To what extent did the existing health and safety legislation protect the health and safety of healthcare workers in the UK during the Covid-19 pandemic?

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Abstract

This thesis aims to examine whether existing health and safety laws were sufficient to protect the health and safety of healthcare workers in the United Kingdom during the Covid-19 pandemic. The Covid-19 pandemic was incredibly challenging to National Health Service (NHS) healthcare workers due to a multitude of reasons. Healthcare workers were required to provide care to patients that contracted the novel virus without knowing its severity. The highly transmissible nature of the virus overwhelmed hospitals with a surge of critically ill patients. This ultimately led towards overworking workers, causing immense physical and mental distress. Having learned the highly infectious nature of the virus, NHS healthcare workers were required to wear personal protective equipment (PPE) to protect themselves and reduce the transmission of infection. However, due to the widespread transmission of the virus, there was a shortage of PPE, significantly increasing the risk to workers' health and safety. Despite these impacts, workers were hopeful that their employers would protect them from the occupational health and safety hazards. Employers are under a legal duty to ensure that the health and safety of their employees are protected as far as it is reasonably practicable. This is highlighted under the Health and Safety at Work etc. Act 1974. In line with the above, the research aims to explore if the health and safety of healthcare workers was adequately protected during the Covid-19 pandemic.

This study adopted a socio-legal methodology and thematic qualitative analysis to answer the research question. Socio-legal method examines the relationship between law and society. In the context of health and safety, while the Health and Safety at Work etc. Act 1974 was enacted with the intention of protecting workers, the legal rules are interpreted and applied differently in practice within the NHS. In order to understand this further, data was collected through reviewing testimonies published by healthcare workers online. Collecting secondary data was straightforward due to the vast number of testimonies available online. The testimonies were naturally categorised into themes which assisted the data analysis. Five key themes emerged from the data analysis; prejudicial treatment of black minority ethnic workers, the lack of support for migrant workers, supply of PPE, inconsistent advice across the NHS workforce and the intention to leave the healthcare profession.

Having established the methodology and theoretical framework, the analysis explored the effectiveness of the health and safety laws and how it was practised by employers within the workplace. The mental and physical health impact on healthcare workers were significant.

The unfair treatment that minority groups faced during the pandemic exposed them to higher risks of infection. The shortage of PPE resulted in a series of unfortunate incidents, it increased the risk of workers contracting the virus and elevated their anxiety when providing care to patients. When PPE was available, workers were subjected to wearing it for prolonged periods of time which caused physical discomfort. Workers also had to provide care whilst navigating the constantly changing government guidelines, which were often more of an encumbrance than a support.

The research concludes that in instances where legislation fails to offer adequate protection for the health and safety of workers, the trade unions are able to play a vital role in advocating for health and safety policies to be implemented and protective equipment to be stipulated. The analysis also highlights that while the health and safety legislation enables employers to implement health and safety policies for the specific needs of their workplace through the self-regulating system, the lack of consistency in implementation across different NHS trusts caused confusion amongst workers. Overall, although legislation exists to protect workers, many health and safety safeguards were not effectively implemented to adequately protect the health and safety of healthcare workers during the Covid-19 pandemic.

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Author's Declaration

" I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution. "

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Introduction

The Covid-19 pandemic of 2019-2023 created a great deal of global turmoil, from which the world is still recovering.[1] Recovery does not only include economic recouping, but more importantly, dealing with the social and cultural consequences involved in the long-term effects on nations.[2]

The National Health Service (NHS) in the United Kingdom (UK) is at the heart of society providing healthcare to patients at general practitioner (GP) centres, clinics, hospitals, care homes and ambulance services.[3] The British public turn to the NHS when they are at their most vulnerable, in sickness or pain. At times, NHS workforces sacrifice their own physical and mental health and in rare cases, even their own lives, in order to meet their work demands.[4] Over time, a consensus has been formed that healthcare workers (HCWs) hold an ethical duty to treat patients with infectious diseases, even if doing so puts the HCWs themselves at risk of infection.[5] Being part of the medical profession, these workers are required to adhere to ethical codes of conduct that prioritize providing sufficient and adequate care to patients.[6] They undertake special training and have the expertise to bear the high burden of responsibility that comes from taking care of an infected patient. In doing so, the workers putatively hold a social contract with the public in return for benefits such as social prestige, high levels of training and, for some, such as senior doctors and consultants, a relatively high income.[7]

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[1] Gita Gopinath, 'The Great Lockdown: Worst Economic Downturn Since the Great Depression' (IMF Blog, 2020) <https://www.imf.org/en/Blogs/Articles/2020/04/14/blog-weo-the-great-lockdown-worst-economic-downturn-since-the-great-depression> accessed 19 December 2023.

[2] British Academy, 'The Covid decade: Understanding the long-term societal impacts of Covid-19' (In British Academy, 2021).

[3] 'Working in partnership with people and communities: Statutory guidance' (NHS England, 2023) <https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/> accessed 19 December 2023.

[4] 'Workforce burnout and resilience in the NHS and social care' (House of Commons Health and Social Care Committee, 2021) <https://committees.parliament.uk/publications/6158/documents/68766/default/> accessed 05 March 2022.

[5] Heidi Malm, Thomas May, Leslie P Francis, et al., 'Ethics, pandemics and the duty to treat' (The American Journal of Bioethics 8, 2008).

[6] 'The code: professional standards of practice and behaviour for nurses, midwives and nursing associates' (Nursing and Midwifery Council (Great Britain), 2018), General Medical Council, 'Good Medical Practice' <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice> accessed 05 March 2022.

[7] Teck-chuan Voo and B Capps, 'Influenza pandemic and the duties of healthcare professionals' (Singapore Med J 51, 2010).

I am Coronavirus!

Coronavirus (Covid-19) is a respiratory virus which is caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) virus.[8] It is an infectious disease that affects humans to varying degrees: most people can recover without needing any medical treatment while others can become very unwell and require special care.[9] The nature of the Covid-19 virus and its associated infectious behaviour was the root of many complications on the road to recovery. This could be attributed to several factors, including the rapid spread of the virus across the globe which affected nearly every individual. The initial failure to fully grasp the severity of the virus allowed its transmission and impact to become widespread.

Governments across the world implemented a number of measures in order to safeguard their people, their economies and most importantly, their health systems from the pandemic. Having learnt that the virus can easily spread through close contact with an infected person by breathing in or touching surfaces covered in droplets containing the virus,[10] the UK imposed restrictions on human interaction in order to impede its spread. While the social restrictions helped curb the spread of the virus they created socioeconomic hardships.[11] It was a balancing act of prioritizing the lesser of two evils. While some nations prioritised public health, others focused on political expedience which further complicated global cooperation, impacting the global economy.[12]

The UK sprang into action to curb the rapidly increasing number of Covid-19 cases in the country in order to prevent the healthcare system from becoming overwhelmed. The state interventions to contain the virus included the restriction of work and business activities. Key workers including workers in health and social care, food and other necessary goods, public safety and national security, transport and border, education and childcare, local and national government and financial services were involved in the radical adjustment.[13] HCWs

[8] Marco Cascella, 'Features, evaluation, and treatment of coronavirus (COVID-19)' (National Library of Medicine, 2020).
[9] 'Coronavirus disease (COVID-19)' (World Health Organisation) <https://www.who.int/health-topics/coronavirus#tab=tab_1> accessed 05 March 2023.
[10] 'How to avoid catching and spreading COVID-19 infection' (NHS, 2023) <https://www.nhs.uk/conditions/covid-19/how-to-avoid-catching-and-spreading-covid-19/#:~:text=You%20can%20catch%20it%20by,do%20not%20have%20symptoms> accessed 05 April 2023.
[11] Noah S Diffenbaugh, Christopher B Field, Eric A Appel, et al., '(The COVID-19 lockdowns: a window into the Earth System' (Nature Reviews Earth & Environment, 2020).
[12] John N Nkengasong, 'Covid-19: Unprecedented but expected' (Nature Medicine, 2021).
[13] 'Coronavirus and key workers in the UK' (Office for National Statistics, 2020) <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/coronavirusandkeyworkersintheuk/2020-05-15>accessed 05 April 2023.

experienced particular pressure as they were forced to provide care to an influx of patients, who had contracted the virus, without themselves knowing the severity of the disease.

The health system

Research has indicated that HCWs experienced anxiety, stress and fear, having to provide direct care to infected patients during the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak, which was the first major pandemic of the 21st century.[14] The Covid-19 pandemic was akin in this regard to the predicaments that HCWs faced. First of all, the overall wellness of the workers decreased dramatically due to the high infectious nature of the virus triggering psychological burnout, anxiety, depression and stress.[15] It was as if the lessons learnt from the 2003 SARS outbreak had been entirely forgotten as the workers who were treating infected patients were denied adequate protection.[16] As the NHS was already dealing with a significant number of backlog cases prior to the pandemic, its capacity to provide emergency care was declining at an alarming rate.[17] The mental and physical health of HCWs was subjected to difficulties during the pandemic, which negatively affected the quality of care provided. The health and safety of these workers took a backseat as priority was given to providing care to infected patients.

Health and safety

Employers are legally required to protect the health, safety and wellbeing of workers. A 'self-regulating' system was adopted by the UK under the enactment of the Health and Safety at Work etc. Act 1974 (1974 Act) (HSWA).[18] Rather than setting prescriptive standards the goal-oriented approach enables workplaces to adopt a system whereby responsibilities and duties are consulted on by both employers and employees. In 1972, the

[14] Cecilia Vindrola-Padros, Lily Andrews, Anna Dowrick, et al., 'Perceptions and experiences of healthcare workers during Covid-19 pandemic in the UK' (BMJ, 2020).
[15] Nishtha Gupta, Sana Dhamija, Jaideep Patil and Bhushan Chaudhari, 'Impact of Covid-19 pandemic on healthcare workers' (Industrial psychiatry journal, 2021).
[16] 'How well protected was the medical profession from Covid-19?' (British Medical Association, 2024) <https://www.bma.org.uk/media/fhmi01p2/bma-covid-review-report-review-1-september-2024.pdf> accessed 17 November 2024.
[17] 'Covid-19: Impact of the pandemic on healthcare delivery' (British Medical Association, 2024) <https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-impact-of-the-pandemic-on-healthcare-delivery#:~:text=After%20years%20of%20declining%20bed%20stock%2C%20hospitals,any%20increases%20in%20demand%2C%20such%20as%20those> accessed 12 October 2024, 'NHS backlog data analysis' (British Medical Association, 2024) <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis> accessed 12 November 2024.
[18] David Eves, ''Two steps forward, one step back' A brief history of the origins, development and implementation of health and safety law in the United Kingdom, 1802-2014' (History of Occupational Health and Safety) <https://www.historyofosh.org.uk/brief/index.html> accessed 12 February 2021.

Robens Committee of Inquiry on Safety and Health at Work provided recommendations on how best to protect workers, which led to the enactment of the 1974 Act.[19] The recommendations provided by this Act enabled the UK to be a front runner in the field of occupational health and safety as the UK was already exercising rules and regulation in high-risk occupations, albeit at the very early stages of enforcement. The Robens Committee provided guidance in understanding ambiguities in the legislation and on how to interpret statutory regulations. Employers were also encouraged to work in collaboration with inspectors who were responsible for making sure that both employers and employees were aware of their responsibilities and to be cautious of the environment in which they carry out their work. The United Kingdom proved that legislation and public policy could contribute to reducing the number of fatal accidents at the workplace. This positive trend persisted, culminating in a record low of 111 worker fatalities in 2019/2020, which was a decrease of 38 workers since the previous year.[20] This demonstrated that the 1974 Act had been effective in mitigating the dangers at work and protecting the health and safety of workers. Undeniably the self-regulating system enabled employers to enhance worker safety by way of structuring the health and safety measures to the specific needs and circumstances of their workplace. However, this prompts the question of whether the self-regulatory approach to workers' health and safety adopted by the UK was fit to provide an effective means of protecting frontline HCWs against the effects of a global pandemic?

Prior to the pandemic, the self-regulating system was generally judged to be effective, having several strengths including flexibility when implementing workplace regulations and employer 'ownership', which enabled responsive decision making. The pandemic presented unique challenges, however, which even showed these supposed strengths to be weaknesses. During the pandemic, the lack of consistency in implementing safety measures across the healthcare sector caused suffering for many workers, specifically with regards to the use, training and fit testing of personal protective equipment (PPE). Employers were also required to prioritise delivery of care above certain occupational health and safety measures. The constantly evolving health and safety guidance made it incredibly challenging for employers to adhere to safety protocols. Accordingly, the main aim of the thesis is to explore whether the health and safety of HCWs in the United Kingdom was adequately protected during the Covid-19 pandemic. Addressing this question raises further, secondary research questions such as: *What were the conditions that led towards* HCW*s' health and safety being*

[19] 'The Robens Report' (Health and Safety Executive) <https://www.hse.gov.uk/aboutus/40/robens-report.htm> accessed 12 May 2021.
[20] 'Workplace fatal injuries in Great Britain 2020' (Health and Safety Executive, 2020) <https://www.hse.gov.uk/statistics/pdf/fatalinjuries.pdf> accessed 17 May 2021.

put in jeopardy? Were health care workers treated equally during the Covid-19 pandemic, when it came to their health and safety? What health and safety measures did the government introduce to meet the novel challenges and risks occasioned by the nationwide pandemic?

In my thesis, I have sought to answer the main research question and secondary research questions by conducting qualitative thematic analysis. From the outset, I felt strongly that it was important to understand the HCWs' perspective and experience of working during the Covid-19 pandemic. Consequently, the use of qualitative data analysis was the best-fit for the proposed research questions. Qualitative data is gathered most commonly through conducting interviews, as it allows the researcher to have a direct and interactive understanding of the participants' emotions and social cues that other methods may not provide. While I recognise that conducting interviews can provide an insight and deeper understanding of the experience of participants, I chose instead to rely on collecting and analysing secondary data, especially published testimonies of HCWs. The reasons for my decision were three-fold. First, I quickly realised that significant amounts of good quality secondary data were available as frontline HCWs began to share their experiences of working during the pandemic. The unique experiences of frontline HCWs were intriguing to the general public as they provided insight into the hardships and realties of working during the pandemic. Sharing their experiences provided a platform for HCWs to connect with each other while also raising awareness for change. Interviews and other forms of primary data collection tend to be extremely time consuming. By relying on this secondary data, I was able to save a considerable amount of time, which enabled me to focus more effectively and concentrate on the data analysis. Secondly, I was confident that choosing secondary data for the analysis was the most suitable choice for answering the research question, as the data enabled me to address the main research question that was not originally considered when the primary data was collected. Third and finally, I was conscious of recruiting suitable HCWs for the study during an ongoing pandemic, while also considering their willingness to participate due to the sensitive nature of the research. I wanted to avoid inadvertently triggering and exacerbating emotional distress for these workers. I was committed to conducting the data collection in a manner that minimized any potential harm for participants and prioritised their well-being.

While the thesis does not present original data, it nonetheless makes an original contribution to the existing literature by analysing the available secondary data thematically to construct an argument which highlights the various inadequacies of the existing legal framework and

the important role of trade unions in rule-setting and rule-enforcement around workers' health and safety.

The structure of the thesis

The thesis is comprised of seven chapters. The first chapter describes the NHS healthcare system in the UK and how it functions. It describes, in particular, the way in which healthcare provision is administered by NHS trusts and NHS foundation trusts. This chapter helps the reader understand that the different NHS trusts are governed under their unique policies which become a topic of discussion in the following chapters. The chapter also reviews the literature which highlighted the problems and challenges faced by HCWs in the NHS prior to the outbreak of Covid-19. Reviewing this literature reveals that while HCWs experienced significant problems and challenges prior to Covid-19, for example, excessive workload due to a persistent shortage of staff, other challenges occasioned by the pandemic were quite novel, for example, the continuous and rigorous use of PPE. On the basis of this literature review, it was evident that the challenges faced by HCWs were exacerbated during the pandemic, prompting the need for improved health and safety regulations.

The second chapter explores the theoretical framework and the methodology chosen to address the research questions. This chapter will provide the reader with an overview of the research process and how the data was collected and analysed. This involved a process of collecting data by reviewing testimonies presented by HCWs who worked during the Covid-19 pandemic. The testimonies provided first-hand accounts of the experiences encountered by workers and I was able to identify the particular health and safety issues that were at risk. The testimonies presented recurring themes and this enabled me to analyse each of them in a fruitful manner. The analysis was then conducted with the use of a socio-legal methodology. This was the most suitable legal research method because it enabled me to identify how the legal rules and regulations had been applied within the societal context. It was specifically interesting to note how the health and safety legislation, which intended to foster a 'self-regulating system,' had been applied during a pandemic.

Chapter three provides a detailed consideration of the role and operation of law in the current context. It explains how health and safety legislation came into being and the legal duties and responsibilities that parties owe each other in relation to health and safety within the workplace. The chapter highlights the legislative framework that is the focus of the analysis.

It further stresses the significance of a self-regulating system that enables employers to implement measures to ensure the safety of the working environment. It emphasises that the Health and Safety at Work Act 1974 places employers under a duty to ensure that the health and safety of workers are protected by taking reasonably practicable measures.

The fourth chapter explores the important role played by trade unions and more specifically how they assisted in protecting the health and safety of HCWs during the Covid-19 pandemic. Unions strive to ensure that their members are treated with respect within their employment and they fulfil an important function in negotiating for better job security and improved terms and conditions. This chapter explores the role of collective bargaining and how HCWs were able to use this mechanism to achieve essential improvements in health and safety systems during the pandemic. It concludes by asserting that collective bargaining was a particularly successful tool in the protection of HCWs during the Covid-19 pandemic and was more effective in this respect than the existing framework of health and safety legislation.

Chapter five and six present the data analysis. The data is organised thematically into five key overarching themes namely:

(i) prejudicial treatment of black minority ethnic workers,
(ii) the lack of support for migrant workers,
(iii)supply of PPE,
(iv)inconsistent advice across the NHS workforce
(v) the intention to leave the healthcare profession.

These themes are then analysed in the two chapters. Chapter five focuses on the question, whether the health and safety laws pertaining to mental health were properly deliberated and utilised by the employers within the NHS to support and safeguard the mental health of HCWs during the Covid-19 pandemic. In order to address this question, three of the five themes were addressed. The testimonies presented by the HCWs under (i)-(iii) highlighted that the workers experienced mental health issues in varying degrees during the pandemic. Many Black Minority Ethnic (BME) HCWs were subjected to prejudicial and unfair treatment at work even prior to the pandemic and yet this treatment was only exacerbated. BME is an umbrella term used in literature to discuss the various ethnic and racial groups. While it is a broad term, the research will make reference to the term BME to assess the unique experiences faced by this group of people. The analysis showed that, in general, BME workers were being treated unfairly compared to their white colleagues and even in instances

where this mistreatment was voiced the working condition remained unchanged. Many migrant workers struggled mentally, having to navigate the constantly changing visa and immigration rules whilst having to provide care to Covid infected patients. The lack of sufficient PPE was one of the main reasons that affected workers' mental health whilst at work. Due to the unpredictable nature of the virus, workers were constantly in fear of contracting the virus without the adequate protection when providing care to patients. The NHS as an employer failed to provide satisfactory care to these workers.

Chapter six focuses on the physical health of workers and addresses themes (iii)-(v). Analysis reveals that the strengths of the self-regulating system were really put to the test during the pandemic. A self-regulating system enables employers to identify hazards at work and enforce reasonably practicable measures to completely remove them or provide adequate PPE in order to protect workers. This leaves room for significant enforcement irregularities which creates a risk of inconsistencies in health and safety regulations across the workforce. Chapter six also analyses the use of PPE and the physical issues that workers faced due to the prolonged use of protective equipment, which resulted in causing heatstroke to workers. It discusses the government's important initiative to mandate the vaccination programme for HCWs as a significant decision taken to protect their health and safety.

Finally, chapter seven sets out the conclusions of this thesis. Drawing on the findings of the preceding chapters, it consolidates the research undertaken to provide answers to the research questions specified above. In summary, the HCWs' health and safety were jeopardized during the Covid-19 pandemic primarily due to the inconsistent supply and shortage of PPE, which left workers highly vulnerable to infection. The lack of proper training and the ill-fitting PPE, specifically for female HCWs, exposed workers to the virus. The constantly changing government guidelines caused confusion amongst the workforces. The analysis also highlighted that BME and migrant workers were subjected to a significant increase in discrimination and disparities in their treatment were exacerbated. These workers were exposed to the potential infection and were at a higher risk of infection when compared to their white colleagues. Lastly, despite the controversial nature of the vaccination programme, mandating the Covid-19 vaccine enhanced the health and safety of workers during the pandemic.

