead some respondents to question the nature and underlying reasons for them.

'sceptical and concerned by the speed we forget our fundamental ethos'

They described feeling that some NHS trusts were making 'excuses' and using the changes to move more births into hospital.

'Very frustrated that some areas are thinking outside of the box whilst others using every excuse to get women herded into hospitals'

Responses implied a lack of trust, and a frustration that the reasons behind the decision making were not made clear.

'It is a very scared time for everyone. I honestly feel there are sinister roots to all this, but we have to handle the situation as instructed by departments who perhaps don't have a lot of real understanding of our roles and responsibilities'

'Angry at the lack of transparency in the reasons behind decision making' p165

Support available to staff

To better understand how staff are being supported during this time, respondents were asked whether they are receiving emotional support and how this support is provided to them from the following three options: 1. No, no-one has asked about my wellbeing; 2. Yes, peer support from colleagues or 3. Yes, support from senior members of the team. Respondents were able to select 'Other' if none of these options applied to them. The results from this survey item are presented in *Figure 5.*

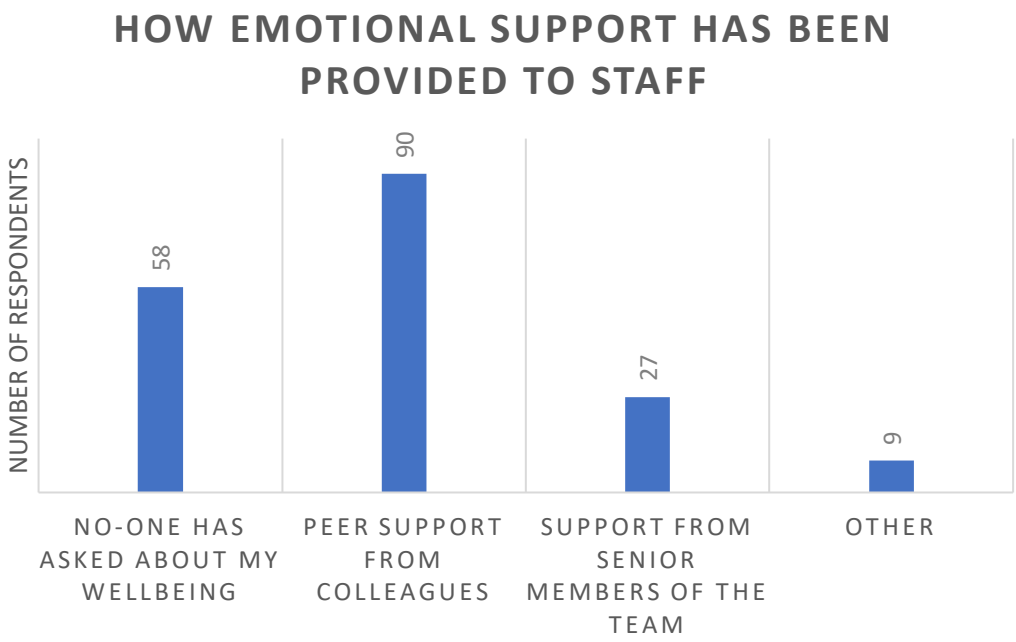


Figure 5. A bar chart representing all responses to the survey item pertaining to how staff have been supported during Covid-19

As demonstrated in *Figure 5,* **the majority of healthcare professionals (49%) reported that the emotional support they have received during the Covid-19 crisis has been in the form of peer support from colleagues. A further 31% reported that they have not received any emotional support.** Only 15% of healthcare professionals surveyed reported to have received emotional support from senior members of staff.

Nine healthcare professionals selected 'Other' and used the free-text response field to type the form of emotional support provided to them. These responses were coded into two additional categories. Five healthcare professionals reported to have received emotional support online or via social media, and four respondents outlined receiving support from a personal mentor.

There were no statistically significant differences between type of support available to staff and UK region or job sector.

How Are You Feeling?

Staff were asked whether they would like to share how they were feeling; changes they were experiencing; or support they received. Responses were analysed thematically and are provided below.

Overall theme: The cost of caring – impact of changes on staff

'Sad and heartbreaking': emotional responses of staff

Staff described their concern for the impact that the changes would have on women, and their own emotional response to this.

