Some staff also felt guilt due to being redeployed and knowing their own department waiting lists and people needing care are being 'abandoned to their own fate' at some points there were more staff than patients on wards. Others felt de skilled where they had been sent to wards and given tasks to do that they did not feel competent to undertake and those isolated and working from home also expressed fear and vulnerability and potential social inadequacy around re-entering the physical work space.

'I have a tremendous sense of guilt as a leader because of the demands I have placed upon my team has been hard for me to bear. I have reneged on my duty of care toward them.' (Head, corporate departments)

Issues of safety are what presented the biggest response and where the potential biggest legacy for the organisation are.

In terms of physical safety, the lack of physical safety was felt unanimously whether interviewing frontline workers, domestics or office bound work force. Feeling unsafe in the workplace is the single largest work based stressor whether someone feels physically threatened or psychologically threatened the equal result is work based stress and the resultant absenteeism or presentism in its lesser form. Much rebuilding needs to be considered to allow people to feel safe once again in their work space.

'This is a small hospital, and space is an issue, our staff rooms are so small we are unable to socially distance whilst using the facilities for a break. Give us a small space in the grounds of the hospital - a garden with a bench to sit on or, a good size restroom'. (Nurse)

In terms of psychological safety, during the height of the pandemic, although staff felt physically unsafe many said they felt psychologically supported. Appreciation of the commitment staff gave to care during the first wave of the pandemic, with the clapping and food and wellbeing gifts was amazing and uplifiting and much appreciated. For those working 12-14 hours a day in procurement, IT and workforce who did not receive the level of appreciation as frontline staff, this has led to a mixed psychological state of knowing they have given to breaking point but not necessarily been appreciated to the same level.

What was also clear was that people made huge sacrifices to continue working safely and securely. Some of our nurses and frontline staff left their family homes to continue working; some lived in holiday homes or caravans isolated from their loved ones. The fear of infecting family and friends through cross infection was in some cases psychologically debilitating and staff only had each other to lean on. One nurse put on a full PPE suit, booties, gloves, viser and mask to visit her children in the garden of her family home as she had not seen them in weeks. Some staff also struggled with Covid19 on their own in isolation as they fought to recover and re-enter the work place to assist colleagues who were struggling with staff numbers.

One member of staff had Covid 19 and said her mum and family caught it too, and she is still feeling guilty. This same member of staff stated she was told off for ordering visers for staff to use on the ward. She felt let down and not well protected to the extent her family suffered as a result of her doing her job. Many respondents who had caught Covid19 also returned to work still feeling unwell, with shortness of breath, fatigue and brain fog. Everybody felt guilty when they weren't at work and when they weren't working they couldn't switch off, worrying about their colleagues, patients and what they were going to return to.

These feelings of fear, shame, guilt and loss of confidence were highlighted as a big concern and will need to be managed in the workspace. Many of the interviews were moving towards these emotional expressions, although many were remaining in the moment and just coping on adrenalin. Emotional safety may need to be addressed, not just individually but corporately to acknowledge that work will be a safe place and there is a need for non- judgemental spaces to express concerns. Trauma responses are already beginning to show. Some participants were beginning to move out of crisis management and into crisis reflection and move towards the 'what if' mode of negative reflection.

Positively, closer working arrangements and better communication developed between primary, secondary and community care during the pandemic.

'Different parts of the system started respecting the pressure on different services… it allowed secondary care to understand the pressures on primary care and vice versa and allowed us to challenge more effectively' (GP)

What worked well?

- Better communication between hospital sites e.g. covering on call duties, sharing staff on rotation, daily cross-hospital meetings (ICU)
- Teams that had good information and effective communication channels both vertically and horizontally performed well.
- Actual hospital sites feeling a lot closer as a hospital – sense of belonging, 'one team' ethos,
- Many teams moved from paper notes to electronic notes making referrals faster and more efficient;
- Some teams looking further afield for partnership e.g. one physician now looking to work with Cardiff and Vale to cover some of our clinics as they are now done virtually;
- Providing a blended approach to clinics – some prefer virtual and some don't need to come in which has provide to be much more efficient and frees up staff to deal with emails, calls and learning.
- There is now better access to training due to virtual training;
- Virtual MDTs has meant much improved working relationships between teams, hospitals, acute and community care/social services and primary and secondary care. Consult anywhere? Dr Doctor and e consult have changed the face of patient engagement. These platforms have allowed speed of response and shorter 'wait' times. MDTs have worked so much better as professionals are willing to engage because they do not have to travel between sites and lose valuable patient contact time.

What can we learn?

- There has been a great sense of momentum in breaking down barriers to get things done and staff want this to remain by increasing communication.
- A lack of communication often ends in misunderstanding and mistrust. We cannot over-communicate and thought needs to be given to how we can increase how we communicate messages across a large organisation that supports people to feel connected to the strategic direction of the organisation;
- We need to break down barriers between hierarches to support better communication and move away from a 'them and us' culture.
- Increase managerial presence to understand conditions and co-produce pathways of care by building vertical as well as horizontal teams.

f. Working environment

The working environment was cited as being a source of work based anxiety. This was mostly due to a lack of breaks but also a lack of anywhere to take a break also loomed large in the reports. Quite a few staff took their breaks sat in their cars in the car park eating sandwiches with a flask of coffee.

Staff reported not having enough adequate toilet facilities or donning and doffing areas. Along with the lack of side rooms and isolation rooms, unventilated waiting areas were among many things staff asked to consider when planning the new hospital in light of our recent experiences with a highly infectious virus.

Staff reported the need for basic facilities to help them cope with emotional stress and trauma, including places to rest and reflect or simply 'have a cry' when they needed to. Some staff reported that facilities were not available and that they would go to their cars to rest or to a cupboard under the stairs.