In summary, the analysis undertaken for this thesis challenges the conventional understanding of the health and safety legislation. It was expected that the self-regulating system that enables employers to ensure workplace safety coupled with the health and safety

legal framework that is designed to protect worker safety would provide the effective protection. Yet the analysis demonstrated that the trade unions play a crucial role, especially in times of crisis advocating for better safety measures.

Having outlined the structure of the thesis, the next chapter will provide an in-depth understanding of the internal administration of the national health service in the UK. Highlighting the enforcement of trust specific policies to recognise the complexities and variations within the different NHS trust. The chapter will also provide the reader with an initial understanding of pre-pandemic challenges faced by workers and how they were exacerbated during the pandemic.

Chapter 1 The National Health Service and Healthcare Workers

Introduction

The overall aim of this thesis is to explore if the health and safety of HCWs in the United Kingdom was adequately protected during the Covid-19 pandemic. Bearing that in mind, this chapter aims to provide an overview of the healthcare system in the UK. Using this as my starting point enabled me to narrow my research to look at NHS HCWs in England. This chapter also highlights some of the mental and physical health issues that HCWs face as a result of their occupation. While these issues are broad, this shows that they existed prior to the Covid-19 pandemic and only got worse when it occurred.

In the first section of the chapter, I provide a brief outline of the healthcare system and the NHS structures across the four nations of the UK. These structures vary from nation to nation, which led me to decide that in order to research how health and safety laws affect HCWs, I would have to narrow the research to look at one nation. The four nations of the UK were affected by the Covid-19 pandemic in unpredictable ways. Although the pandemic was not constrained by political boundaries, the severity of its impact was shaped, in part, by the rules that were in place in each of the devolved nations. As each devolved nation had its own rules during the pandemic, it would not be an accurate study of HCWs to focus on the impact of the pandemic on their wellbeing across the UK as a whole. For example, a healthcare worker in England may have been exposed to different risks and for a longer period compared to a healthcare worker in Scotland or vice versa. For this study I will therefore be focusing on the impact of the pandemic on HCWs in England as it has the highest population out of the four nations, had the least restrictions in place during the pandemic and has a more complex NHS structure than Scotland, Wales or Northern Ireland with the highest number of NHS trusts compared to the other regions.

In the second section of the chapter, I will explore how NHS trusts were established. Manchester University NHS Foundation Trust (MFT) is used as an example to understand the internal administration of trusts. It is also important to understand the health and safety standards within the hospitals and other facilities that NHS trusts represent. Although all trusts are legally required to abide by health and safety law, the individual trusts are given flexibility over how to implement policy guidelines.

Working in the NHS comes with its challenges. This is highlighted in the final section of the chapter, as I aim to explore the mental and physical health risks that workers had to endure as a result of poor health care policy and its implementation during the pandemic. This chapter will conclude by stating that HCWs' health has worsened as a result of the Covid-19 pandemic. However, these health and safety risks did not transpire solely due to the Covid-19 pandemic as there were pre-existing deep rooted concerns related to health and safety policy and its implementation, which were exacerbated by the pandemic.

1. Devolution and the National Health Service

The NHS is one of the largest healthcare systems in the world, responsible for providing care to the whole of the UK. Following devolution in the late 1990s, it was split into several separate bodies.[21] Health and social care have been funded and policy-led by the devolved governments in Scotland, Wales and Northern Ireland in the UK for the past twenty years.[22] These separate health systems under the NHS were reformed with the hope that resources and services could be tailored in the most effective and efficient way for each nation and region.[23] The Scottish Parliament, the Welsh Senedd and the Northern Ireland Assembly primarily dealt with health and a number of other devolved matters when powers were transferred from Westminster on 1st of July 1999 and on the 2nd of December 1999 respectively.[24]

Despite the establishment of the three devolved administrations in the UK, the separate health services predate the devolution reforms of 1999. The National Health Services Act established in 1948 created a system whereby the UK government held responsibility comprehensively to provide care for the whole population.[25] The newly established system granted authority to the NHS for England and Wales to be responsible for hospitals which were previously run by local authorities. Similar powers were granted to Scotland with very limited institutional differentiations. The Northern Ireland NHS system was merged with the Health and Social Care system. Although separate from the NHS, the Northern Ireland social care system encapsulated the general NHS system. For instance, it provides free healthcare

[21] Gwyn Bevan, 'The impacts of asymmetric devolution on health care in the four countries of the UK' (London Health Foundation, 2014).
[22] Konstantina Grosios, Peter B Gahan and Jane Burbidge, 'Overview of healthcare in the UK' (EPMA Journal, 2010).
[23] Katherine Smith and Mark Hellowell, 'Beyond rhetorical differences: A cohesive account of post-devolution developments in UK health policy' (Social Policy & Administration, 2012).
[24] Scott L Greer, 'Territorial politics and health policy: UK health policy in comparative perspective' (Manchester University Press, 2004).
[25] Peter Greengross, Ken Grant and Elizabeth Collini, 'The history and development of the UK National Health Service 1948-1999' (DFID Health Systems Resource Centre, 1999).

at the point of services, it is funded by taxes, and the primary pathways that a patient can access are similar everywhere in the UK with some minor differences in the three devolved administrations. For instance, in Scotland and Wales prescriptions issued by the NHS are free of charge and free social care is provided for citizens aged 65 and over. The institutional differences were very indistinct immediately following devolution, as policies in Scotland, Wales and Northern Ireland were influenced by policies developed for England. Although at first glance they looked different, they were distinctive only at the margins.[26]

1.1 National Health Service structures across the United Kingdom

Following devolution, the NHS has undergone major reforms in each of the four nations. Scottish health policy was broadly similar to the English system until devolution.[27] However, as health is a fully devolved matter with responsibility resting with the Scottish Parliament, Scottish health policy is now one of the most divergent policy fields compared to the other nations.[28] Policy decisions such as providing free care for the elderly and banning smoking in public places indicated a system focused on strengthening the role of the medical profession as opposed to the English system that has been more concerned about the introduction of the NHS internal market.[29] This might be due to the size of Scotland as a country, which helps policymakers to take a less formal and a more personalised approach to building personal relationships of collaboration as opposed to acting in an authoritarian role. For instance, Scotland was more focused on breaking down boundaries between health and social care by putting more emphasis on partnerships between health and social care providers and less emphasis on the private sector.[30] In the year 2004, Scotland removed the NHS 'internal market' which resulted in abolishing the NHS trusts through The National Health Service Reform (Scotland) Bill which, was passed into law in 2004.[31] Unlike the English system where the responsibility for healthcare lies with the national government and social care in the hands of local authorities, in Scotland health and social care are regulated and managed at the national level. The system is led through legislation unlike in England,

[26] Sian E Maslin-Prothero, Abigail Masterson and Kerry Jones, 'Four parts or one whole: The National Health Service (NHS) post-devolution' (Journal of Nursing Management, 2008).
[27] Ellen Stewart, 'A mutual NHS? The emergence of distinctive public involvement policy in a devolved Scotland' (Policy & Politics, 2013).
[28] Katherine E Smith, David J Hunter, Tim Blackman, et al., 'Divergence or convergence? Health inequalities and policy in a devolved Britain' (Critical Social Policy, 2019).
[29] Scott L Greer, 'The territorial bases of health policymaking in the UK after devolution' (Regional & Federal Studies, 2005).
[30] Allan Bruce and Tom Forbes, 'Delivering community care in Scotland: Can local partnerships bridge the gap?' (Scottish Affairs, 2005).
[31] Shane Dohney, 'The Organisation of the NHS in the UK: Comparing Structures in the Four Countries' (National Assembly for Wales Research Service, 2015).

where it is led by individual local authorities. Although Scotland currently does not have NHS trusts, NHS Scotland consists of 14 NHS Boards, 7 Special NHS Boards and 1 public health body, that are responsible for providing protection and improving the health of its population.[32]

Welsh health policy reform following devolution was radical as the Welsh Senedd believed that it was the right time to re-launch the NHS in Wales. The newly devolved government proposed 'Improving Health in Wales - A plan for the NHS with its partners'. These proposed changes would build upon the existing structure of the Welsh NHS, which was seen as symbolic due to Wales's identity as the birthplace of the modern NHS.[33] As a result, the new structure sought to achieve a system that was easier for patients to navigate with the NHS taking more responsibility for the services it delivered and the actions it took. The administration was to take a more democratic approach by placing citizens at the centre of the NHS.[34]

The health system in Northern Ireland (NI), referred to as the Health and Social Care in Northern Ireland or Health & Social Care (HSC), has the most unique system in comparison to the three national health services within the UK.[35] This is predominantly due to the fact that the NI Department of Health has overall responsibility for the health and social care services. As social care services are integrated under the HSC, they provide family and children's services, day care services, social work services and home care services.[36] Currently there are 6 HSC trusts in NI, 5 of these trusts provide integrated health and social care services in NI across their corresponding areas. The NI ambulance service, which is the 6th HSC trust, provides high quality ambulance services to people in need and aims to improve the health and well-being of the community.

English NHS policy has been influenced by the introduction of the internal market in the 1990s that intended to improve the quality of care given to patients by creating competition between healthcare providers, ultimately aiming to reduce unnecessary spending and control costs within the NHS. The Labour government of 1997-2007 headed by Tony Blair was

[32] 'Scotland's Health on the Web, Putting Scotland's Health on the Web. Structure of NHS Scotland' (NHS Scotland, 2022) <https://www.scot.nhs.uk/about-nhs-scotland/> accessed 01 March 2022.
[33] Phil Carradice, 'Healthcare in Wales before the NHS' (BBC, 2015) <https://www.bbc.co.uk/blogs/wales/entries/ee3858cf-074e-42a4-b4df-ac5afcc4e962> accessed 02 March 2022.
[34] 'Improving Health in Wales, A plan for the NHS with its partners' (NHS Wales) <http://www.wales.nhs.uk/publications/from-plan-to-action-e.pdf> accessed 02 March 2022.
[35] Angela Jordan, Jackie McCall, William Moore, et al., 'Health Systems in Transition: The Northern Ireland Report' (World Health Organisation, 2006).
[36] Deirdre Heenan and Derek Birrell, 'The integration of health and social care the lessons for Northern Ireland' (Social Policy & Administration, 2006).

responsible for this policy, promising to provide better care to patients by reducing the waiting times.[37] These policies are integrated into the core values of the NHS as it strives to deliver care to meet the needs of everyone, for its services to be free at the point of delivery and for care to be provided on a clinical basis rather than on the ability to pay.[38] As part of the broader administrative policy, NHS trusts were established. There are currently 227 NHS trusts that provide care in England which include acute, ambulance, community and mental health care.[39]

2. National Health Service trusts and the associated internal administration

2.1 A brief introduction to National Health Service trusts

NHS trusts were first established under the National Health Service and Community Care Act 1990, that introduced major reform to the NHS in the UK.[40] Originally under section 5 of the act, the Secretary of State was given the power to establish NHS trusts by order.[41] These trusts were given the responsibility of overseeing the ownership and the management of hospitals and other facilities that were previously managed by regional, district or special health authorities.[42] Since their inception, NHS trusts have been effectively responsible for providing high standards of health care and for employing medical staff for their respective hospitals.

Although the internal administration of each NHS trust may be different when compared to one another, the structure of the NHS trusts is similar. The core statutory powers are set out under the National Health Service Act 2006 (2006 Act).[43] All NHS trusts are public sector corporations that have a board of directors which consists of executive directors and non-

[37] Polly Toynbee, 'NHS: the Blair years' (BMJ, 2007).
[38] 'Building a healthy NHS around people's needs, An introduction to NHS foundation trusts and trusts' (Foundation Trust Network, 2015) <https://nhsproviders.org/media/1036/introduction_to_nhs_fts_and_trusts_-_nhs_providers_-_may_2015.pdf> accessed 07 March 2022.
[39] 'Authorities and Trusts: NHS trusts' (NHS) <https://www.nhs.uk/ServiceDirectories/Pages/NHSTrustListing.aspx> accessed 07 March 2022.
[40] Peter Greengross Ken Grant and Elizabeth Collini, 'The history and development of the UK National Health Service 1948- 1999' (HSRC, 1999).
[41] National Health Service and Community Care Act 1990. s5.
[42] 'Building a healthy NHS around people's needs, An introduction to NHS foundation trusts and trusts' (Foundation Trust Network, 2015) <https://nhsproviders.org/media/1036/introduction_to_nhs_fts_and_trusts_-_nhs_providers_-_may_2015.pdf> accessed 17 March 2022.
[43] 'Handbook to the NHS constitution for England, Department of Health and Social Care' (GOV.UK, 2022) <https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england> accessed 20 March 2022.

executive directors.[44] Schedule 4, para 3(3) of the 2006 Act states that all executive directors are required to be employees of the NHS trust and non-executive directors are not to be employed under the NHS trust.[45] The board of directors also consists of a chairman appointed by the Secretary of State.[46]

More than a decade after the NHS trusts were established, in the year 2004 the first foundation trusts in England and Wales were established.[47] Similar to the NHS trusts, the foundation trusts were responsible for providing goods and services for the purpose of the health service in England. The NHS foundation trust is a public benefit corporation, which was designed to allow people from the communities who are serviced by NHS trusts, to also take part in governing them and to move away from the central government and the governance structure.[48]

In the next section, I will explore the administrative arrangements and operation of the MFT which provides an example of how large and complex organisations implement and develop health and safety policies. I will also consider how other trusts such as Harrogate and District have adopted similar practices in order to create a safe and healthy environment for workers while adhering to legal requirements. It should be noted that these examples are not intended to be exhaustive, but rather to offer a general overview of the internal administration of trusts.

2.2 Manchester University NHS Foundation Trust

Amongst the different NHS trusts in England, the MFT is the largest acute trust (governing hospitals that provide medical and surgical treatments)[49] in the UK, overseeing ten hospitals across six individual sites providing a wide range of services.[50] The MFT was created in 2017 following the merger of the Central Manchester University Hospitals NHS Foundation

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[44] 'Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts' (NHS, 2019) <https://www.england.nhs.uk/1sthi5thew4y/wp-content/uploads/sites/54/2020/08/Chair_and_NED_Remuneration_Structure_1nov.pdf> accessed 18 March 2022.
[45] National Health Service Act 2006. Schedule 4, para 3(3)
[46] Ibid.
[47] 'Your statutory duties, A reference guide for NHS foundation trust governors' (Monitor, Making the health sector work for patients, 2013) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_guide_August_2013_UPDATED_NOV_13.pdf> accessed 18 March 2022.
[48] Richard Q Lewis, 'NHS foundation trusts' (BMJ, 2005).
[49] 'Have your say- definitions'(North Devon Healthcare NHS Trust, 2017) <https://www.northdevonhealth.nhs.uk/have-your-say/past-consultations-and-engagement-projects/successregime/acute-services-review/definitions/> accessed 16 March 2022.
[50] 'The Trust' (Manchester University NHS Foundation Trust, 2022) <https://mft.nhs.uk/the-trust/> accessed 18 March 2022.

Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM).[51] Following the merger, the MFT administered a wide spectrum of sites that provided comprehensive local general hospital care through to highly specialised regional and national services.

According to its own website, the MFT aims to improve the health and quality of patients by creating an organisation that values the quality of care provided, the safety of their patients and excels in research, innovation and teachings. It has ambitions to be recognised globally as a leading healthcare provider.[52] In order to attain these aims, a clear set of duties and rules are set out under the trust constitution.

The MFT constitution specifies the general duties and roles the board of directors and the council of governors should comply with in order to fulfil their responsibilities. The trust board consists of a chairman and a deputy chairman, chief executive and deputy chief executive, chief nurse, chief finance officer, chief operating officer, two medical directors, executive director of workforce and corporate business, director of strategy and seven non-executive directors.[53] According to section 24 of the constitution, the board of directors are individually responsible for promoting the success of the trust.[54] This success is predominantly measured in the ways in which they aim to provide goods and services to the health services in England and the management of the health and safety standards within the trust.[55]

2.3 The health and safety standard within the hospital and other facilities

The general duties that employers have towards employees and employees have to themselves, each other and members of the public are set out under the Health and Safety at Work etc. Act 1974.[56] In order to fulfil the requirements of the law, most NHS trusts/foundations have utilised policy as a tool to manage the health and safety of employees

[51] 'Manchester University NHS Foundation Trust' (NHS, 2019) <https://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=R0A> accessed 16 March 2022.
[52] 'The Trust' (Manchester University NHS Foundation Trust, 2022) <https://mft.nhs.uk/the-trust/> accessed 18 March 2022.
[53] The Board' (Manchester University NHS Foundation Trust, 2022) <https://mft.nhs.uk/the-trust/the-board/> accessed 18 March 2022.
[54] 'Manchester University NHS Foundation Trust Constitution' (Manchester University NHS Foundation Trust, 2021) <https://mft.nhs.uk/app/uploads/2021/03/MFT-Constitution-Feb-2021.pdf> accessed 18 March 2022.
[55] Ibid.
[56] 'Your statutory duties, A reference guide for NHS foundation trust governors' (Monitor, Making the health sector work for patients, 2013) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_guide_August_2013_UPDATED_NOV_13.pdf> accessed 18 March 2022.

effectively and systematically. The customised policy guides employees in the ways in which they are to avoid or adapt to workplace hazards.

As mentioned above in the introduction of this chapter, the MFT, one of the largest acute trusts has provided an example to other trusts by implementing several health and safety policies within the organisation. For instance, the trust has a specific 'patient safety incident response policy' where it aims to provide an in-depth understanding of the importance of patient safety. The trust also has a 'equality, diversity and inclusion strategy' that stresses the importance of upholding inclusivity within the work environment in order to ensure the workers are given the optimal foundation for success.[57] This is an important implementation within the workplace which will be highlighted in chapter five.

Following in these footsteps, one NHS foundation trust that has an integrated health and safety and welfare policy for employees and patients is the Harrogate and District NHS Foundation Trust (Harrogate Trust). The Harrogate Trust is responsible for the population in Harrogate and across the local areas of North Yorkshire and Leeds. The trust sets yearly goals that aid them to meet their vision and mission. Whilst their annual goals place the patients' needs at the heart of decision making, the trust also aspires to support and engage with their staff in order to promote staff health and wellbeing and an open and honest culture in order to enable them to thrive in their workplace.[58] The Board of Directors appointed under the trust is responsible for the day-to-day management and provide appropriate accountability and strong decision making.[59]

These intentions are further elaborated under the Harrogate Trust health and safety policy. The trust acknowledges that their main intention by drafting a health and safety policy is to abide by the 1974 Act and the Management of Health and Safety at Work Regulation 1999 that further reinforces and amplifies the duties set out under the 1974 Act.[60] In order to comply with the above acts, the Harrogate Trust uses Salus as the trust's external health and safety advisor.[61]

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[57] 'Equality, Diversity and Inclusion' (Manchester University NHS Foundation Trust) <https://mft.nhs.uk/the-trust/equality-diversity-and-inclusion/#:~:text=On%201st%20October%202017%20Central,Inclusive%20leadership> accessed 10 January 2023.
[58] 'The Trust- Our plans' (Harrogate and District NHS Foundation Trust, 2022) <https://www.hdft.nhs.uk/about/trust/our-plans/> accessed 17 March 2022.
[59] 'The Trust- How we work' (Harrogate and District NHS Foundation Trust, 2022) <https://www.hdft.nhs.uk/about/trust/how-we-work/> accessed 17 March 2022.
[60] 'Health and Safety Policy' (Harrogate and District NHS Foundation Trust, 2019) <https://www.hdft.nhs.uk/content/uploads/2017/10/Health-and-Safety-policy-15-Aug-17.pdf> accessed 20 March 2022.
[61] Ibid.