> *'heartbroken for the women and their families'*
>
> *'So disappointed for local families - homebirth, water birth ceased and no visitors antenatally / postnatally, no support during induction, four-hour slots once daily for one parent for babes on NICU.... so sad and heartbreaking'*
>
> *'sad for the women I support and frustrated I can't help more'*

They reflected on the changes to the way in which they are able to support women, and how this differed from the way they usually work.

> *'I'm used to advocating for women I care for and have forged relationships with […] it is a way of working that is alien to what we normal strive to provide'*

This appeared to challenge their values as clinicians, and created a dissonance between the way they wanted to work, and the way that they felt they had to work due to Covid-19.

> *'when patients are angry with us for not being able to provide bits of the service they want e.g. more than one birth partner it is really upsetting because I feel like we are in this together but it makes it feel like it is them against us which is not the partnership I want to have with women'*
>
> *'It's difficult to be able to provide the care that I came into the profession to provide. I spend a lot of time apologising for the changes to services. I feel like covid-19 has sadly overshadowed the beauty and wonder of birth and autonomy of the woman'*

Wellbeing & self-care: Support for staff

Many described the multiple pressures on staff, and the challenge to look after yourself, and your personal safety, within these pressures. They felt it was important to recognise that these pressures affected all staff, not just frontline staff.

> *'It is a very difficult time at the moment. The pressure to provide high levels of care while looking after your personal safety is incredibly hard. I feel so torn at the moment and am trying to do all that I can'*
>
> *'feel my resilience is dropping. I can see people around me getting tired and I am as well'*
>
> *'I've never wanted to leave the profession more'*

Respondents described a hope for the emotional impact of the changes (described by one respondent as a 'trauma' in itself) to be recognised, and to receive further emotional support.

> *'We should be acknowledging the impact of this trauma on our staff, whatever their role as it doesn't just effect those providing direct care'*

> *'Having someone ask 'how are you really feeling' gives you permission to open up'*

> *'More focus on managers actually putting systems in place to support staff more from an emotional wellbeing'*

A number of strategies were used to support wellbeing: including friends, family and partners; doing valued activities; setting boundaries around work; knowing your job is important; and professional supports such as supervision and training.

'Horizontal violence' – challenges to communication within, and between, staff groups

A number of difficulties in interactions with colleagues were described, including divides with between 'shop floor' staff and management; between organisations; and between colleagues working in the same team.

> *'Unfortunately it's fallen to 'shop floor' staff to set up support systems, I think management are just too busy'*

> *'We are not being communicated with as a community organisation […] We sit on a maternity committee with staff but we have 100% been ignored when we have asked for questions to be answered'*

> *'There is great potential for horizontal violence in the workplace as tensions are running high […] On the subject of PPE, I have personally felt attacked by colleagues in public spaces on wards, for wearing 'too much' PPE, despite them having no knowledge of the work I was about to do, or of my own vulnerabilities'*

Alongside this were a number of responses describing collaboration and support between colleagues, and the sense that people were 'pulling together' in order to provide the best care to patients.

> *'my colleagues and I are not front line but support each other so we can support those who are'*

> *'Senior staff have been brilliant'*

> *'I am pleased that I work for a hospital at present where there has been good MDT collaboration to keep choice for families open'*

Discussion

Most participants reported changes to the maternity services they worked in. These changes were made primarily for the safety of mum and baby; for the safety of staff; or because there was a lack of staff (due to redeployment) and resources. Many questioned the basis on which the changes to services were made, particularly in the absence of an evidence base to support them. Some felt the changes were reactive and based on fear, whereas others were apprehensive that there was a lack of a process to review the efficacy of these changes. Some staff believed that Covid-19 related changes made by their organisation masked an ulterior motive; that they wanted births to become more medicalised. They were concerned services would not revert back to how they had operated before the restrictions were implemented. Others felt that although they found the changes emotionally laden, that the right decisions were being made in line with the professional guidance received.

Many felt that the changes made to maternity services negatively impacted on women. Alongside the Make Birth Better report (2020), there has been increasing momentum from the #ButNotMaternity campaign, highlighting the negative psychological impact not having partner's present at antenatal appointments, and labour has had on women and families. The government and campaign groups are putting increasing pressure on maternity services within Trusts, not to treat birth partners as visitors. Staff were angered at the lack of partner's being able to attend appointments, to support their partner. They felt this would compound those already vulnerable, including some from ethnic minority groups, those with a history of past trauma, and women with mental health difficulties. It was hoped that when the restrictions ended, there would be service provision to support those families that would undoubtedly be affected, by the changes made. Staff discussed that the differing approaches across Trusts caused confusion for women, with some offering home birth, for example, and others not. Many felt that women's choices were being significantly compromised, particularly as they had little choice but to birth in hospital, where it would be more medicalised, and an increased risk of interventions, as well as risk of contracting the coronavirus. Some staff shared that containing the spread of Covid was the only focus, to the exclusion of women's needs.