In contrast to the above Harrogate Trust, the health and safety policy of the South London & Maudsley NHS Foundation Trust (South London Trust) takes a different approach in taking reasonably practical steps to protect their health and safety and welfare of the trust's employees and other individuals affected by it.[62] As opposed to relying on health and safety advisors, the South London Trust have created a more holistic approach to appropriately and effectively manage the health, safety and welfare within the trust.[63] The management of health and safety within the trust is overseen by the trust chief executive who bears the overall accountability to ensure that policies and procedures are formally monitored and evaluated against statutory obligations. Alongside the chief executive, the chief operating officer takes responsibility for reporting the status of health and safety within the trust board whilst directing, guiding, supporting, organising, monitoring and reviewing the trust's health and safety.

2.4 The NHS as employer

The NHS is one of the largest employers in the UK, with approximately over 1,164,000 staff as of September 2020.[64] This includes professionally qualified staff, such as doctors and nurses, all of whom are employed by the NHS under employment contracts.[65] However, the NHS faces difficulties when protecting its workers' health and safety at work due to the very broad and general legislation provided by the 1974 Act. Due to this gap, the NHS is required to implement its own health and safety policies which often leads towards complications within the occupation, as there is no standardised implementation of the 1974 Act across the NHS work force. As mentioned above, the two foundation trusts have rather different strategies of health and safety management in the workplace. This creates discrepancies across the different workforces which may result in them facing other more critical issues within the working environment.

The prevailing reason that the general health and safety legislation has not been adequate for the protection of HCWs is due to the unique nature of work that they have to carry out. For instance, healthcare professionals are expected to take care of patients and to abide by the

[62] 'The trust- Our strategy' (London & Maudsley NHS Foundation Trust) <https://www.slam.nhs.uk/about-us/who-we-are/our-strategy/> accessed 24 March 2022.
[63] 'Health and Safety Policy' (London & Maudsley NHS Foundation Trust, 2021) <https://www.slam.nhs.uk/media/6903/health-and-safety-policy-v6-may-2021.pdf> accessed 20 March 2022.
[64] 'Record numbers of doctors and nurses working in the NHS' (Department of Health and Social Care, 2020) <https://www.gov.uk/government/news/record-numbers-of-doctors-and-nurses-working-in-the-nhs> 04 November 2020.
[65] 'NHS Standard Contract 20/21 General Conditions (Shorter form)' (NHS Standard Contract Team, NHS England, 2020) <https://www.england.nhs.uk/wp-content/uploads/2020/03/6-SF-GCs-comp-1920-vs-2021.pdf> accessed 07 November 2020.

"duty of care" despite the circumstances that they have to face. The duty of care is an issue that especially concerns HCWs when they are expected to provide care even during global pandemics as medical professionals. According to the Royal College of Nursing (RCN), HCWs "cannot refuse to be involved in the care of patients because of their condition or the nature of their health problems".[66] When considering this duty of care that the HCWs hold, it is necessary to consider if in the normal course of their work a healthcare professional would be able to permissibly deny treatment to a patient if they are met with a health and safety risk to themselves or other staff members.

3. Workplace tribulations in the healthcare occupation

A plethora of research has been conducted entailing the topic of patient quality of care and wellbeing.[67] Over the years, patient satisfaction has been an indicator for evaluating the above, without regard to the negative impact that may be felt by HCWs.[68] This is not unexpected given the six principal values that all NHS staff are expected to abide by. The principal value "Patients come first in everything we do",[69] sits at the heart of what HCWs are expected to demonstrate.

However, there is an imbalance between patient satisfaction and the health of HCWs. The NHS management emphasises that the patient's wellbeing remains a priority. Although a respectable goal which is aligned with the NHS principles, achieving this objective can come at the expense of HCWs' wellbeing, who are not given the same care and attention.[70] A domino effect of the above has resulted in an increase of physical and mental health risks amongst HCWs, and healthcare leaders are being pressured to do more to improve working conditions of HCWs in order to carry out their work effectively.[71]

Due to the nature of the work that HCWs carry out, many industrial countries have reported an alarming rise in workplace stress and as a result, a higher risk of both mental and physical

[66] 'Refusal to treat' (Royal College of Nursing, 2020) <https://www.rcn.org.uk/get-help/rcn-advice/refusal-to-treat> accessed 04 September 2020.
[67] Paul D Cleary and BJ McNeil, ' Patient satisfaction as an indicator of quality care' (Inquiry, 1988).
[68] Piergiorgio Argentero, Bianca Dell'Olivo, Maria Santa Ferretti, and Working Group on Burnout, 'Staff burnout and patient satisfaction with the quality of dialysis care' (American Journal of Kidney Diseases, 2008).
[69] 'Values of the NHS Constitution' (NHS) <https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-constitution> accessed 04 January 2022.
[70] Stefan De Hert, 'Burnout in healthcare workers: prevalence, impact and preventative strategies' (Local and regional anaesthesia, 2020).
[71] Lene E Søvold, John A Naslund, Antonis A. Kousoulis, et al., 'Prioritizing the mental health and well-being of healthcare workers: an urgent global public health priority' (Frontiers in public health, 2021).

health problems amongst these workers compared to professionals in other occupations.[72] Mental and physical health problems among HCWs are a challenging topic to consider, due to the stigma that is often surrounded by these issues. HCWs are seen as individuals who are immune to any mental and physical health problems. They are employed into the profession of healthcare with the intention of providing care to others whilst concealing their own needs.

One of the very pressing issues that is faced within the nursing profession is the phenomenon of 'horizontal violence' where nurses discriminate against colleagues who have an identified mental health illness.[73] Although this phenomenon was first identified over three decades ago it continues to be an issue within the nursing occupation. Over the years the phenomenon has taken different forms. One such form, according to Quine, that is interchangeable to the term horizontal violence is bullying. Bullying is a form of violence where the victim is exposed to a series of systematic stigmatisation from fellow workers.[74] There are three main types of bullying namely, direct physical, verbal and indirect bullying.[75] This behaviour makes a victim feel harassed and intimidated which can create an imbalance of power between the victim and the bully. This negative effect on the victim will often lead towards greater problems in healthcare as the consequences of the workplaces are not only individual but organisational. This will not only have a negative impact on the quality of care, but also patient safety.

According to Sheridan-Leos, horizontal violence is also interchangeable with the term lateral violence.[76] Sheridan describes this phenomenon as the nurses directing their dissatisfaction towards those who are in less powerful positions than themselves. This issue of horizontal violence is extremely difficult to identify due to the stigma and shame surrounding mental health issues, the reluctance to disclose troubles to others in the field or the reluctance to seek help.

Whilst there are a number of potential barriers that affect HCWs from seeking help, the most commonly associated is the self-stigmatisation and the anticipated discrimination from others that reduce the willingness to seek professional help for mental health disorders. According to Moll, early intervention for mental health has shown the optimal results

[72] Aristotelis Koinis, Vasiliki Giannou, Vasiliki Drantaki, et al., 'The impact of healthcare workers job environment on their mental-emotional health. Coping strategies: the case of a local general hospital' (Health psychology research, 2015).
[73] Rosemary Taylor, 'Nurses' Perceptions of Horizontal Violence' (Global Qualitative Nursing Research, 2016).
[74] Lyn Quine, 'Workplace bullying in nurses' (Journal of health psychology, 2001).
[75] D Olweus, R Catalano, P Slee, 'The nature of school bullying; A cross-national perspective' (London and New York, 1999).
[76] Norma Sheridan-Leos, 'Understanding lateral violence in nursing' (Clinical Journal of Oncology Nursing, 2008).

especially for workers in healthcare. Often individuals delay intervention until issues have escalated to a crisis point.[77]

One of the main reasons that HCWs conceal their mental and physical health issues is due to concerns about how it might affect their reputation.[78] Their credibility as healthcare professionals would be compromised if their patients were to discover their problems. One barrier that seemed to be specific to the healthcare environment, is that there is an image or an expectation that healthcare providers are invincible and therefore are able to cope with the stress that they have to endure.

This is mainly due to the fact that it is frowned upon for HCWs to have any kind of mental health issue since they are responsible for patients' care. There is little to no empathy, but rather a sense that if you are not able to cope with the risks associated with the profession then you are at risk of dismissal.[79] Timely access to mental health support has been a recurring problem. Workers are often unable to attend therapy appointments during their working hours. This is due to a variety of reasons, such as a lack of staffing but is mostly due to many HCWs putting their occupation as their priority rather than their own health needs.

4. Challenges of working in the NHS

With the advancement of technology, healthcare has become very progressive and complex which has imposed a number of hazards. Common hazards faced by HCWs include sharps injuries, radiation exposure, reproductive health hazards, physical burnout, chemical and biological hazards.[80] These health hazards intensified during the Covid-19 pandemic and HCWs were unaware of the preventive measures that they should take, having been exposed to these hazards. Some workers have often lost sight of their own health needs whilst attending to the needs of their patients. Within the organisation (NHS) patient care is

[77] Sandra E Moll, 'The web of silence: a qualitative case study of early intervention and support for healthcare workers with mental ill-health' (BMC Public Health, 2014).
[78] Bruna Sordi Carrara, Carla Aparecida Arena Ventura, Sireesha Jennifer Bobbili, et al., 'Stigma in health professionals towards people with mental illness: an integrative review' (Archives of psychiatric nursing, 2019).
[79] Stephanie Knaak, Ed Mantler and Andrew Szeto, 'Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions' (SAGE Publications, 2017).
[80] Aroop Mohanty, Anita Kabi and Ambika P Mohanty, 'Health problems in healthcare workers: A review' (Journal of family medicine and primary care, 2019).

prioritised with a focus towards patient satisfaction, disregarding the health and safety of HCWs.[81]

4.1 Sharps injuries

When delivering healthcare, sharps are commonly used and found in almost all care settings.[82] While it is necessary, it can result in accidents that cause a risk of infection if a healthcare worker sustains an injury of a contaminated needle stick with potentially infected blood.[83] It is reported that during the years between 2012-2022, needlestick injury claims were reported 2,600 times.[84] Although these injuries are common in the healthcare sector, it is still unclear if the above claims of the number of injuries sustained by HCWs are accurate due to the lack of reporting.[85]

The most common health risk associated with needles stick injuries are blood born risks commonly recognised as Human Immunodeficient Virus (HIV) infection, Hepatitis B (HBV) and Hepatitis C (HCV).[86] The most common environments that reported a high number of sharps injuries was the general wards which was closely followed by the operating theatre.[87] These environments posed a significant risks to nurses, doctors and surgeons compared with their colleagues from other specialties. Although risks were most common amongst surgeons, the circumstances in which needle stick injury could transpire was not limited to wards and operating theatres. It also regularly occurred when disposing needles, cleaning up, recapping needles, manipulating a needle or collision with a worker.[88]

As a means to limit sharps injury the Health and Safety Executive (HSE) provided guidance on how to minimise risks by encouraging safer practice, providing the relevant legislation and regulations.[89] The Health and Safety (Sharp Instruments in Healthcare) Regulations

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[81] Bhanu Prakash, 'Patient Satisfaction' (J Cutan Aesthet Surgery, 2010).
[82] 'Sharps safety' (Royal College of Nursing, 2023) < https://www.rcn.org.uk/Professional-Development/publications/rcn-sharps-safety-uk-pub-010-596> accessed 09 July 2023.
[83] 'Safer Sharps' (NHS supply chain) <https://www.supplychain.nhs.uk/programmes/safer-sharps/#:~:text=Needlestick%20injuries%20occur%20when%20healthcare,in%20the%20UK%20every%20year > accessed 09 July 2023
[84] 'Preventing needlestick injuries' (NHS Resolution, 2023) <https://resolution.nhs.uk/resources/preventing-needlestick-injuries-2/#:~:text=Leaflet%20resource,needlestick%20injuries%20are%20largely%20avoidable> accessed 11 July 2023.
[85] JC Trims and TSJ Elliot, 'A review of Sharps injuries and prevention strategies' (Journal of Hospital Infection, 2003).
[86] E Au, JA Gossage and SR Bailey, 'The reporting of needlestick injuries sustained in theatre by surgeons: are we under-reporting? (Journal of Hospital Infection, 2008).
[87] 'Sharps injuries' (Health and Safety Executive) <https://www.hse.gov.uk/healthservices/needlesticks/> accessed 07 January 2022.
[88] Aroop Mohanty, Anita Kabi and Ambika P Mohanty, 'Health problems in healthcare workers: A review' (Journal of family medicine and primary care, 2019).
[89] WJ Thomas, JR Murray, 'The incidence and reporting rates of needle-stick injury amongst UK surgeons' (The Annals of The Royal College of Surgeons of England, 2009).

2013 imposes duties on employers in the healthcare sector to safeguard HCWs from injuries caused by sharps.[90] Despite the numerous safety policies that are in place, the adherence to these safety policies by individuals in the healthcare sector has been found to be very poor.[91] Amongst the many reasons, the lack of time, the inability to leave the theatre/surgical procedure, the excessive paperwork and the inadequate support given to workers from reporting out of working hours all remain problematic.[92] In addition to the ineffective reporting system, health workers stated that they did not report some injuries as they were not concerned, or they did not have time. They often thought that the patient was of low risk, or they were of the opinion that with double gloving and using a solid needle the risk of virus transmission was low.[93] This lack of enthusiasm to safeguard one's life begs the question, whether HCWs are working with one goal in mind which is to provide care to patients disregarding the health and safety of themselves. A new and more effective user-friendly reporting system needs to be in place, as it is not realistic or practical to report some minor injuries. The lack of an effective reporting system will only lead towards a lengthier process of reporting and could result in the decline in care with the possibility of postponing surgery, if a HCW become ill after contracting a sharps injury.

4.2 Radiation exposure

With the progression of technology, medical radiation is increasingly being used in diagnosis, procedural and surgical treatment.[94] Yet it begs the question, if this advancement is at the expense of the health and safety of HCWs who are exposed to radiation at their workplace. The use of both ionizing and non-ionizing radiation is commonly seen in medical practice, where ionizing radiation is predominantly used in the form of x-rays.[95] Medical radiation could occur from three different sources: namely, through direct exposure from the primary x-ray beam, scattered radiation from patient body surface and a leakage of x-rays where, radiation is emitted from the x-ray tube in areas other than the primary beam.[96] Ionizing radiation imposes hazardous effects on workers who are exposed to radiation in

[90] 'Sharps injuries' (Health and Safety Executive) <https://www.hse.gov.uk/healthservices/needlesticks/> accessed 07 January 2022.
[91] Alexander Elder and Caron Paterson, 'Sharps injuries in UK health care: a review of injury rates, viral transmission and protentional efficacy of safety devices' (Occupational medicine, 2006).
[92] WJ Thomas, JR Murray, 'The incidence and reporting rates of needle-stick injury amongst UK surgeons' (The Annals of The Royal College of Surgeons of England, 2009).
[93] Hui-Ling Kerr, Nicola Stewart, Alistair Pace and Sherief Elsayed, 'Sharps injury reporting amongst surgeons' (The Annals of The Royal College of Surgeons of England, 2009).
[94] Aroop Mohanty, Anita Kabi and Ambika P Mohanty, 'Health problems in healthcare workers: A review' (Journal of family medicine and primary care, 2019).
[95] Armagan Dagal, 'Radiation safety for anesthesiologists' (Current Opinion in Anesthesiology, 2011).
[96] Ibid.

their workplace. These hazards take the form of cataract, bone marrow suppression, birth deformities, infertility and different types of cancer.[97] Therefore, a good understanding of awareness and knowledge about radiation hazards and protective measures play an important role in reducing radiation exposure among HCWs.

4.3 Reproductive health

HCWs exposed to hazards could negatively impact their reproductive health such as menstruation, ovulation, fertility and quality of life which may lead towards harmfully effecting the foetus.[98] As discussed above, one of the main consequences that arise as a result of radiation is the risks associated to the reproductive health of workers in the workplace.

Many HCWs experience strenuous work due to the nature of their occupation, for instance workers experience prolonged standing, which may result in reduced blood flow and circulation.[99] This may be especially pertinent to women who are at the later stage of pregnancy and are advised to exercise with caution. The healthcare sector has been vigilant of the risks that might have a negative effect on pregnant women as reproductive health problems may cause miscarriage and birth defects.[100] It can be argued that this is due to the fact that pregnant women are easily identified in the workplace, albeit during the later and mid trimesters. The same attention and care would not be given to females who are at the early stages of pregnancy or non-pregnant women.

Despite the above, the attention has shifted towards considering the reproductive system of both genders. Radiation has a negative effect on males as it could cause infertility amongst the individuals due to reducing their sperm production or even effecting the shape and the movement of the sperm.[101]

[97] WN Sont, JM Zielinski, JP Ashmore, et.al, 'First analysis of cancer incidence and occupational radiation exposure based on the National Dose Registry of Canada' (American journal of epidemiology, 2001).
[98] Stephanie Knaak, Ed Mantler and Andrew Szeto, 'Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions' (SAGE Publications, 2017).
[99] Joyce Hood, 'The pregnant health care work- An evidence-based approach to job assignment and reassignment' (Aaohan Journal, 2008).
[100] Irene Figa-Talamanca, 'Reproductive problems among women health care workers: epidemiologic evidence and preventative strategies' (Epidemiologic Reviews, 2000).
[101] Cynthia Gonzalez, 'Occupational reproductive health and pregnancy hazards confronting health care workers' (AAOHN Journal, 2011).

4.4 Chemical hazards

The nature of HCWs' occupation makes it impossible to refrain from being exposed to a variety of chemical hazards. The most common agents that affected the above diseases were detergents and soap, wet work, PPE and sterilizing agents.[102] Exposure can be through the most basic form of inhalation, vapours or skin exposure. These chemical exposures would lead towards irritation of the eyes and cause sore throat, cough and nasal irritation. Further, direct exposure to the skin could result in itching, burning, redness or even swelling. Handling chemical substances in the workplace is difficult, as for instance, chemical hazards could include cleaning agents that are being used for general housekeeping. A number of studies have investigated the skin disorders that HCWs endure.[103] Common disorders were infective skin diseases, contact dermatitis or contact urticaria.[104] Contact dermatitis is the most common skin disease in the healthcare occupation.[105] It is a type of eczema which can be triggered when contact with chemical substances such as soap.[106]

4.5 Burnout

Physical and mental health burnout can occur in any profession. Burnout can be defined as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment, which can affect an individual physically or mentally.[107] In the year 2019 the World Health Organisation (WHO) defines burnout as an occupational phenomenon that results from chronic workplace stress which has not been adequately managed. This occupational phenomenon has three dimensions: there can be seen tendencies of energy depletion or exhaustion, increased mental distance from one's job due to feelings of negativism or cynicism and reduced professional efficacy.[108] The WHO further states that burnout should only be referred to in the occupational context and should not be applied to describe experiences in other areas of life.[109]

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[102] J Smedley, S Williams, P Peel and K Pedersen, 'Management of occupational dermatitis in healthcare workers: a systematic review' (Occupational and environmental medicine, 2012).
[103] S Turner, M Carder, et.al, 'The incidence of occupational skin disease as reported to The Health and Occupation Reporting (THOR) network between 2002 and 2005' (British Journal of Dermatology, 2007).
[104] 'Work-related contact dermatitis in the health services' (Health and Safety Executive) <https://www.hse.gov.uk/skin/employ/highrisk/healthcare.htm> accessed 17 January 2022.
[105] Keith T Palmer, RAF Cox and Ian Brown, 'Fitness for work: the medical aspects' (Oxford University Press, 2007).
[106] 'Contact dermatitis' (NHS) <https://www.nhs.uk/conditions/contact-dermatitis/> accessed 12 January 2022.
[107] Christina Maslach, 'Burnout: The cost of caring' (2003).
[108] 'Burn-out an "occupational phenomenon": International Classification of Diseases' (WHO, 2019) <https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases> accessed 12 January 2022.
[109] Ibid.

As a result of burnout being referred to in the occupational context, the negative effect is not only to oneself but to everyone that encircles them in the work environment. This poses a significant risk to HCWs as their burnout might lead towards greater impairments than other occupations. Researchers over time have voiced their concerns about the negative effect of burnout on HCWs.[110] However, some have failed to identify the true reasons as to why HCWs are more prone to burnout. Burnout poses significant risks to HCWs' profession, some of these consequences take the form of impaired quality of care, low patient satisfaction and medical errors, which might potentially result in malpractice.

4.6 Biological hazards

Health workers' exposure to infectious diseases has currently become a major health and safety risk. Infectious diseases can transmit through various means, the most common being by way of respiratory droplets and exposure to blood.[111] However, even the modern viral surveillance systems are unable to detect a novel virus being circulated and it will be an extended period before a pandemic is announced. As a result, HCWs are one of the first people who are exposed to the virus during the early stages of an outbreak, as individuals with the respiratory disease will be treated by these HCWs without them knowing the severity of the novel virus.

Many studies have been carried out in different countries examining the HCWs' willingness to attend work during public health emergencies.[112] For instance after the 2009 influenza pandemic, a study was conducted and nearly 10% of the nursing staff refused to attend work.[113] Amongst the many issues the most frequently reported reasons were personal health reasons, childcare, transportation, elderly care responsibilities and fear and concern for family.[114] The above reasons often lead towards HCWs being dismissed from their work.

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[110] Abhiram Sharma, DM Sharp, et al, 'Stress and burnout among colorectal surgeons and colorectal nurse specialists working in the National Health Service' (Colorectal Disease, 2008).
[111] Jeffery K Taubenberger and David M Morens, '1918 Influenza: the mother of all pandemics' (Revista Biomedica17, no1, 2006).
[112] Boris P Ehrenstein, Frank Hanses, and Bernd Salzberger, 'Influenza pandemic and professional duty: family or patients first? A survey of hospital employees' (BMC Public Health, 2006); Kristine Qureshi, Robyn RM Gershon, Martin F Sherman, et al., 'Health care workers' ability and willingness to report to duty during catastrophic disasters' (Journal of urban health, 2005); Anas Khan and Mohammad Al Johani, 'Level of willingness to report to work during a pandemic among the emergency department health care professionals' (Asian Journal of Medical Science, 2014).
[113] Sharon Dezzani Martin, 'Nurses ability and willingness to work during pandemic flu' (Journal of Nursing Management, 2011).
[114] Kristine Qureshi, Robyn RM Gershon, Martin F Sherman, T Straub, Eric Gebbie, Michael McCollum, Melissa J Erwin, and Stephen S Morse, 'Health care workers' ability and willingness to report to duty during catastrophic disasters' (Journal of urban health, 2005).

However, by nature of the HCWs' profession they are subjected to and required to face a certain level of danger.

Protecting health workers' health is key to not only ensuring a functional health system but also a functioning society. As a result, the WHO has urged governments to take actions to better protect HCWs to ensure that they have a safe working condition, training, pay and the respect that they deserve.[115] According to WHO, HCWs are needed in a society to take care of patients.[116] Their primary duty is to attend to the needs of their patients despite the circumstances they have to put themselves in. The most intriguing aspect of this issue is that the HCW is viewed as a device that needs to be present at all times in order to serve the purpose of caring and looking after patients. Seeing the core needs of these HCWs and their own rights and obligations as individuals is often overlooked. However, the current Covid-19 crisis has completely changed this position as the employers who request the employees to attend work may themselves be breaching the implied duty of trust and confidence.[117] As a result, the employer is under a duty to ensure that these HCWs are provided with the maximum protection and safety to ensure that they feel confident and comfortable working in a high-risk environment.[118]

The Covid-19 pandemic put to test the care and assistance given by the health systems across the UK. As the Covid-19 virus began to spread rapidly in the UK during March 2020, the four nations implemented similar policies such as the use of face masks being mandatory in public indoor spaces, urging people to work from home, social distancing, self-isolation rules, vaccine programs and the use of Covid passports.[119] Coronavirus legislation was imposed with the hope of controlling the spread of the virus and how best to keep the population safe. The majority of coronavirus legislation is secondary legislation that was made under the powers of primary legislation. Each nation imposed these restrictions through public health legislation.[120]

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[115] 'Keep health workers safe to keep patients safe' (World Health Organisation, 2020) <https://www.who.int/news/item/17-09-2020-keep-health-workers-safe-to-keep-patients-safe-who> 08 November 2020.
[116] Ibid.
[117] Joe Atkinson, 'COVID-19 and employee rights: securing the right to safe working conditions' (LSE, 2020) <https://blogs.lse.ac.uk/politicsandpolicy/covid-19-safe-working-conditions/> 18 March 2022.
[118] 'Personal protective equipment (PPE) at work regulations from 6 April 2022' (Health and Safety Executive, 2022) <https://www.hse.gov.uk/ppe/ppe-regulations-2022.htm> accessed 15 March 2022.
[119] Emily Cameron-Blake, Helen Tatlow, Andre Wood, et al., 'Variation in the response to Covid-19 across the four nations of the United Kingdom' (Blavatnik School of Government, University of Oxford, 2020).
[120] 'Coronavirus Legislation' (Legislation.gov.uk) <https://www.legislation.gov.uk/coronavirus> accessed 05 March 2022.

The key piece of coronavirus legislation is the Coronavirus Act 2020, which was introduced by the preceding Secretary of State for Health and Social Care that gave powers to England, Scotland, Wales and Northern Ireland to effectively respond to the Covid-19 pandemic.[121] After receiving the Royal Assent on the 25th of March the four governments worked closely and co-ordinated their response to the Covid-19 pandemic. For instance, England, Scotland and Wales introduced their first lockdown restrictions on the 26th of March which was shortly followed by Northern Ireland on the 28th of March. Whilst the four nations agreed on some aspects, such as the correct use, guidance and types of PPE and expanding critical care capacity by constructing temporary hospitals across the four nations in the UK, there have been some major disagreements.[122] The most major of which, was the different lockdown restrictions that each country announced. This ultimately resulted in each nation having different outcomes, whether it is with regards to the infection rate, death toll or how it affected the health and safety of workers.

5. The main risks to healthcare workers' health since the outbreak of the Covid-19 pandemic

In line with the above, when the Covid-19 pandemic hit, many of these HCWs were classed as essential workers and had no choice but to continue working physically.[123] As a result, many were exposed to Covid-19 and risked becoming severely ill or transmitting the infection to others, which at times included their close family members.[124] The early stages of the ongoing pandemic adversely affected both the physical and mental health of workers to a great extent. The workers were unaware of the severity of the virus and as they were the first point of contact with infected patients, many HCWs became reluctant to attend work.

As well as a lack of medical staff, other serious problems affecting HCWs included rapid infection rates, quarantines and extended working hours wearing uncomfortable and cumbersome PPE. Deaths were also recorded to be rapidly increasing amongst HCWs.[125] As

[121] 'Coronavirus Act analysis' (Department of Health) <https://www.health-ni.gov.uk/coronavirus-act-analysis> accessed 05 March 2022.
[122] Stephen Cushion, Nikki Soo, Maria Kyiakidou, et al., 'Different lockdown rules in the four nations are confusing the public' (LSE, 2020) <https://blogs.lse.ac.uk/covid19/2020/05/22/different-lockdown-rules-in-the-four-nations-are-confusing-the-public/> accessed 08 March 2022.
[123] 'Supporting Mental Health of Health Workforce and other Essential Workers Opinion of the Expert Panel on effective ways of investing in Health (EXPH)' (European Commission, 2021).
[124] Kristine Qureshi, Robyn RM Gershon, Martin F Sherman, T Straub, Eric Gebbie, Michael McCollum, Melissa J Erwin, and Stephen S Morse, 'Health care workers' ability and willingness to report to duty during catastrophic disasters' (Journal of urban health, 2005).
[125] Emira Kursumovic, Simon Lennane and Tim M Cook, 'Deaths in healthcare workers due to COVID-19: the need for robust data and analysis' (Anaesthesia, 2020).

a result, many HCWs performed to their highest potential. During the months of March and August 2020 it was reported that 60% of hospital doctors in England and Wales worked additional hours in response to the Covid-19 outbreak.[126]

Working extremely long hours in these high-pressure environments exposed workers to trauma, anxiety and at times difficult moral dilemmas.[127] Frontline HCWs faced unusual challenges during the Covid-19 pandemic. Workers had to console and comfort dying patients who were isolating from their family and friends and in some instances had to choose which patients got to live and die.[128] Many also had to watch their colleagues suffer from the virus while trying to look after them and informing family members of difficult and upsetting news about the patient. Most workers were ill-equipped for the unfamiliar nature and scale of these events.[129] As a result of these unprecedented circumstances an increasing number of mental health disorders particularly anxiety, depression, stress and post-traumatic stress disorder (PTSD) were seen amongst many HCWs.[130]

As medical professionals, HCWs are expected and required to face a certain level of risk by the nature of their occupation.[131] Covid-19 brought about new challenges to workers by intensifying these pre-existing issues. Grief, in response to patients' loss, suffering and death have been problematic prior to the Covid-19 pandemic among HCWs.[132] However, during the early stages of the Covid-19 pandemic HCWs encountered grief in various forms. Prior to the Covid-19 pandemic medical practitioners often dealt with various causes of death such as road accidents, cancer and influenza and managed to accept the bereavement of patients. However, during the pandemic HCWs experienced death out of proportion to what they had experienced beforehand.[133] This experience of grief was often exacerbated as medical practitioners felt anger towards missed opportunities for preventing deaths due to the rapid rate that the patients were dying. They would often be optimistic of patient recovery when discharged home or if transferred to rehabilitation facilities only to find such patients

[126] 'Health at a Glance: Europe 2020 State of Health in the EU Cycle' (Organization for Economic Cooperation and Development/European Union, 2020) <https://ec.europa.eu/health/system/files/2020-12/2020_healthatglance_rep_en_0.pdf> accessed 04 February 2022.
[127] Neil Greenberg, Mary Docherty, Sam Gnanapragasam and Simon Wessely, 'Managing mental health challenges faced by healthcare workers during covid-19 pandemic' (bmj, 2020).
[128] Abigail Beall, 'The heart-wrenching choice of who lives and dies' (BBC-Health, 2020) <https://www.bbc.com/future/article/20200428-coronavirus-how-doctors-choose-who-lives-and-dies> accessed 03 February 2022.
[129] Keith C Meyer, 'Covid-19: a heavy toll on health-care workers' (The Lancet, 2021).
[130] Neil Greenberg, 'Mental health of health-care workers in the COVID-19 era' (Natural Reviews Nephrology, 2020).
[131] Leonard M Fleck, 'Are there moral obligations to treat SARS patients' (Medical Humanities Report, 2003).
[132] Lois J Davitz and Joel R Davitz, 'How do nurses feel when patients suffer?' (AJN The American Journal of Nursing, 1975).
[133] 'How have Covid-19 fatalities compared with other causes of death?' (University of Cambridge) <https://wintoncentre.maths.cam.ac.uk/coronavirus/how-have-covid-19-fatalities-compared-other-causes-death/> accessed 07 February 2022.

deceased. These unexpected deaths would intensify the grief that the health workers had to endure.

HCWs experienced grief as they started to feel impotent due to the uncertainty of the best practice that they could use to treat patients and felt that the NHS was proving to be inadequate in providing the best care available to the patients. This was predominantly seen in the early stages of the pandemic, prior to the vaccine rollout. Medical practitioners often at times felt that they were unable to do their job properly as they did not have adequate PPE to feel or be safe.[134] In the early stages of the Covid-19 pandemic the World Health Organisation urged governments to increase PPE manufacturing by 40% in order to meet the rising needs of the global demand.[135]

Grief also took the form of feeling guilty due to the prioritised protection and care that was given to frontline workers.[136] As NHS frontline staff were given access to PPE, vaccines and other facilities, they often felt selfish when they witnessed misery of patients suffering from the virus who were yet to receive the vaccine.[137] Workers often felt that they could have done more to prevent deaths. This heightened sense of survivor's guilt amongst HCWs often lead towards more complex mental health issues if the proper assistance was not given to these workers. As for instance, in the aftermath of the severe acute respiratory syndrome outbreak in 2003, a study found that even after one year the survivors persistently had high levels of psychological distress and stress compared to non-healthcare worker survivors.[138] Although HCWs are honoured as heroes during pandemics, which included a weekly clap, posters and songs thanking healthcare heroes, the recognition might be waning off as the pandemic fades, even if the grief that many health care workers face does not.

Due to the unprecedented nature of the Covid-19 virus, HCWs were responsible for bridging the gaps created by social distancing. Workers were exposed to new roles of caretaking. New and vulnerable roles included appearing as proxy family, holding smart phones and tablets up to dying patients to say their final goodbyes to close family and friends. This intense

[134] Melanie Newman, ''Covid-19: doctors' leaders warn that staff could quit and may die over lack of protective equipment' (BMJ: British Medical Journal, 2020).
[135] Fadela Chaib, 'Shortage of personal protective equipment endangering health workers worldwide' (WHO, 2020) <https://www.who.int/news/item/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide> accessed 07 February 2022.
[136] Bjorg Thorsteinsdottir and Bo Enemark Madsen, 'Prioritizing health care workers and first responders for access to the COVID19 vaccine is not unethical, but both fair and effective- an ethical analysis' (Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine, 2021).
[137] Michael W Rabow, Chao-hui S Huang, et al., 'Witnesses and victims both: Healthcare workers and grief in the time of Covid-10' (Journal of Pain and Symptom Management, 2021).
[138] Antoinette M Lee, Josephine GWS Wong, et al., 'Stress and psychological distress among SARS survivors 1 year after the outbreak' (The Canadian Journal of Psychiatry, 2007).

suffering that the workers were exposed to, was a new responsibility that was entrusted upon bedside care assistances. The stress associated with this responsibility formed grief amongst HCWs as they had not developed the personal or professional resources to manage their heightened emotions.

Based on research carried out in the aftermath of previous pandemics such as Ebola Virus Disease (Ebola), SARS and the Middle East respiratory syndrome, HCWs who worked in the frontline were at risk of developing PTSD and experienced psychological distress compared to workers who were not in contact with these patients.[139] A similar pattern of such issues are emerging from research conducted on Covid-19 and frontline workers.[140] Workers were faced with difficult decisions as the number of Covid positive patients started to escalate at an alarming rate. Even though many of these patients required beds in intensive care, there were many cases where health workers were unable to provide any as all were occupied. In the event that a bed did become free, doctors had to make the difficult decision of deciding who deserves urgent care amongst the already vulnerable patients.[141] The HCWs were faced with the impossible question of which patients to save and had to put the triage protocols into practice, which often made them questioned their ethical and moral principles.

Triage is the process of providing treatment to patients according to the seriousness of their injuries, disregarding other factors such as rank or nationality.[142] The Manchester Triage System is the most frequently used in the Emergency Departments (ED) in the UK.[143] It enables the HCWs to rely on the five-step process of triage decision making to manage patient flow when clinical needs exceed capacity.[144] During the Covid-19 pandemic medical triage was put to the test and medical practitioners could no longer practice the principle, first come first served nor give priority to older or younger patients.[145] As the virus affected each patient differently, HCWs were forced to make decisions of choosing who to care for first. This emotional turmoil of the pandemic will have lasting mental health impacts on HCWs.

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[139] Sonja Cabarkapa, Sarah E nadjidi, et al., 'The psychological impact of COVID-19 and other viral epidemics on frontline healthcare workers and ways to address it: A rapid systematic review' (Brain behaviour & immunity-health, 2020); Robert G Maunder, William J Lancee, et al., 'Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak' (Emerging infectious diseases, 2006).
[140] Ibid.
[141] Neera Bhatia, 'We need to talk about Rationing: The need to normalize discussion about healthcare rationing in a post Covid-19 Era' (Journal of Bioethical Inquiry, 2020).
[142] Martin Edwards, 'Triage' (The Lancet, 2009).
[143] Sarah J Dickson, Colin Dewar, et al., 'Agreement and validity of electronic patient self-triage (e Triage) with nurse triage in two UK emergency departments: a retrospective study' (European Journal of Emergency Medicine, 2022).
[144] Kevin Mackway-Jones, Janet Marsden and Jill Windle, 'Emergency triage: Manchester triage group' (John Wiley & Sons, 2013).
[145] R Jaziri and S Alnahdi, 'Choosing which Covid-19 patient to save? The ethical triage and rationing dilemma' (Ethics, Medicine and Public Health, 2020).

This exposure to unprecedented events may give rise to HCWs experiencing moral injury. Moral injury is defined as the psychological distress that occurs following events that violate someone's moral or ethical code.[146] Unlike PTSD that affects a person's mental health following threat-based trauma, moral injury disappoints workers as they might believe that they failed to provide adequate care to patients.[147] However, they might not realise that some degree of medical triage is necessary as it enables the NHS to disperse limited resources to attain a rational equilibrium.[148] A similar nature of disappointment and worry was seen amongst HCWs who found it challenging to witness their fellow colleagues suffer from the virus and for them to still continue treating patients.

As the pandemic continued to spread around the world the psychological impact on HCWs might go beyond the most apparent and common risks. For instance, research has indicated that individuals who have pre-existing mental illnesses have a lower life expectancy and poorer physical health outcomes when compared to the general population.[149] As a result, taking the above-mentioned mental health disorders into consideration, HCWs who have already established mental health illnesses will be in a precarious position as they will be working in a high-risk environment treating Covid-19 positive patients. This may increase the risk of not only worsening their pre-existing mental illnesses but also the physical danger that derives from the pandemic.

Research from previous pandemics indicates a correlation between the deterioration of physiological conditions to high risk of suicide ideation.[150] Individuals who experience suicidal thoughts require special attention, as they might fear seeking help due to being overwhelmed with their emotions and a fear of attending face-to-face appointments due to the negative stigma associated with mental health disorders.[151] Suicide risks for HCWs have increased at an alarming rate, according to the Office for National Statistics, during the first six months of the years 2019 and 2020, 117 HCWs committed suicide. These workers were

[146] 'Health at a Glance: Europe 2020 State of Health in the EU Cycle' (Organization for Economic Cooperation and Development/European Union, 2020) <https://ec.europa.eu/health/system/files/2020-12/2020_healthatglance_rep_en_0.pdf> accessed 04 February 2022.
[147] Victoria Williamson, Dominic Murphy, et al., 'Moral injury: the effect on mental health and implications for treatment' (The Lancet Psychiatry, 2021).
[148] Kevin Mackway-Jones, Janet Marsden and Jill Windle, 'Emergency triage: Manchester triage group' (John Wiley & Sons, 2013).
[149] Mark Rodger, Jane Dalton, et al., 'Integrated care to address the physical health needs of people with severe mental illness: a mapping review of the recent evidence on barriers, facilitators and evaluation' (International Journal of integrated care, 2018).
[150] David Gunnell, Louis Appleby, et al., 'Suicide risk and prevention during the COVID-19 pandemic' (The Lancet Psychiatry, 2020).
[151] Susanna Gobbi, Martyna Beata Plomecka, et al., 'Worsening of pre-existing psychiatric conditions during the COVID-10 pandemic' (Frontiers in psychiatry, 2020).

between the ages of 18 to 64 years who were registered in England and Wales.[152] Suicide is likely to become a more pressing concern as the pandemic continues as frontline workers might suffer from long-term psychological effects.

Although the pandemic affects individuals who have pre-existing mental health illnesses, research has indicated a considerable increase in depression and anxiety amongst workers who have not had any pre-existing mental health illnesses.[153] This will often be due to the high-risk environment that the workers have endured during the pandemic, and they might have not experienced high levels of pressure in their work previously.

Prior to the Covid-19 pandemic, the mental health of HCWs was gaining a lot of attention due to the threat that it imposed on the quality of care provided.[154] If the health issues of workers were not dealt with accordingly it may result in psychological distress, depression, anxiety and sleeping disorders which may give rise to a public health concern.[155] The WHO estimated that by 2030 there would be a projected shortfall of approximately 18 million workers in low and lower-middle income countries.[156] The Covid-19 pandemic would only exacerbate these pre-existing health issues amongst HCWs globally.

Conclusion

In conclusion, the lack of a standardised implementation of health and safety policy across the NHS trusts in England has contributed to the discrepancies in health problems across the workforce. These discrepancies ultimately contribute to both mental and physical health problems amongst HCWs. As a result, these prevailing health problems have been exacerbated during the Covid-19 pandemic. In this chapter, I have explored the variations in the health systems in the UK and laid the foundation for the research to be built by focusing specifically on the NHS in England. I have also highlighted the pre-existing challenges with regards to health and safety within the NHS. In the next chapter, I elaborate the methodology

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[152] 'Deaths by suicide in the medical profession' (Office for National Statistics, 2021) <https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/numberofnursesmidwivesandstudentnursesandmidwiveswhohavecommittedsuicide> accessed 08 February 2022.