Other staff shared their difficulty with knowing how to convey compassion behind their mask, or over the telephone. Some evidence has suggested that wearing face masks affected patients' perceptions of empathy, and satisfaction with the care they received (Wong, 2013). Compassionate care is an integral part of the role maternity staff have, and watching/hearing women distressed and not being able to display usual acts of compassion, potentially heightens their risk of compassion fatigue. Therefore, having creative ways that staff feel able to display compassion, even when adhering to social distancing and personal protective equipment, will be mutually beneficial to staff and women.

The reduction in face-to-face appointments worried some staff, where they felt that safeguarding issues for mum and baby would go undetected, particularly amidst reports of an increase in domestic violence. The Institute of Health Visiting, reported that in England at least 50% of health visitors have been redeployed into other health services. Some of these health visitors were from perinatal mental health and parent-infant teams, and would have

supported parents and safeguard babies. Others were aware that some women were deciding to free birth, and felt that the changes being made were compromising patient safety. The lack of access to postnatal care, some feared, would have long-term implications on mum and baby. The NSPCC's campaign Fight for a Fair Start is pressing the government to consider the support that parents need as Covid restrictions ease, and urge them to create a plan to return health visitors to teams, and for perinatal services to meet the needs of parents.

The participants conveyed the heartache they experienced not being able to provide the care and service to women they were trained to deliver. Some felt their mental wellbeing was compromised, to the extent that they wanted to leave their profession, whereas others felt traumatised. Not being able to provide the usual quality of care to all patients (Rosenbaum, 2020), could lead to moral injuries and trauma-related symptoms. Moral injury is the psychological distress resulting from actions, or lack of them, which violates individual's moral, or ethical code (Litz, Stein, Delaney, et al., 2009). The individual often feels shame and guilt, alongside negative thoughts about oneself/others (Williamson, Stevelink, Greenberg, 2018), which are also symptoms of Post-Traumatic Stress Disorder (PTSD; Barnes, Hurley, Taber et al., 2019). Moral injury is not a mental illness, but exposure and the meaning made of the events can lead to mental health difficulties like PTSD, suicidal ideation, depression and anxiety (Litz et al., 2009; Williamson et al., 2018), which has a short and longer-term impact.

It is impossible to predict the long-term psychological consequences maternity staff will experience following Covid-19. However, from other pandemics (e.g. SARS), 12- 26 months after the outbreak, healthcare workers reported significantly higher levels of burnout, psychological distress, and post-traumatic stress (Maunder, Lancee, Balderson, et al., 2006). To mitigate the potential psychological impact on staff offering a range of different support options in the short and longer term will undoubtedly be of benefit. Staff reported that peer support from colleagues was the main emotional support they received. A significant number had not been offered any support from their organisation. Some felt that the management of their service were too busy to support the staff serving on the 'shop floor'. Whereas, others described the tension there was between colleagues, which further compromised their mental wellbeing. For some, they identified strategies which positively impacted on them, which included, spending time with family and friends, setting boundaries around work, engaging in valued activities away from work, and seeking professional support from their mentor, or supervisor. Participants also described the positive impact this time has had on their team, with colleagues coming together to support one another, and a sense of camaraderie.

Conclusion

Staff felt the changes to maternity staff negatively impacted women and birthing partners in the short term, worried about the longer-term effects on them, and hoped services would be in place to offer adequate support. Many found it emotionally difficult to see how these changes affected women, and found it difficult to provide compassionate care to women from behind their mask. Not being able to provide the usual quality of care potentially created moral injury and trauma-related symptoms, in some staff. Support from colleagues

was the primary avenue of help staff had to help them cope, with the uncertain times they worked in. Others found coping strategies which positively impacted on their wellbeing. However, drawing parallels with previous pandemics, having provision for staff to be supported in the future will also be required to ensure their mental wellbeing is optimised.

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