[153] Walter Cullen, Gautam Gulati and Brendan D Kelly, 'Mental health in the COVID-19 pandemic' (QJM: An International Journal of Medicine, 2020).

[154] Stefan De Hert, 'Burnout in healthcare workers: prevalence, impact and preventative strategies' (Local and regional anaesthesia, 2020).

[155] Pratik Khanal, Navin Devkota, et al., 'Mental health impacts among health workers during COVID-10 in a low resource setting: a cross-sectional survey from Nepal' (Globalization and health, 2020).

[156] 'Working for Health and Growth: Investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth' (World Health Organisation, 2016) <https://apps.who.int/iris/bitstream/handle/10665/250047/9789241511308-eng;jsessionid=6A1FA03186C1198DD92573B5ECFBA6F7?sequence=1> accessed 10 February 2022.

and the theoretical framework that guided this research; providing a comprehensive overview of the specific legal research and data collection methods used and how they contribute to the overall research objective.

Chapter 2 Methodology and Theoretical Framework

Introduction

In Chapter one, I discussed the UK's healthcare system, specifically the NHS structure and the challenges faced by HCWs before and during the Covid-19 pandemic. In this chapter, I turn to explain the theoretical framework and the methodology used to address the research questions. The first section of the chapter takes the form of a 'research diary', which guides the reader through the processes that lead me to develop my approach to data collection and data analysis. As I will explain, the thesis uses a socio-legal methodology and thematic qualitative analysis to answer the research questions. Doctrinal legal research involves the analysis of legislation, authoritative literature and case law.[157] Researchers aim to analyse and comment on case law and legislation, often with the intention of proposing reforms that could enhance the legal system.[158] Since my aim was to understand both the health and safety laws in force in the UK and their adequacy when it came to the health and safety of HCWs during the pandemic, I quickly realised that doctrinal legal research would not be adequate to my task. A socio-legal approach aligns better with this research question, as it examines the effectiveness of the law. Although when legislation is drafted it may have an intended purpose, often to bring about social justice and to maintain order, this proposed purpose of an Act of Parliament does not always have its intended effect on society.[159] Socio-legal research intends to look at how societal norms have formed and analyse their relationship to formal law.

The second section of this chapter explains why the data used for the analysis was collected through secondary data rather than conducting interviews. The thesis was conducted in the aftermath of the Covid-19 pandemic and accessing credible and reliable participants for the research would have been challenging. With the passage of time, meanwhile, HCWs in the NHS began to express their first-hand experiences of working during the pandemic. Due to this notable volume of online recounts, data collection was conducted by gathering testimonies published online by HCWs. Lastly this section will explain why I used thematic qualitative research methods to analyse the HCWs' health and safety while working during the Covid-19 pandemic. Section two will provide a brief literature review on qualitative

[157] Philip M Langbroek, Kees van den Bos, Marc Simon Thomas, J. Michael Milo and Wibo M Van Rossum, 'EditorialMethodology of legal research: Challenges and opportunities' (Utrecht law review, 2017).
[158] Ibid.
[159] Ruth Dukes, 'Critical labour law: then and now' (In Research handbook on Critical Legal Theory' (Edward Elgar Publishing, 2019).

research and the intricacies of its application in labour law. Under section three, I will discuss how the data collection and analysis was conducted. This section will elaborate the themes that emerged and how the data was thematically analysed. The final section will include a summary of the data that was collected for the thesis.

1. Legal research

Legal research can generally be categorised as doctrinal or non-doctrinal. This is based on the fact that such research is focused on examining the theoretical and analytical aspects of the legislation or observing how the law is interrelated within society.[160] Simply put, if a researcher is attempting to conduct 'research in law' they will be conducting doctrinal legal research, while non-doctrinal research will entail 'research about the law', where research is conducted on social values and people.[161] Doctrinal research is conducted through the analysis of case law and existing statutory provisions and analysing legal institutions by applying reasoning and rational deduction.[162] Scholars Dobinson and Johns define doctrinal research as theoretical legal research as it is concerned with the analysis of legal reasoning, how it has been developed and applied.[163] Doctrinal legal research will enable the researcher to ascertain how certain legal principles, doctrines or concepts proceed while also identifying the ambiguities, gaps, loopholes and/or inconsistences in the law.[164] While these distinctive characteristics of doctrinal legal research are intriguing, the study of law in doctrinal legal research is conducted in isolation from the study of human society which identifies gaps between legal norms and social behaviour. Clearly, doctrinal legal research on its own would not be sufficient in answering my research question.

In contrast to doctrinal research, non-doctrinal research can be categorised as problem-, policy- and law reform-based research.[165] The three categories are not mutually exclusive. In order to explore whether the health and safety laws in the United Kingdom were sufficient to safeguard the health and safety of HCWs, I first determined what the existing law was in the area of occupational health and safety. I then considered the problems currently affecting this area of law and the flaws in the policy that underpins the existing law which could ultimately lead towards proposing changes to the law. This is also known as socio-legal

[160] Amrit Kharel, 'Doctrinal legal research' (SSRN, 2018).
[161] Paul Chynoweth, 'Legal research' (Advanced research methods in the built environment, 2008).
[162] S. N. Jain, 'Doctrinal and non-doctrinal legal research' (Journal of the Indian law Institute, 1975),
[163] Mike McConville and Wing Hong Chui, 'Research methods for law' (Edinburgh: Edinburgh University Press, 2007).
[164] Bhat P Ishwara, 'Idea and methods of legal research' (Oxford University, 2020).
[165] Ian Dobinson and Francis Johns, 'Legal research as qualitative research' (Research methods for law, 2017).

research.[166] According to legal scholar Webley, socio-legal research examines how the legal system impacts society and enables analyses of the law, legal phenomena and their intricate relationship to the wider society.[167] Researchers who conduct socio-legal research aim to understand law as a social phenomenon. When doing so, socio-legal research assists in the evaluation of particular pieces of legislation and assesses its effectiveness in achieving the legislation's intended social goals.[168]

The Covid-19 pandemic was the perfect example of a social phenomenon that enabled me to examine the extent to which the NHS as an employer fulfilled its obligations according to the health and safety laws when protecting the health of HCWs. The analysis aims to answer the following secondary research questions:

- *What were the conditions that led towards HCWs' health and safety being put in jeopardy?*
- *Were health care workers treated equally during the Covid-19 pandemic, when it came to their health and safety?*
- *What health and safety measures did the government introduce to meet the novel challenges and risks occasioned by the nationwide pandemic?*

These questions will enable me to determine whether the existing health and safety legislation in the UK provided sufficient protection for HCWs throughout the Covid-19 pandemic.

2. Collecting qualitative data

Having established that I would use a socio-legal research approach, my next step was to consider how I would collect the data. At the outset, it seemed likely that the data would be gathered by conducting interviews with HCWs concerning their experiences of working during the Covid-19 pandemic. Conducting interviews is one of the most common methods of acquiring data for thorough analysis.[169] Interviews can take several forms, ranging from interviews that are highly structured, which often takes the form of a survey-like interview, to entirely unstructured interviews, which gives the researchers a free-flowing approach, and lastly semi-structured interviews providing a balance between the two.[170] The different

[166] Salim Ibrahim Ali, Zuryati Mohamed Yusoff and Zainal Amin Ayub, 'Legal research of doctrinal and non-doctrinal' (International Journal of Trend in Research and Development, 2017).
[167] Lisa Webley, 'The why and how to of conducting a socio-legal empirical research project' (In Routledge Handbook of Socio-Legal Theory and Methods, 2019).
[168] Paul Chynoweth, 'Legal research' (Advanced research methods in the built environment, 2008).
[169] Owen Doody and Maria Noonan, 'Preparing and conducting interviews to collect data' (Nurse researcher, 2013).
[170] Hamza Alshenqeeti, 'Interviewing as a data collection method: A critical review' (English linguistics research, 2014).

interview formats enable the researcher to choose the best suited form when answering their respective research question. Similar to any other type of data collection method, the process of gathering data through conducting interviews has its strengths and weaknesses. Conducting interviews, myself would have allowed me to get first-hand information from HCWs who worked during the Covid-19 pandemic. On the other hand, I knew that conducting interviews can be very time-consuming and that, given the ongoing pandemic, accessing credible participants for the interview and establishing a trusting relationship with the interviewees might be especially challenging.[171]

Having read some of the testimonies of HCWs' experience as frontline staff during the Covid-19 pandemic, it was evident to me that I would be interviewing HCWs on extremely sensitive and provoking topics. Conducting interviews on sensitive topics is widely discussed by scholars. Although there is no agreed definition for sensitive research, Johnson and Macleod Clark state that sensitive research includes any kind of research conducted on emotionally difficult topics that make participants relive deeply personal issues which could cause them distress.[172] These topics are often intrusive, stigmatising, and at times potentially dangerous and traumatising. The experiences that HCWs faced during the Covid-19 pandemic caused anxiety and depression. In more severe cases workers felt moral distress having to treat patients who were extremely unwell or dying and experienced post-traumatic stress disorder having worked in such environments.[173] Participant wellbeing was at the forefront of my mind when deciding on whether to conduct interviews for this research. I was aware that the interviews needed to be conducted in a sensitive manner in order to avoid re-victimizing participants. Moreover, I was conscious, that identifying and recruiting HCWs who would be willing to participate in the study during an ongoing pandemic might be especially challenging and time-consuming.

At first, one of the ways in which I considered recruiting participants for the study was to contact trade unions and request them to circulate my participant information sheet and flyer which would give details for the potentially interested. Due to the sensitive information that was being required by the participants and out of concern for participant safety, the testimonies of potentially relevant participants would remain privileged. Furthermore, I was aware of the significant time that it would take to conduct interviews or focus groups. Having

[171] Catherine Pope, Sue Ziebland and Nicholas Mays, 'Analysing qualitative data' (BMJ, 2000).
[172] Barbara Johnson and Jill Macleod Clarke, 'Collecting sensitive data: The impact on researchers' (Qualitative health research, 2003).
[173] Siobhan Hegarty, Danielle Lamb, Sharon AM Stevelink, et al., ''It hurts your heart': frontline healthcare worker experiences of moral injury during the COVID-19 pandemic' (European journal of Psychotramatology, 2022)

explored the possibility of carrying out my data collection by conducting interviews it was apparent to me that it is not the only credible technique that a researcher can use to collect data. My initial research indicated that there were a number of testimonies published online, especially in the context of HCWs and the Covid-19 pandemic. I began to wonder whether sufficient secondary data existed that would allow me to answer my research questions without the need to conduct my own interviews.

I read and re-read newspaper articles, journals, magazines, books, NHS website articles and listened to podcasts of various stories and recounts of first-hand experiences that HCWs faced during the Covid-19 pandemic. The pool of secondary data began to grow very rapidly at this time, approximately two years since the official date that the first positive test of a Covid-19 patient was announced, and the country entered a world-wide pandemic.[174] During the first waves of the Covid-19 pandemic, HCWs experienced life changing circumstances that they may not have been keen on expressing or may not even have come to terms with acknowledging the distress that they themselves experienced. However, with the passage of time HCWs began to express their traumatic experiences that they faced as a result of working in the frontline during the Covid-19 pandemic. Due to this lapse of time, it was no surprise that I was able to broaden my data pool as more and more testimonies were coming to light. As a result, I realised that it was not necessary for me to conduct face-to face interviews in order to develop answers to my research questions.

I then decided that the most suitable way to analyse the collected data would be by way of conducting thematic qualitative analysis. Simply put, qualitative research is the analysis of non-numerical data. In this respect, it can be contrasted with quantitative research.[175] While conventionally the use of qualitative research is commonly used across the social sciences disciplines and perhaps considered as a non-legal research method,[176] the use of qualitative and quantitative research can be considered as empirical research. According to scholars Epstein and King's empirical research implies that research is based on observing facts.[177] In the legal context, empirical research entails the understanding of legislation and or case law and its impact on society. Accordingly, the secondary data collected for the purpose of

[174] '2 Years of Covid-19 on GOV.UK' (GOV.UK) <https://gds.blog.gov.uk/2022/07/25/2-years-of-covid-19-on-gov-uk/> accessed 19 August 2023.
[175] Michael McConville and Wing Hong Chui, 'Research Methods for Law' (Edinburgh University Press, 2007).
[176] Katerina Linos and Melissa Carlson, 'Qualitative methods for law review writing' (The University of Chicago Law Review, 2017).
[177] Eleanor Knott, Aliya Hamid Rao, Kate Summers and Chana Teeger, 'Interviews in the social sciences' (Nature Reviews Methods Primers, 2022).

this thesis can be categorised as empirical data as it concerned the lived experiences of HCWs during the Covid-19 pandemic.

In the legal research field, Strauss and Corbin categorise qualitative research as analysing data by any means other than a statistical procedure or quantification.[178] They further state that qualitative research incorporates multiple realities and the research could range from a person's life, behaviours, emotions and feelings to social and cultural phenomena.[179] The notion of incorporating multiple realities is also mentioned by Flick: he mentions that researchers are interested in analysing issues relating to social issues, events or practices.[180] He also states that qualitative analysis involves the analysis of texts rather than numbers or statistics. Subsequently, qualitative methodology enabled me as a researcher to undertake an in-depth understanding of the phenomena and report findings of multiple realities in an unbiased context whilst being committed to participants' viewpoints.[181] Amongst many, one of the advantages of applying a qualitative research design was that it allowed me to produce detailed descriptions of the participants' personal observations and awareness of the Covid-19 pandemic and how it affected them on a personal and professional level. These characteristics of qualitative methodology provided the best fit research method to assist me in addressing my research questions.

It is important to draw attention to the possible biases that may result when conducting research and analysing data that was collected through secondary data. Since the data collected in this research was compiled by other researchers to address similar yet different questions, this may introduce several biases. Researchers strive to minimise various biases when collecting secondary data to ensure the integrity of their study, as biases could affect their subsequent findings. When collecting and interpreting testimonies published of HCWs during the pandemic, workers who endured emotional, dramatic and novel experiences, whether positive or negative, may have been more inclined to share their experience and publishers may have been more inclined to advertise these experiences. Media sources, specifically news outlets, are likely to have focused on newsworthy stories that aim for reader engagement which could have led to overrepresentation of certain types of experiences, while other testimonies that were more mundane or monotonous might have been less prominent. In this instance, publication bias could skew the literature towards a

[178] Juliet Corbin and Anselm Strauss, 'Basics of qualitative research: Techniques and procedures for developing grounded theory' (Sage publications, 2014).
[179] Ibid.
[180] Uwe Flick, 'Introducing research methodology: A beginner's guide to doing a research protect' (Sage, 2015).
[181] M Vaismoeadi, H Turunen and T Bondas, 'Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study' (Nursing & Health Science, 2013).

successful hypothesis. Publication bias occurs where a research study that has significant and or positive results are more likely to be published than those with non-significant and or negative findings.[182]

Although, this is a common risk when using secondary data, I was actively mindful and sought to reduce publication bias in testimonies by making a conscious effort to gather HCWs' experience of working during the pandemic from a wide range of individuals with different experiences. For instance, the pool of data encompassed a variety of people with diverse demographic characteristics. It includes individuals from various nationalities and cultural heritages representing a spectrum of race and religion. A diverse age range, gender and ethnicities of individuals from all walks of life are also comprised within the data pool. This diversity is further made clear in the rest of the chapter. Similarly, during data collection a variety of different sources were used rather than solely looking at news outlets. Although the study does make reference to news articles, they were critically evaluated to understand the context of the testimony. This included asking questions such as who is being represented in the article and the potential impact of the narrative. Systematically comparing testimony findings with the results from other data sources, such as surveys and official statistics, to provide a more coherent understanding of the data, helped validate and verify certain data sources. Through this approach I was also able to recognise inconsistencies in the data.

3. Conducting the research

3.1 Research aim

My thesis addresses the question, whether the health and safety laws in the UK were sufficient to protect the health and safety of the HCWs during the Covid-19 pandemic. With this primary research question in mind, the thesis also addresses these secondary research questions: what were the conditions that led towards HCWs' health and safety being put in jeopardy? Were health care workers treated equally during the Covid-19 pandemic, when it came to their health and safety? What health and safety measures did the government introduce to meet the novel challenges and risks occasioned by the nationwide pandemic?

[182] Ana Mlinarić, Martina Horvat, and Vesna Šupak Smolčić, 'Dealing with the positive publication bias: Why you should really publish your negative results' (Biochemia medica, 2017).

3.2 Data collection and analysis

Collecting data is an integral part of conducting research. Amongst the plethora of different data collection methods, this thesis collects data contained in the published testimonies of HCWs. Testimonies involve a narrator, who is either the protagonist or a witness, giving an account of the event in first person.[183] As the account is narrated in first person, the narrators feel empowered by voicing their experience. Often, the process of telling the story is liberating and it raises awareness among readers.[184]

The first step in collecting the data was to look at readily accessible online sources. These included trade union websites, newspaper articles, NHS website articles, blogs, books published by former frontline workers and podcasts. One of the challenges I faced when choosing potentially relevant data was the credibility of the sources. For this reason, I followed a checklist in order to filter credible data sources, as the credibility of the source depends on the context in which it was published.[185] Firstly, I looked at the source's author and ensured that they were from a well-established organisation or an expert in the subject area. These included published books, verified social media accounts, trade union articles published by the main trade unions, namely UNISON, the British Medical Association and the Royal College of Nursing, and the government formed and led evidence sessions of the All-party Parliamentary Groups- Coronavirus (APPG). The APPG is a cross-party group formed by MPs and Members of the House of Lords that came together in order to discuss issues related to the Covid-19 pandemic. Having verified the author, I would then look at the content of the sources. As remaining impartial when conducting the data collection and analysis was crucial, I avoided sources that appeared biased in their content. The data ranged from workers who were employed in the frontline and to workers who were carrying out their work as normal. For this study only testimonies published between March 2020 and May 2023 were included in the analysis. This timeframe was selected as it covers the period from the start of the Covid-19 pandemic until its end.[186] This timeframe enabled me to look at testimonies published by HCWs who were working on the frontline during the peak of the Covid-19 pandemic.

[183] Kathryn Blackmer Reyes and Julia E Curry Rodriguez, 'Testimonio: Origins, terms and resources' (Equity & Excellence in Education, 2012).
[184] Torill Moen, 'Reflections on the narrative research approach' (International journal of qualitative methods, 2006)
[185] Marcus Renner and Ellen Taylor-Powell, 'Analyzing qualitative data' (Programme Development & Evaluation, University of Wisconsin-Extension Cooperative Extension, 2003).
[186] The World Health Organisation declared the end of the pandemic on 5 May 2023.

Having established the data collection framework and decided on collecting data by looking at testimonies published online by HCWs during the pandemic, it is important to highlight the potential limitations that may arise when using testimonies. While it is clear that testimonials provide first-hand recounts of individuals experience of certain events, these very events are inherently personal and subjective. They are often laced with existing beliefs and emotions of individuals which could represent a skewed representation of the overall situation. The stress and trauma caused by the pandemic may have exerted personal biases due to the highly emotional nature of the experience. Nevertheless, the inherently personalised and subjective nature of testimonies enable unexpected themes, that might have not been considered by previous research, to be identified and may also add broader understanding to existing literature.[187]

Using testimonials in research may also lead towards selection bias, where the individuals who are perceived to have a strong positive or negative experience are more prone to share their stories.[188] This could result in over representing a certain group of individuals while underrepresenting other viewpoints. While this is a potential limitation of using testimonies, the current research makes a conscious effort to include HCWs from various demographics, their experience levels within different speciality roles and undertake a multi-faceted approach in order to broaden the pool of healthcare worker representation. A potential limitation could also arise due to the fact that individuals might express their experiences in a socially acceptable manner to satisfy public opinions. Especially in the instance of a global pandemic, fearmongering was prevalent and HCWs would have been reluctant to fully express their experience.[189] While this would have been true during the very early stages of the pandemic, as it progressed, workers were expressing their experiences of working during the pandemic regardless of the perceived expectations. This is highlighted in the current chapter. Moreover, while the individual experiences of HCWs are difficult to generalise, across the broader healthcare workforce the very nature of this limitation enables the research to highlight potential systematic issues within the healthcare sector through their individual and unique recounts.

When discussing the potential limitations and biases of using testimonies, it is crucial to consider where they came from and why they were created. While the source will help

[187] Virginia Braun and Victoria Clarke, 'Using thematic analysis in psychology' (Qualitative research in psychology, 2006).
[188] Rebecca V Bell-Martin and Jerome F Marston Jr, 'Confronting selection bias: The normative and empirical risks of data collection in violent context' (Geopolitics, 2021).
[189] Ian Freckelton Qc, 'Covid-19: Fear, quackery, false representations and the law' (International journal of law and psychiatry, 2020).

validate the credibility of the testimony, the purpose will determine its objectivity. In order to determine credibility, I utilised the CRAAP test method. The test looks at five elements of a source namely; currency, relevance, authority, accuracy and purpose.[190]

Currency refers to the time period that the article was published, this is to ensure that information published is relevant and in line with the research topic.[191] This was quite straightforward when conducting my data collection. From the outset, I formed a time frame to only include testimonies that were published between March 2020 and May 2023 in the study, so that the testimonies were suitable and relevant.

The second element refers to the relevance of the sources which is directly linked to the information provided in the article and its relevance in addressing the research question.[192] When looking at this element it prompts several questions. Does the information directly address the research question? The researcher must be aware that the information presented in the article relates to the research topic and answers the overall question. In this research the testimonials provided information that was unwaveringly of HCWs' experiences of working during the pandemic. For instance, the testimonials published by the trade union UNISON in the article 'Covid pressures triggering mental health issues among health staff' highlighted the struggles of HCWs during the pandemic and leaving the healthcare profession due to the mental health struggles. These testimonies helped me understand the pressures that workers endured during the pandemic, which is directly relevant to my research question about why the health and safety of workers were not adequately protected during the pandemic. Additionally, an article published by the BBC revealed the unfortunate working conditions that HCWs had to withstand during the pandemic. This was highly relevant to my research as it presented a direct breach of the workers right to have adequate PPE, which as the article subject quoted, "it's wrong. And that's why we're having to put bin bags and aprons on our heads".[193] By having to resort to makeshift PPE when these workers are engaging in a highly contagious environment their employer, the NHS, is in direct breach of their right to suitable PPE in accordance with Regulation 4 of the Personal Protective Equipment at Work (Amendment) Regulations 2022 (PPER 2022).[194]

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[190] Adeva Jane Esparrago-Kalidas, 'The Effectiveness of CRAAP test in evaluating credibility of sources' (International Journal of TESOL & Education, 2021).
[191] Krista Renee Muis, C Denton and Adam Dubé, 'Identifying CRAAP on the internet: A source evaluation intervention' (Advances in Social Sciences Research Journal, 2022).
[192] Adeva Jane Esparrago-Kalidas, 'The Effectiveness of CRAAP test in evaluating credibility of sources' (International Journal of TESOL & Education, 2021).
[193] Claire Press, 'Coronavirus: The NHS workers wearing bin bags as protection' (BBC, 2020) <https://www.bbc.co.uk/news/health-52145140> accessed 12 May 2023.
[194] Personal Protective Equipment at Work (Amendment) Regulations 2022, Regulation 4(1).

Moreover, the findings presented by the trade union TUC in the article 'One in five BME workers treated unfairly at work during Covid-19 TUC reveals', emphasised the prejudicial treatment faced by black NHS workers. The testimonials directly addressed the unjust treatment towards these workers when compared to their white colleagues. Care worker Precious's testimonial provides valuable insights into the unfair treatment as she was allocated to wash Covid positive deceased patients without adequate PPE while white colleagues were exempt from this task. The testimony provided unique insight, enabling me to look at the broader context of HCWs' health and safety during the pandemic. It revealed that certain groups of workers not only navigated the hardships of working during the pandemic, but also having to bore the burden of systematic discrimination within the workforce.

The third element, authority, refers to the credentials of the author and the credibility of the publishing body.[195] From the outset, it should be established that the sources used to collect the testimonials are all websites. A variety of domain names are included in the research, ranging from government (.gov), organisation (.org), commercial (.com) to country domains (.uk). The majority of the testimonials in this research were collected through trade union websites. I was able to verify the authority of these trade union websites by looking at the organisations 'about us' section. These statements helped me understand union goals and who they are curated for, accrediting their credibility and authority.

For instance, the RCN being the largest nursing union, aspires to provide the highest quality of care through guaranteed evidence-based learning to improve patient safety and advocate for fair working conditions to their nursing members.[196] Furthermore, the trade unions mentioned in this study are affiliated with a reputable larger national or international trade union federation which adds an additional layer of credibility.[197] In instances where the author is mentioned in an article I was able to conduct a credibility check under the authority criteria. I firstly, conducted a name search online which often lead towards the authors previous work, professional LinkedIn profiles or to the organisation that they represent. Author Helen Coffeey, who wrote the piece "I am an NHS nurse treating coronavirus patients in the ICU. We're fighting a war and soon we won't have any bullets" had her article published under the Independent and is a senior features writer who has previously worked under other reputable organisations such as the BBC News channel, Daily Telegraph, Radio

[195] Adeva Jane Esparrago-Kalidas, 'The Effectiveness of CRAAP test in evaluating credibility of sources' (International Journal of TESOL & Education, 2021).
[196] 'What the RCN does' (RCN, 2025) <https://www.rcn.org.uk/About-us/What-the-RCN-does> accessed 02 April 2023.
[197] 'Union listing' (TUC, 2025) <https://www.tuc.org.uk/unions> accessed 19th April 2025.

4 and Daily Standard. This lends significant authority to her current article. By making these additional checks it helps verify the credibility of the author.

The fourth element, accuracy, under the CRAAP test refers to the reliability and truthfulness of the information presented in the article.[198] As mentioned above, since testimonials provide deeply personal information, it is important to understand the origin of the research. When considering testimonials direct verification of an individual's personal experience is difficult. However, I was able to cross reference the information from other sources which enabled me to look for patterns and for consistency. The testimony presented by Dr Meenal Viz under the source, Global Citizens, was cross referenced by other sources to check for accuracy. I was able to find three separate sources in addition to the original source, that mentioned the same or akin issue with regards to the lack of suitable PPE for pregnant HCWs.[199] As mentioned above, due to the inherently subjective nature of testimonials and since testimonials are not often peer reviewed, I paid close attention to the choice of words and the tone throughout each article. I was also aware of overly positive or negative connotations and endeavoured not to be persuaded by emotions, but rather focused on the accuracy of the source.

The last and final element is the overall purpose of the source, why the testimony was given and the motivation behind it.[200] HCWs were under immense pressure working during the pandemic, these stressful and traumatic experiences may overshadow the purpose of sharing the experience. While these emotions are valid it is important to distinguish and separate the purpose of testimonials and their emotional context. This helps understand the potential for influencing and advocating for policy changes within the healthcare system. The testimony provided by HCW Arun Panabaka emphasises the government's decision to refuse visa renewals for migrant workers. While this is an extremely emotional testimony, as Arun expresses the uncertainties he had to endure for himself and his family during this unprecedented time, the testimony also brings to light the chronic NHS staff shortages.

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[198] Adeva Jane Esparrago-Kalidas, 'The Effectiveness of CRAAP test in evaluating credibility of sources' (International Journal of TESOL & Education, 2021).

[199] 'Coronavirus: Doctors hail progress after PPE legal Challenge' (BBC, 2020) <https://www.bbc.co.uk/news/uk-england-beds-bucks-herts-55497010> accessed 18 June 2023, Michelle Rugeroni, 'Women Rising- Dr Meenal Viz (and Radika)- Activist.' On The Sofa with Rouge (ACAST, 2022) <https://shows.acast.com/on-the-sofa-with-rouge/episodes/women-rising-dr-meenal-viz> accessed 18 June 2023, Carole Cadwalladr, 'They can't get away with this': doctor who took protest to No 10' (The Guardian, 2020) <https://www.theguardian.com/society/2020/apr/20/coronavirus-doctor-ppe-protest-downing-street-london> accessed 18 June 2023.

[200] Adeva Jane Esparrago-Kalidas, 'The Effectiveness of CRAAP test in evaluating credibility of sources' (International Journal of TESOL & Education, 2021).

While the purpose of testimony could range from providing information, education, entertainment or persuasion, it is essential to contextualise the objectivity and the trustworthiness of the testimonial's subject matter. Together these five elements, currency, relevance, authority, accuracy and purpose, help evaluate the information and encourages the researcher to think critically about the reliability of the source.

In total, 33 testimonies were gathered for analysis. At first, I was concerned that this might not be sufficient. I soon recognised, however, that the HCWs' testimonies presented a close connection between their first-hand experiences and the questions I hoped that the analysis would answer. For instance, HCWs voiced their opinions on having to work during the Covid-19 pandemic without PPE or having to work overtime due to the lack of adequate staff. However, the relatively limited data pool raised concerns about potential limitations.

While the data offers a range of healthcare occupations, the small number of testimonies might reduce the broader applicability to the wider population of HCWs. The data represents HCWs ranging from nurses, doctors, care workers, managers to healthcare assistants in a multidisciplinary workforce. However, the limited number of testimonies could result in under-representing a certain group of workers or over-represent other groups and it could also completely overlook others. It is also important to highlight that when testimonies are shared by individuals, they are often context dependent and influenced by positive or negative events, policies within the workforce and local factors, such as socioeconomical conditions and religious or cultural values. This begs the question, if this is an unavoidable limitation when collecting testimonies and conducting data analysis.

As individuals are recounting their distinctive experiences, in this instance, working during a global pandemic which is a completely novel experience for them, it is difficult to completely isolate their experience from the contextual factors. While it could be debated that these contextual factors could be controlled, it would strip away that value and nuance that testimonial data provide. As mentioned above, the testimonies provide HCWs' first-hand experience of working during the pandemic. The rich and personalised experiences are the essence of testimonies, attempting to control the contextual elements in order to generalise the findings would diminish and reduce the impact of testimonies.

Finally, the limited number of testimonies may focus only on certain issues that HCWs faced during the pandemic. While some issues maybe missed in the overall study, this limitation

can be mitigated by future research as it could diversify the sample size by addressing a broader range of issues faced by HCWs. Furthermore, since this research is conducted in the immediate aftermath of the pandemic, future research may provide a more comprehensive and nuanced understanding of HCWs' experience of working during the pandemic and bring to light whether the health and safety of workers were protected.

While reading and re-reading the testimonies, patterns and themes emerged. I have categorised these into broader themes and subsequently broken into subcategories. The broader themes are:

- the racial discrimination within the workplace,
- mistreatment towards workers from minority ethnic groups,
- PPE shortages causing distress within the workforce
- lack of reassurance given to HCWs during an unprecedented time.

These broader themes were recurring throughout the data collection and aligned with the secondary research questions I wanted to address. The questions included *what were the conditions that led towards HCWs' health and safety being put in jeopardy? Were health care workers treated equally during the Covid-19 pandemic, when it came to their health and safety? What health and safety measures did the government introduce to meet the novel challenges and risks occasioned by the nationwide pandemic?* These questions guided the initial structure of the data analysis.

Having identified the broader themes mentioned above, they were further split into five refined themes: prejudicial treatment of black minority ethnic workers, lack of support for minority workers, inconsistent advice across the NHS workforce, the intention to leave the healthcare profession and supply of PPE.

The first theme is deeply rooted in academic literature, as the unfair treatment towards BME workers has been discussed and agreed upon by many scholars. Kline states that the majority of leadership and governance positions are held by white males and this racial discrimination transpires within the NHS.[201] The majority of BME workers are represented in medical roles rather than managerial roles and this discriminatory treatment towards BME workers is also

[201] Roger Kline, 'The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England' (2014).

seconded by Paradies et al. The research further discussed the significant mental health issues faced by BME workers due to experiencing racial discrimination at work.[202]

The second theme, which explores the lack of support for migrant workers builds upon pre-existing literature explored by scholars Vaillancourt-Laflamme et al, which states that migrant workers were more likely to be exposed to the virus due to the shortage of HCWs and had a significantly higher risk of contracting Covid-19.[203] However, migrant HCWs had to endure the hardships of working during the pandemic at the cost of their mental health, including stress, depression and loneliness.[204]

When engaging with the third theme, the supply of PPE, extensive research has been conducted on both the physical and mental health effects it has on HCWs. This stems from the research presented by scholars, such as Chan, where HCWs had reservations of providing care to patients without appropriate protective equipment due to the fear of contracting the virus.[205] High levels of anxiety and stress were seen amongst these workers which was rooted due to the lack of sufficient and suitable PPE available to them. Scholars Ascott et al, further states that female workers had to undergo added hardships of having to continue their work with ill-fitting protective equipment as the generic protective equipment are catered towards the wider white male population.[206]

Similar to the mental health issues, the physical health issues faced by workers due to the lack of suitable and sufficient PPE is reinforced by the arguments made by Candido et al. Musculoskeletal conditions, skin problems, urinary issues, respiratory and nervous disorders were common physical health issues encountered by HCWs and were caused by the prolonged use of protective equipment. [207] Contact dermatitis was the most prevalent skin issue, resulting from over washing of hands and use of protective equipment.[208]. O'Neill et al, states that if adequate care is not given to contact dermatitis issues it could result in major

[202] Yin Paradies, Jehonathan Ben, Nida Denson, et al., 'Racism as a determinant of health: a systematic review and meta-analysis' (PloS one, 2015).
[203] Catherine Vaillancourt-Laflamme, Jane Pillinger, Nicola Yeates, et al., 'Impacts of Covid-19 on migrant health workers: a review of evidence and implications for health care provision' (The Open University, 2022).
[204] Munyi Shea and Y Joel Wong, ' A two-way street: immigrants' mental health challenges, resilience, and contributions' (One Earth, 2022).
[205] Hui Yun Chan, 'Hospitals' liabilities in times of pandemic: Recalibrating the legal obligation to provide personal protective equipment to healthcare workers' (Liverpool Law Review, 2021).
[206] Anna Ascott, Paul Crowest, Eleanor de Sausmarez, et al., 'Respiratory personal protective equipment for healthcare workers: impact of sex differences on respirator fir test results' (British Journal of Anaesthesia, 2021).
[207] Giuseppe Candido, Constanza Tortù, Chiara Seghieri, et al., 'Physical and stressful psychological impacts of prolonged personal protective equipment use during the COVID-19 pandemic: a cross-sectional survey study' (Journal of Infection and Public Health, 2023).
[208] Ghassan M Barnawi, Azhar M Barnawi and Sahal Samarkandy, 'The association of prolonged use of personal protective equipment and face mask during Covid-19 pandemic with various dermatologic disease manifestations: a systematic review' (Cureus, 2021).

chronic illness which may even result in workers being unable to continue their role.[209] While early detection and treatment of dermatitis is most effective, it was difficult to adhere to the generic safety measures during the Covid-19 pandemic.

The next theme presented in this research, inconsistent advice across the NHS workforce and its effect on workers' health, specifically in relation to PPE is strongly supported by scholars Zhang et al,. The physical barrier provided by protective equipment is crucial for when HCWs provide care to patients as it is effective in blocking droplet spread, which in turn creates a better environment to continue their work.[210] When this barrier is not present workers feel apprehensive providing care to patients. Kim et al mentions that HCWs' fear of contracting the virus could lead to physical health issues including difficulty in breathing, acute lung injury, low oxygen saturation and abnormal chest x-rays.[211] This theme also makes reference to the financial stress endured by workers due to the inconsistent advice provided during the pandemic on working conditions and self-isolation. Scholars Kiecolt-Glaser and Glaser states that stress and depression endured at work could affect the physical health by weakening the immune system and changing cellular immunity.[212]

The last theme makes reference to the chronic workforce shortage that the NHS is facing due to HCWs leaving the profession. This theme draws attention to the NHS mandating the Covid-19 vaccine on all NHS HCWs. Wilder-Smith states that the vaccine provides an added layer of protection from infection, which in turn aids in protecting the physical health of workers.[213] The wider literature also discusses the health issues that workers face as a consequence of working for longer periods. Research conducted by Wong et al, draws attention to the physical health effects endured by workers due to long work hours in the form of chronic pain, type 2 diabetes and/or high level of body mass index.[214]

Having discussed about the literature in relation to the themes above table 1 below shows the number of case studies chosen under each theme for the analysis. Since the testimonies

[209] H O'Neill, I Natang, D A Buckley, et al., 'Occupational dermatoses during the Covid-19 pandemic: a multicentre audit in the UK and Ireland' (British Journal of Dermatology, 2021).
[210] Chen Zhang, Peter V Nielsen, Li Liu, et al,. 'The source control effect of personal protection equipment and physical barrier on short-range airborne transmission' (Building and Environment, 2022).
[211] Hyunju Kim, Sheila Hegde, Christine LaFiura, et al., 'Access to personal protective equipment in exposed healthcare workers and COVID-19 illness, severity, symptoms and duration: population – based case-control study in six countries' (BMJ global health, 2021).
[212] Janice K Kiecolt-Glaser and Ronald Glaser, 'Psychoneuroimmunology: can psychological interventions modulate immunity?' (Journal of consulting and clinical psychology, 1992).
[213] Annelies Wilder-Smith, 'What is the vaccine effect on reducing transmission in the context of the SARS-CoV-2 delta variant' (The Lancet Infectious Diseases, 2022).
[214] Kapo Wong, Alan HS Chan and S C Ngan, 'The effect of long working hours and overtime on occupational health: a meta-analysis of evidence from 1998-2019' (International journal of environmental research and public health. 2019).

had already been published online, I did not need to use pseudonyms to protect the identity of the healthcare worker.

Table 1: Number of HCWs included within each theme

Theme	Number of HCWs
Prejudicial treatment of black minority ethnic workers	9
Lack of support for minority workers	9
Inconsistent advice across the NHS workforce	5
The intention to leave the healthcare profession	5
Supply of PPE	5

Whilst deciding on how to conduct the data analysis, each theme presented a natural and close link to how working during the pandemic affected the HCWs' mental health or physical health. This was an interesting observation as both mental and physical health are interconnected.[215] Often when an individual is physically affected by an incident it could indirectly affect their mental health.[216] Because mental health struggles are generally difficult to recognise as there are no physical signs, individuals can struggle in silence. When conducting the analysis, however, it was important to pay close attention to the mental health struggles that HCWs faced during the pandemic. In most instances, the healthcare worker would voice how they mentally struggled whilst working as a healthcare professional. In other instances, workers would indirectly imply that they were mentally struggling to work despite presenting no physical health issues. In these instances, I made a calculated decision to analyse why the workers' mental health was negatively affected at work. For instance, a black nurse would be subjected to unfair treatment at work if she was refused opportunities to apply for promotions hindering her professional progress. Although this incident would not present any physical health concerns, the worker might be mentally stressed and anxious while continuing to work in an environment that does not value her.

Having categorised the case studies into effects on workers' mental and physical health, I utilised the above-mentioned socio-legal method to observe how and in what way the 1974 Act applied to the social situations in protecting the health and safety of the HCWs. Table 2 below represents some of the most fundamental and basic health and safety laws that employers are under a duty to ensure towards their employees. In the analysis, I aimed to bring together the testimonies and the law pertaining to the health and safety; to judge whether HCWs were protected during the Covid-19 pandemic; and to understand the reasons why, if at all, the health and safety of these workers were not protected.

[215] Julius Ohrnberger, Eleonora Fichera and Matt Sutton, 'The relationship between physical and mental health: A mediation analysis' (Social science & medicine, 2017).
[216] Nikunj Makwana, 'Disaster and its impact on mental health: A narrative review' (Journal of family medicine and primary care, 2019).

Table 2: Key legal duties of employers concerning health and safety

Health and Safety at Work etc. Act 1974	Section
Outlines the core responsibility to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all their employees.	Section 2(1)
Provide instructions with regards to storage/ transport	Section 2(2)(b)
Provide adequate information, instruction, training and supervision	Section 2(2)(c)
Provide adequate protection to third parties and those who are self-employed	Section 3
No charge can be made by the employees for things done or provided	Section 9

The above duties come with a caveat as the employers are only expected to ensure that they have taken all 'reasonably practicable steps' to safeguard the health, safety and welfare whilst their employees are at work. The analysis considered the health and safety legislation and how it was applied within the workplace to safeguard workers. While the 1974 Act is at the forefront, the analysis also considers the impact of other relevant legislation on workers.

The Equality Act 2010 emerged across the different themes, highlighting the duty that employers have towards protecting workers from unfair treatment and discrimination at work, which could have an adverse effect on workers' mental and physical health. Furthermore, the Management of Health and Safety at Work Regulations 1999 is an important piece of legislation, that is vital when discussing and analysing the health and safety of workers. The legislation covers a number of health and safety concerns, including stress at work and places a duty on the employers to conduct risk assessments to identify potential hazards and implement measures to adequately reduce these risks for their workers. Additionally, the PPER 2022, places employers under a legal duty to provide suitable PPE for workers. This was a crucial matter during the Covid-19 pandemic due to the supply and demand of protective equipment. The data analysis also made reference to the Working Time Regulations 1998, which is a vital set of guidelines that employers are required to follow in order to ensure that workers get adequate rest to protect their mental and physical wellbeing. The amalgamation of the legislation alongside the regulations enabled me to holistically analyse the data gathered and to determine if the health and safety of workers were adequately protected during the Covid-19 pandemic.

4. Data

4.1 Introduction

Table 3 below represents the data gathered for the research. The first column states the names of the participant. Since this research is based on secondary data it should be noted that these names are the names of HCWs as recorded by the source material. The second column indicates the category of work that the HCWs belong. The middle column shows the source that the data was gathered from, which is followed by the main issues that highlight the importance of including this data in the research. In the final column the themes are presented in a colour-coded manner.

4.2 Data collection

Table 3: Summary of data

Name	Category of work	Source	Main issues	Themes
Sarah	Nurse	Trades Union Congress (TUC)[217]	Patient care was provided for suspected Covid-19 patients and when asked to be rotated with other staff in order to minimise the spread of the virus and give breaks for workers looking after Covid-19 patients, she was threatened that she would lose her job. She was forced to resign her job not because she was incompetent at her work, but because she believed that she had the wrong skin colour.	Prejudicial treatment of BME workers
Precious	Care worker	TUC[218]	She was expected to work in a care home amongst patients who had Covid-19 and wash deceased Covid-19 patients, seven in total, without appropriate PPE. She expressed that white colleagues did not have to do any of the work that she did and she believed that it was because of the	Prejudicial treatment of BME workers

[217] 'One in five BME workers treated unfairly at work during Covid-19- TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 30 January 2023.
[218] 'One in five BME workers treated unfairly at work during Covid-19- TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 30 January 2023.

			colour of her skin that she was expected to do anything she was asked.	
Estelle	Midwife	TUC[219]	A disproportionate number of black midwives were sent on home visits compared to white workers. Concerns were raised as BME workers were at the risk of dying from the virus. However, no measures were taken to alleviate these concerns.	Prejudicial treatment of BME workers
Gabriella	Agency nurse	TUC[220]	She was allocated to work in a Covid-19 confirmed red zone without adequate PPE, while white workers were sent to work in the blue zone and telephone triage. When concerns were raised about the lack of proper PPE and why she was sent to the red zone she was removed from the rota.	Prejudicial treatment of BME workers
Michelle Cox	Healthcare manager	RCN[221]	The worker was purposefully excluded from applying to senior positions within her team. She was further subjected to discrimination when she was excluded from team events.	Prejudicial treatment of BME workers

[219] 'One in five BME workers treated unfairly at work during Covid-19- TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 30 January 2023.
[220] 'One in five BME workers treated unfairly at work during Covid-19- TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 30 January 2023.
[221] 'North West nurse wins landmark case against NHSE&I for racial discrimination' (Royal College of Nursing, 2023) <https://www.rcn.org.uk/news-and-events/news/220223-nw-michelle-cox-tribunal#:~:text=The%20tribunal%20heard%20how%20Ms,occasions%20she%20couldn%27t%20attend> accessed 18 August 2023.

Efe Obiakor	Nurse	Cable News Network (CNN)[222]	She recounts that whilst working in the NHS she was subjected to discrimination on a daily basis. This was evident to her during the Covid-19 pandemic as the number of Covid infected patients began to flood the NHS, a majority of the nurses providing care to these patients were black nurses.	Prejudicial treatment of BME workers
Monifa Thompson	Nurse	CNN[223]	During the pandemic she was required to provide care to a surplus of patients which was beyond her capacity. Although she wanted to raise concerns over this increased workload, she was reluctant to do so due to the fear of being labelled as "a lazy nurse".	Prejudicial treatment of BME workers
Neomi Bennett	Nurse	CNN[224]	Having feared that she would contract the Covid-19 virus, she raised concerns to her managers of the unfair treatment at work. She was always allocated to attend to patients who were at high risk without proper PPE.	Prejudicial treatment of BME workers

[222] Salma Abdelaziz, 'From the front lines, Black nurses battle twin pandemics of racism and coronavirus' (CNN, 2020) <https://edition.cnn.com/2020/07/10/europe/black-nurses-nhs-discrimination-gbr-intl/index.html>accessed 10 March 2022.
[223] Salma Abdelaziz, 'From the front lines, Black nurses battle twin pandemics of racism and coronavirus' (CNN, 2020) <https://edition.cnn.com/2020/07/10/europe/black-nurses-nhs-discrimination-gbr-intl/index.html>accessed 10 March 2022.
[224] Salma Abdelaziz, 'From the front lines, Black nurses battle twin pandemics of racism and coronavirus' (CNN, 2020) <https://edition.cnn.com/2020/07/10/europe/black-nurses-nhs-discrimination-gbr-intl/index.html>accessed 10 March 2022.

Anu Agboola	Deputy sister	Independent Television (ITV) news[225]	In instances where she desired to raise concerns to human resources, she felt reluctant as often the majority of representatives in the human resources sector were not from her background.	Prejudicial treatment of BME workers
Folasade	Healthcare assistance	The Guardian[226]	The visa application fees for her dependant's visa negatively impacted her mental health whilst working during the pandemic.	Lack of support for migrant workers
Jeri Lee	Care home manager	The Guardian[227]	Due to the fear of contracting the virus the worker was reluctant to attend work which affected her wages. However, she was faced with the heavy burden of having to pay for a visa application which caused her mental distress.	Lack of support for migrant workers
Eva Omondi	Healthcare worker	RCN[228]	The constantly changing visa requirements and application fees displaced this low paid migrant worker.	Lack of support for migrant workers

[225] 'Discrimination' on frontline of coronavirus outbreak may be factor in disproportionate BAME deaths among NHS staff' (ITVX, 2020) <https://www.itv.com/news/2020-05-13/discrimination-frontline-coronavirus-covid19-black-minority-ethnic-bame-deaths-nhs-racism> accessed 18 January 2023.
[226] Sarah Marsh and Harriet Grant, 'We feel insulted': migrant health workers on PM's refusal to scrap NHS surcharge' (The Guardian, 2022) <https://www.theguardian.com/society/2020/may/20/we-feel-insulted-migrant-health-workers-react-boris-johnson-refusal-to-scrap-nhs-surcharge> accessed 18 August 2023
[227] Sarah Marsh and Harriet Grant, 'We feel insulted': migrant health workers on PM's refusal to scrap NHS surcharge' (The Guardian, 2022) <https://www.theguardian.com/society/2020/may/20/we-feel-insulted-migrant-health-workers-react-boris-johnson-refusal-to-scrap-nhs-surcharge> accessed 18 August 2023.
[228] Rachael Healy, 'Fighting an unfair fee' (Royal College of Nursing, 2020) <https://www.rcn.org.uk/magazines/Activists/2020/July-2020/Eva-Omondi-immigration-health-surcharge-campaign> accessed 18 August 2023.

Mictin Ponmala	Nurse	Migrant Voice[229]	Migrant worker who experienced mental distress due to the hostile visa and immigration system.	Lack of support for migrant workers
A healthcare worker from Nigeria	Healthcare assistant	UNISON[230]	The worker's immigration status did not qualify for a free renewal of her visa because her visa expired outside of the dates that the Home Office imposed.	Lack of support for migrant workers
A healthcare worker from Kenya	Healthcare worker	UNISON[231]	The worker did not qualify for the free visa extension and is struggling to find money for the visa extension.	Lack of support for migrant workers
A nurse from the Philippines	Nurse	UNISON [232]	A pregnant worker was shielding according to the government guidance. Her husband who also worked in healthcare, had to give up his job to protect them from contracting the virus while she was pregnant. They are struggling to save the money to pay for the visa extension and the NHS health surcharge.	Lack of support for migrant workers

[229] Doaa Khalifeh, 'It's not my story, its every migrant's story' (Migrant Voice) <https://www.migrantvoice.org/our-stories/its-not-my-story-its-280723101357> accessed 18 August 2023.
[230] 'Frontline care and health workers face thousands of pounds of government visa charges' (UNISON, 2020) <https://www.unison.org.uk/news/2020/07/frontline-care-health-workers-face-thousands-pounds-government-%E2%80%8Bvisa-charges/> accessed 30 July 2023.
[231] 'Frontline care and health workers face thousands of pounds of government visa charges' (UNISON, 2020) <https://www.unison.org.uk/news/2020/07/frontline-care-health-workers-face-thousands-pounds-government-%E2%80%8Bvisa-charges/> accessed 30 July 2023.
[232] 'Frontline care and health workers face thousands of pounds of government visa charges' (UNISON, 2020) <https://www.unison.org.uk/news/2020/07/frontline-care-health-workers-face-thousands-pounds-government-%E2%80%8Bvisa-charges/> accessed 30 July 2023.

Arun Panabaka	Senior nursing assistant	UNISON [233]	The migrant worker was refused to renew their visas at the end of their sponsorship and was forced to leave the country having worked during the start of the Covid-19 pandemic.	Lack of support for migrant workers
Dr Meenal Viz	Doctor	Global Citizens[234]	The pregnant healthcare worker strived to achieve better protection for workers who were working in compromised work environments.	Lack of support for migrant workers
Dr Amun Sandhu	Doctor	Canadian Broadcasting Corporation (CBC)[235]	The PPE provided to female HCWs was not properly 'fit-tested' and was ill-fitting, which put workers at risk of infection.	Supply of PPE
Chika Reuben	Frontline residential care worker	APPG-Coronavirus[236]	Care home HCWs were not given accurate information on the use of PPE. They were advised that they did not need the same PPE as workers in hospitals. However, workers were contracting the virus due to the lack of PPE and risked not getting paid.	Inconsistent advice across the NHS workforce

[233] Janey Starling, 'How the Home Office is risking lives in the NHS' (UNISON, 2020) <https://magazine.unison.org.uk/2020/11/20/how-the-home-office-is-risking-lives-in-the-nhs/> accessed 30 March 2023.
[234] 'I held a One-Woman Protest After the Death of a Nurse from Covid-19. Here's Why It Mattered' (Global Citizens, 2020) <https://www.globalcitizen.org/en/content/health-care-protests-meenal-viz/> accessed 18 June 2023.
[235] Lauren Sproule, 'From pay gap to ill-fitting PPE, female workers highlight challengers in U.K health care' (CBC News, 2020) <https://www.cbc.ca/news/world/uk-health-care-gender-bias-1.5741670> accessed 21 May 2023.
[236] 'Frontline workers' (All Party Parliamentary group on Coronavirus, 2020) <https://www.appgcoronavirus.uk/meetings/blog-post-title-three-chxrx-9txzt-tll2s-d3jna-g9n56-npy4l-xhfng> accessed 30 March 2023.

Zoe Smith	Frontline residential care worker	APPG-Coronavirus[237]	The guidance that HCWs received on shielding constantly changed without informing the workers. Although public service advice encouraged pregnant workers to shield, the workers in the NHS received contradictory rules which resulted in them not getting paid as workers were unable to attend work.	Inconsistent advice across the NHS workforce
Livia	Care home worker	UNISON[238]	Having contracted the virus, she was required to self-isolate. She was not paid for the period of time she was self-isolating. As a result, she had to face financial distress.	Inconsistent advice across the NHS workforce
Maria	Healthcare worker	UNISON[239]	Maria's employer encouraged her to use her holiday leave in lieu of sick leave as she was required to self-isolate due to contracting the virus. She was intimidated into attending work despite being physically unwell.	Inconsistent advice across the NHS workforce
Clare	Healthcare worker	UNISON[240]	Despite being severely unwell she was refused pay and was required to apply for the use of her holiday leave despite providing care to patients who were unwell with the Covid-19 virus.	Inconsistent advice across the NHS workforce

[237] 'Frontline workers' (All Party Parliamentary group on Coronavirus, 2020) <https://www.appgcoronavirus.uk/meetings/blog-post-title-three-chxrx-9txzt-tll2s-d3jna-g9n56-npy4l-xhfng> accessed 30 March 2023.
[238] Care employers still not giving sick pay to Covid-hit staff, says UNISON survey' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/06/care-employers-still-not-giving-sick-pay-to-covid-hit-staff-says-unison-survey/> accessed 11 February 2023.
[239] 'Care employers still not giving sick pay to Covid-hit staff, says UNISON survey' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/06/care-employers-still-not-giving-sick-pay-to-covid-hit-staff-says-unison-survey/> accessed 11 February 2023.
[240] 'Care employers still not giving sick pay to Covid-hit staff, says UNISON survey' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/06/care-employers-still-not-giving-sick-pay-to-covid-hit-staff-says-unison-survey/> accessed 11 February 2023.

Erika Thompson	Midwife	Daily Mail[241]	Erika feared dismissal from the NHS after making a personal decision not to get the vaccine.	The intention to leave the healthcare profession
Nicki Credland	Chair of the British Association of clinical care nurse	APPG-Coronavirus[242]	HCWs were redeployed into Intensive Care Units due to the increase in bed capacity. The staffing ratios that used to be one-to one critical care nursing increased up to one-to six. This created a disparity between the expectation of the standard of patient care and the level of care delivered in practice. It was physically impossible to provide adequate care to all patients which ultimately resulted in workers suffering with moral distress.	The intention to leave the healthcare profession
David	Student ambulance technician	UNISON [243]	He was in the back of the ambulance with suspected Covid patients for hours, confined in a box with no ventilation and just a disposable mask for protection. Workers suffered from mental health issues and these pressures made him give up his occupation.	The intention to leave the healthcare profession

[241] Olivia Devereux-Evans, 'Unjabbed midwife fears losing her job over compulsory vaccines for NHS staff after she chose not to have Covid jab because she has heart condition' (Daily Mail, 2022) <https://www.dailymail.co.uk/news/article-10405625/Unjabbed-midwife-fears-losing-job-compulsory-vaccines-NHS-staff.html> accessed 10 March 2023.
[242] 'Workers: Wellbeing, Burnout and NHS Capacity' (All Party Parliamentary group on Coronavirus, 2020) <https://www.appgcoronavirus.uk/meetings/blog-post-title-three-chxrx-9txzt-tll2s-d3jna-g9n56-npy4l-xhfng-9wjle-kanp2-6h9cz-slp8w-zcekr-my4hr-7t6g6-tj3dc-hn525-35dsd-th664-5nzep-9hk6g-cds9e> accessed 10 February 2023.
[243] 'Covid pressures triggering mental health issues among health staff' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/> accessed 30 March 2023

Michelle	Nurse	UNISON [244]	The unprecedented nature of work that she had to carry out during the pandemic severely affected her mental and physical health. However, she did not receive any support from her workplace which resulted in her leaving the NHS.	The intention to leave the healthcare profession
Jocelyn Blumberg	Clinical Phycologist	Keeping Well North Central London (NCL)[245]	Jocelyn highlighted the importance of other NHS HCWs who are not necessarily working on the front line with patients who had Covid-19.	The intention to leave the healthcare profession
Samantha Margerison	Critical care nurse	Independent[246]	Having to prioritise the patient's need above her personal needs. She had to wear cumbersome PPE for prolonged periods of time.	Supply of PPE
Dr Roberts	Intensive Treatment Unit doctor	British Broadcasting Corporation (BBC)[247]	Due to the rising demand in care required during the Covid-19 pandemic, workers had to resort to using clinical waste bags and wearing skiing goggles and plastic aprons as PPE, due to the shortage of PPE.	Supply of PPE

[244] 'Covid pressures triggering mental health issues among health staff' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/> accessed 30 March 2023
[245] Jocelyn Blumberg, 'Off the frontline? Experiences of NHS staff not working on the Covid wards' (KeepingWell NCL, 2021) <https://keepingwellncl.nhs.uk/podcast/off-the-frontline-experiences-of-nhs-staff-not-working-on-the-covid-wards/> accessed 18 March 2023.
[246] Helen Coffey, 'I am an NHS nurse treating coronavirus patients in the ICU. We're fighting a war and soon we won't have any bullets' (Independent, 2020) <https://www.independent.co.uk/life-style/health-and-families/icu-nurse-critical-care-nhs-hospital-coronavirus-covid-19-ppe-a9477486.html> accessed 12 May 2023.
[247] Claire Press, 'Coronavirus: The NHS workers wearing bin bags as protection' (BBC, 2020) <https://www.bbc.co.uk/news/health-52145140> accessed 12 May 2023.

Dr Helen Kirby-Blount	General Practitioner	BBC[248]	The lack of PPE resulted in workers reusing old protective equipment which defeated the purpose of virus transmission.	Supply of PPE
Anita	Midwife and Nurse	BBC[249]	Anita was not provided with any PPE while waiting for the result of a Covid-19 swab test which could take up to 3 days.	Supply of PPE

[248] 'Coronavirus: Doctors 'buy their own PPE or rely on donations 2020''(BBC, 2020) <https://www.bbc.co.uk/news/uk-52519339#:~:text=%27Our%20biggest%20fear%22&text=She%20said%20staff%20have%20resorted,equipment%20they%20have%20bought%20themselves> accessed 04 May 2023.
[249] 'Stories from behind the mask' (BBC) <https://www.bbc.co.uk/programmes/articles/2cm0PfTtkPqjMymJQl38YJC/stories-from-behind-the-mask> accessed 19 March 2022.

Conclusion

Using a socio-legal research method to analyse the effectiveness of the health and safety laws in the UK at protecting the physical and mental health of HCWs during the Covid-19 pandemic allowed me to address my research questions. It enabled me to understand the extent to which the employers were able to stretch the law by pushing the limit on the interpretation and application of the law and at times breach the law. In order to determine the effectiveness of the health and safety laws at protecting the health of HCWs it was necessary to use empirical data. Since I conducted the data collection after the end of the second lockdown, many HCWs were gradually beginning to publicly express what they encountered during the Covid-19 pandemic. The online testimonies provided a rich data source which enabled me to conduct the core analysis. Analysing labour law and its application, it was interesting to understand that the laws do not perform within society as was intended by the legislature. The hierarchy of primary legislation, specifically the Health and Safety at Work etc. Act 1974, is often pushed to its absolute limit where norms are developed through social behaviours. To illustrate, employers often do the bare minimum when it comes to protecting the workers' health and safety. This could be the result of a lack of awareness or understanding of the legal requirements to a lack of enforcement, where they believe that they do not need to regulate an environment that is safe for workers or they simply foster a work culture where health and safety issues are the individual worker's fault rather than a systemic issue. Along with the socio-legal research method the thematic qualitative data analysis enabled me to find patterns within the data that further enabled me to understand how effective the law was at protecting workers within the healthcare industry.

Prior to presenting the research analysis of the data in chapter five and six it is important to consider how health and safety at work is regulated within the UK and more specifically within the healthcare sector. This is because regulations exist which aim to ensure that workers are protected from the unique hazards within the healthcare settings, which in turn fosters a healthy work environment that ultimately enhances the quality of care provided to patients. In chapter three, I will outline the legal framework relating to workplace health and safety before moving on to consider the impact of trade union membership and collective bargaining on the workplace experiences of HCWs in the UK in Chapter four.

Chapter 3 The Evolution of Workers' Health and Safety Legislation

Introduction

In the UK, the law regulating occupational health and safety was transformed by the introduction of the Health and Safety at Work etc. Act 1974.[250] Although the road to success was challenging, the 1974 Act was a revolutionary statute that brought about several positive changes to labour law and provided statutory protection to workers in all sectors of the economy. Prior to the introduction of the 1974 Act, no legislation comprehensively addressed the health and safety of workers.[251] Instead, there were several different pieces of legislation that addressed different sectors separately. Although these enactments were very prescriptive, they only covered the rights of the workers at a superficial level. In contrast, the 1974 Act covers a larger group of sectors which were not previously included and regulates their health and safety to much greater effect. This chapter aims to explore the duties under the 1974 Act that will be highlighted in the subsequent chapters and how the NHS, as employers, has integrated it into their health and safety policy.

In the first section of this chapter, I will briefly explore the evolution of occupational health and safety legislation prior to the 1974 Act. The Act emerged from the new regime proposed by Alfred Robens and the Committee on Health and Safety at Work. The recommendations proposed by the Committee were important in shaping the Act. The second section of the chapter will discuss the different duties and responsibilities that the 1974 Act confers, not only on employers, but all other parties involved within an employment organisation. The Act can be dissected into four sections, the most important being the first. This first section elaborates on the purpose of the Act, which encompasses setting out the duties and responsibilities that the employers and employees have towards each other, which also sets out the administrative and enforcement structures of the Act. It is important to refer to these duties as this will contribute to the wider research aim of analysing how the law contributes to protecting the health and safety of HCWs. The third section of this chapter will look at the important features of the 1974 Act that enabled health and safety to be prioritised within the workplace and encouraged workers to understand their rights when at work. The fourth section will refer to the European Union (EU) occupational health and safety legislation that

[250] 'Health and safety regulation, a short guide' (Health and Safety Executive) <https://www.hse.gov.uk/pubns/hsc13.pdf> 07 November 2020.
[251] Mike Esbester, 'The Health and Safety at Work Act, 40 years on' (History & Policy, 2014) <https://www.historyandpolicy.org/opinion-articles/articles/the-health-and-safety-at-work-act-40-years-on> accessed 10 November 2023.

has been incorporated into the UK regulations. The influence of EU Directives and regulations required the UK to make structural changes to the implementation of its health and safety laws. Specifically, the Health and Safety Framework Directive (89/391/EEC) which introduced the requirement to conduct risk assessments that will be highlighted in the analysis chapters five and six. The final section of this chapter will focus on how the National Health Service has incorporated and adapted the general health and safety legislation into their own procedures and policies with respect to NHS employees and other workers, seeking to ensure compliance with the 1974 Act.[252] The chapter will conclude by stating that the 1974 Act has been a great success in reducing the fatalities within workplaces as it clarifies the specific duties that employers have towards their employees and vice versa. At present, however, it suffers from a number of shortcomings; funding cuts and resource constraints have a domino effect within the HSE which ultimately affects health and safety regulation within the workplace. However, the law continues to provide a firm platform for any employer who is concerned to ensure a health and safety environment within the workplace.

1. Occupational health and safety

1.1 Evolution of workers' health and safety

One of the most fundamental changes that took place in the history of British labour law was the introduction of the Factory Act (1833 Act), which came into effect in 1833.[253] The government enacted this law to protect the safety of individuals who were engaged in factory work; and, specifically, to protect children working in the lead and cotton mills industry.[254] The 1833 Act paid little to no attention to the health of individuals working in these factories and contracting industrial diseases, which resulted in workers facing accidents, long term illnesses or even death. Although doctors voiced concerns regarding the health of factory workers who were prematurely dying due to lead poisoning and lung diseases, minimum attention was given to the protection of these workers.[255] While the 1833 Act contained

[252] 'Workplace health and safety standards' (NHS Staff Council Working in Partnership, 2013) <https://www.nhsemployers.org/system/files/2021-08/workplace-health-safety-standards.pdf> accessed 15 February 2021.
[253] Matthais Beck and Charles Woolfson, 'The regulation of health and safety in Britain: from old Labour to new Labour' (Industrial Relations Journal 31, No1, 2000).
[254] James R Heaton, 'The Evolution of the Working Conditions and Associated Legislation of Apprentices and Child Labour in British Factories and Trades from the Late 18th to the Middle of the 19th Centuries' (Doctoral dissertation, Rhodes University, 1976).
[255] Charles Turner Thackrah, 'The effects of arts, trades, and professions: and of civic states and habits of living, on health and longevity: with suggestions for the removal of many of the agents which produce diseases and shorten and duration of life' (United Kingdom: Longman, Rees, Orme, Brown, Green & Longman, 1832).

minimal transformations, it initiated the enforcement of regulations to protect factory workers but failed to provide adequate statutory protection to workers of other employment sectors such as schools and hospitals.[256]

By the middle of the twentieth century, the alarming number of workplace related deaths and injuries experienced by workers indicated that the United Kingdom's existing approach to regulating workplace health and safety had long run out of steam and a new and improved system was necessary.[257] In 1969 Lord Alfred Robens was selected as the chairperson of the Committee on Health and Safety at Work, which came to be known as the Robens Committee.[258] Previously, from April 1951 until October 1951, Robens had served as Minister for Labour and National Service, in which role he had consistently promoted the principle of voluntarism in industrial relations.[259] Under his leadership, the Committee strived to change and improve the existing system of health and safety at work and to achieve a system that would reduce the number of workers falling victim to careless work-related accidents and injuries.[260]

1.2 A new dawn

The Committee lead by Robens, drafted a proposal which was known as the Robens Report to answer a fundamental question as to why workplace health and safety law was failing to maintain a standard and the steps that could be taken to minimise the fatalities and injuries suffered by individuals in employment. The Committee researched occupational safety machinery used by countries such as the United States and Canada in order to understand the contemporary legislation enacted in those countries.[261] The Committee hoped to acquire inspiration from the health and safety regimes of those countries to frame their proposals to revise the existing UK law.

The Report stipulated that workplace accidents occurred due to two key reasons, namely the lack of interest and care taken by the workers themselves. Robens named this "apathy",

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[256] Christopher Sirrs, 'Accidents and apathy: the construction of the 'Robens Philosophy' of occupational safety and health regulation in Britain, 1961–1974' (Social History of medicine, 2016).
[257] Christopher Sirrs, 'Risk, Responsibility and Robens: The Transformation of the British System of Occupational Health and Safety Regulation, 1961-1974' (Governing Risks in Modern Britain: Danger, Safety and Accidents, c. 1800-2000, 2016).
[258] Lord Alfred Robens, "History of Occupational Health and Safety" <https://www.historyofosh.org.uk/themes/people/Robens_Alfred.html> accessed 30 March 2021.
[259] Lord Alfred Robens, "History of Occupational Health and Safety" <https://www.historyofosh.org.uk/themes/people/Robens_Alfred.html> accessed 30 March 2021.
[260] Iris Cepero, 'The Act that changed our working lives' (Safety Management, 2014).
[261] Antony D. Woolf, "Robens Report- the wrong approach" (Indus.LJ2, 1973).

which he explained was a consequence of workers deeming that they are immune to accidents, that accidents only happen to other individuals, and that, nothing can be done in order to prevent accidents from happening.[262] Preventing an accident appeared as an alien task to workers, one that was not within the realm of their responsibilities but was a matter of concern only for external regulation and other enforcement agencies. Robens' Report diagnosed apathy as a key cause of workplace accidents. The root cause as to why the subject of health and safety created an apathetic response was partly due to defects in the existing statutory system.[263] The influx of rules and regulations created by different legislation overwhelmed businesses as there was 'too much law'. In an instance where an agency was required to respond to a technical situation, they would set up a new set of rules to be followed.[264] This influx of law not only confused employers but overlooked the facts of who created risks and who was primarily responsible for preventing risks created at work.

Robens proposed that a new system should encompass a more 'voluntary system'.[265] Both individuals who created the risks and those who work with them should be made primarily responsible for their actions. This would motivate workers to go beyond the minimum level of duty that should be stipulated in new legislation. The Committee recommended that rather than providing an unreasonable and strict standard, the government should ensure they promote a system where employers were welcome to ask for advice and assistance, which would ultimately result in a more self-regulating approach to workplace health and safety. This idea of employer-employee consultation was vital for good management as it would lead towards better employee performance within work. When drafting a workplace-specific health and safety policy, the involvement of people at work would not only create a sense of responsibility, but it would stipulate the particular duties that need to be carried out by the employees.

The Robens Report further addressed the various reasons as to why policies that previously had been used to promote health and safety had failed. One of them was the lack of a single unified framework to cover all hazardous employment sectors. Robens stated that legislation was drafted for only a few selected dangerous trades and industries in a fragmented fashion. This piecemeal legislation undoubtably created confusion among employers and workers.

[262] Christopher Sirrs, 'Accidents and apathy: the construction of the 'Robens Philosophy' of occupational safety and health regulation in Britain, 1961–1974' (Social history of medicine, 2016)
[263] Christopher Sirrs, 'Risk, Responsibility and Robens: The Transformation of the British System of Occupational Health and Safety Regulation, 1961-1974' (Governing Risks in Modern Britain: Danger, Safety and Accidents, c. 1800-2000, 2016).
[264] R.W.L Howells, "The Robens Report" (Indus.LJ1, 1972).
[265] R.W.L Howells, "The Robens Report" (Indus.LJ1, 1972).

Robens proposed instead a system where a single agency provided a single and enabling statute. Importantly, this new regime was to provide protection not only to all employees but to all individuals in employment. Prior to the HSWA, health and safety legislation was continually being replaced and repealed which only added to the confusion. Robens stated that the topic of health and safety often provoked a positive response only when there was an additional financial motive. In Robens' own concluding remarks, the Report suggested that a self-regulating system between employers and employees would help move away from a fragmented system to one which is more comprehensive.

2. The Health and Safety at Work etc. Act 1974

The 1974 Act introduced a modern health and safety regime which marked the coming of age of occupational health and safety legislation in the United Kingdom. The Act improved the working conditions of workers and as a result minimised the number of work-related deaths. After the 1974 Act came into force, fatal injuries at work plummeted by 85% from 651 injuries in 1974 to less than 150 in the year 2014 and at present to less than 140 in the year 2023.[266] The regulations that the 1974 Act imposed on both employees and employers assisted in making the workplace a safe place of work. This section will elaborate the key duties and responsibilities that the 1974 Act places not only on employers but also on employees during the course of employment.

2.1 Duties of the employer to employee

2.1.1 Health and Safety at Work etc. Act 1974, Section 2

Employers are under a duty to ensure that the health, safety and welfare of all employees are protected at work. Section 2 of the 1974 Act specifically states that the duty should be fulfilled as far as it is reasonably practicable by the employer, while the employee is engaged in the course of their work.[267] According to section 2(2), this duty can be extended and applied under different settings, which include conducting maintenance of plant and system of work to ensure a safe system of work without risks.[268] Necessary arrangements are required to be made with regards to handling, storage and transport of articles and substances

[266] 'Number of fatal injuries to workers in Great Britain from 1974 to 2022/23' (Statista, 2023) <https://www.statista.com/statistics/292272/fatal-injuries-at-work-great-britain-by-employment-y-on-y/> accessed 21 November 2023, Iris Cepero, 'The Act that changed our working lives' (Safety Management, 2014).
[267] Health and Safety at Work etc. Act 1974, s2(1).
[268] Health and Safety at Work etc. Act 1974, s2(2)(a).

to protect the health of employers.[269] Employees should be given information, instruction, training and supervision to safeguard their health and safety.[270] In order to ensure that workers are safe within their workplace, employers are required to provide and maintain access to and egress from their place of work.[271] Overall, employers are required to ensure so far as is reasonably practicable to provide arrangements and facilitate for their welfare.[272]

Taken together, these rules contained in section 2(2) create an obligation to provide a safe place of work to protect the health, safety and welfare of workers *so far as is reasonably practicable*. When fulfilling this duty 'so far as is reasonably practicable' employers may fail to fully grasp the breadth of the legal responsibility. The HSE has provided guidance to help employers understand the law and the steps they need to take to ensure that they comply with this duty. [273] The HSE states that employers should control and reduce risks as far as is reasonably practicable by conducting risk assessments. Ultimately the court will determine if the employer has complied with the law.[274] Although the precise extent of the employer's duty to remove risks remains ambiguous, case law states that the risks associated with a worker's health and safety have to be weighed against the measures taken to avert the risks. The decision in *Edwards v The National Coal Board* further states that, if the risk is placed on one end of a scale and the measures taken to reduce or eliminate risk is placed on the other end and if it creates an imbalance, it is grossly disproportionate if the risks insignificantly outweigh the sacrifice.[275]

When applying this principle to machinery and equipment, risk assessments should be carried out to ensure that machinery and equipment are maintained by methodically inspecting the manufacturer's recommendations and instructions. These should specify how maintenance should be carried out and what needs to be done in order not only to keep the equipment safe but also to carry out the maintenance safely. The above mentioned HSE guidance is provided in line with the 'Provision and Use of Work Equipment Regulations 1998' (PUWER). PUWER focuses on regulating the use of machinery and other equipment at the workplace. Regulations were put in place to minimise the rising number of workplace fatalities, to prevent injuries and accidents where heavy equipment and machinery was in

[269] Health and Safety at Work etc. Act 1974, s2(2)(b).
[270] Health and Safety at Work etc. Act 1974, s2(2)(c).
[271] Health and Safety at Work etc. Act 1974, s2(2)(d).
[272] Health and Safety at Work etc. Act 1974, s2(2)(e).
[273] 'The History of HSE' (Health and Safety Executive) <https://www.hse.gov.uk/aboutus/timeline/index.htm> accessed 18 February 2021.
[274] 'Principles and guidelines to assist HSE in its judgements that duty-holders have reduced risk as low as reasonably practicable' (Health and Safety Executive, 2001) < https://www.hse.gov.uk/enforce/expert/alarp1.htm> accessed 08 March 2021.
[275] Edwards v National Coal Board [1949] 1 All ER 743 CA.

use.[276] PUWER builds on section 2 of the 1974 Act and reiterates in regulation 5 that all employers should ensure that work equipment should be maintained in an efficient state and should take appropriate measures to manage the risks from maintenance (Regulation 22).[277] In order to make sure maintenance is conducted at a low-risk level, it should be carried out by competent staff and these individuals should be provided with adequate training and supervision. These regulations apply to all types of industries/businesses that use machinery regardless of the size and nature of the business. This duty is one of the key changes implemented by the 1974 Act, compared to previous legislation, as the Act provides a blanket rule that applied to all sectors of employment. Prior to the enactment of the 1974 Act, little to no attention was paid to the maintenance of workplace equipment and especially for the staff who were conducting maintenance work.

Employers must also ensure the safe use, handling, transport and storage of articles and substances used at work. Prior to the 1974 Act, it was the general understanding that only work sectors such as the nuclear and agriculture industry needed comprehensive health protection and safeguards. Pursuant to the Act, employment sectors such as the hospitality industry, healthcare and education have been made to comply with regulations in the delivery, purchase, storage, disposal and handling of hazardous chemicals.[278] To oversee this aspect, the Control of Substances Hazardous to Health Regulations 2002 (COSHH) were introduced under the 1974 Act, highlighting the importance of the employer's duty towards safeguarding the employees from hazardous substances[279] and the duty to provide information, instructions, training and supervision necessary to ensure workers carry out their role in a safe and secure manner at the workplace.

Training workers has always been an essential element of workplace health and safety. For instance, the Factory Act 1802 encouraged employers to train their workers as it was believed it was essential for their health and safety at work. Although training was at the forefront of British health and safety legislation, more attention was given after 1974 to

[276] '6- Provision and Use of Work Equipment Regulations' (Occupational Safety and Health Consultants Register) <https://www.oshcr.org/help/knowledge-base/for-business-owners/puwer/#> accessed 08 March 2021.
[277] 'Provision and Use of Work Equipment Regulations 1998 (PUWER)' (Health and Safety Executive) <https://www.hse.gov.uk/work-equipment-machinery/puwer.htm> accessed 08 March 2021, The Provision and Use of Work Equipment Regulation 1998 s22.
[278] 'Safe storage and disposal of hazardous material and chemicals Department non-statutory guidance for school leaders, governing bodies, academy trusts and local authorities' (Department of Education, 2017) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/660517/Safe_storage_disposal_chemicals_advice_Nov2017.pdf> accessed 18 March 2021.
[279] COSHH (Control of Substances Hazardous to Health)' (Occupational Safety and Health Consultants Register) <https://www.oshcr.org/coshh-control-of-substances-hazardous-to-health/> accessed 15 March 2021, 'Working with Substances hazardous to health, A brief guide to COSHH' (Health and Safety Executive) <https://www.hse.gov.uk/pubns/indg136.pdf> accessed 15 March 2021.

training inspectors rather than training employees. Inspectors were required to have a graduate level degree and to have successfully completed legal and technical exams.[280] While it is important to train inspectors as they play a pivotal role in supervising health and safety at work, training employees at a workplace, educating them and informing them of workplace safety and how to carry out risk assessments to prevent potential harm is vital for themselves and other employees at the workplace.[281] It was the 1974 Act that highlighted the importance of training employees and educating them on how to carry out their work safely. In addition to providing training, employers are under a duty to ensure that they provide a safe place of work free from danger to the employees with safe means of entrance and exit. The 1974 Act ensured that this provision was a legal duty conferred upon employers. Prior to the enactment of the 1974 Act, inspection of factories revealed that fire exits were kept locked and serious injuries were caused due to not having safe means to access and exit the workplace.

Finally, the employer is under an obligation to make sure that all employees are provided with adequate welfare facilities. While employees' welfare has been expressed as a health and safety concern, until the 1974 Act no specific legal requirement voiced the concern for welfare facilities to be provided to those individuals. For instance, before the 1974 Act, basic welfare facilities such as provision of adequate lavatories, washing and changing facilities was not a legal obligation on the part of the employer; it was expected of employers to provide these facilities voluntarily. Since the enforcement of the 1974 Act, providing welfare facilities became a legal obligation and employers are under a duty to abide by these provisions.

2.1.2 Health and Safety at Work etc. Act 1974, Section 9

According to section 9 of the 1974 Act, no charge can be levied on any worker for anything done or provided for health and safety in pursuance of any specific requirements. The most common requirement for employers is to provide PPE for their employees. PPE is a legal right of workers when engaged in work, depending on the work environment. The 1974 Act ensured that if employers were to breach this duty it would not only constitute a criminal offence but would enable the employee to sue the employer for damages for the losses

[280] David Eves, 'Two steps forward, one step back' A brief history of the origins, development and implementation of health and safety law in the United Kingdom, 1802-2014' (History of Occupational Health and Safety) <https://www.historyofosh.org.uk/brief/index.html> accessed 12 February 2021.
[281] 'Section 1 The Health and Safety Law- School Management' <https://schools.bracknell-forest.gov.uk/wp-content/uploads/section-1-health-and-safety-law.pdf> accessed 14 May 2021.

suffered. The employers have a duty to not only provide the necessary PPE for the employees but also to ensure that equipment is readily available and there is sufficient PPE on the premises.[282] In addition to the duty imposed under the 1974 Act, the PPER 2022 places a duty on the employer to ensure that workers are provided with adequate information and sufficient training regarding the proper use of PPE.[283]

2.2 Duties of the employers to others

In addition to the many advancements mentioned above, one of the most significant changes that the 1974 Act introduced is an obligation on every employer to conduct operations in a manner that ensures, so far as is reasonably practicable, that a person who is not in its employment but who may be affected by its activities is not exposed to any risk to their health or safety. This duty, brought in under section 3, applies where an employer has contracted with an outsourced worker, for instance a consultant or a contractor, for a work-related activity. It is the employer's duty to ensure that the work they carry out is done safely.

2.3 Duties of the landlord and building managers

Section 4 of the Act places a duty on any building owner who has control of the work premises used for employment to ensure safe access and egress for the people using the premises as a place of work.

2.4 Duties of the employee

In addition to the plethora of duties imposed on employers, the 1974 Act imposes duties on employees. Under section 7 of the Act, employees are to take reasonable care of themselves and others at their workplace and abide by the rules put in place by their employer. Prior to the 1974 Act, legislation almost always focused on employers' liability. For instance, employees were to be protected from accidents caused by negligence of managers and prevent injuries caused during their employment. However, unlike previous legislation, the 1974 Act places the responsibility of health and safety on both the employer and employee. If a negligent act is committed by an employee, the employer will usually be held vicariously

[282] 'Do employers have to provide personal protective equipment (PPE)' (Health and Safety Executive) <https://www.hse.gov.uk/contact/faqs/ppe.htm> accessed 20 February 2021.
[283] 'Personal protective equipment (PPE) at work regulations from 6 April 2022' (Health and Safety Executive) <https://www.hse.gov.uk/ppe/ppe-regulations-2022.htm> accessed 15 March 2022.

liable; however, the HSE regulations state that where an employer is able to show that they had taken reasonably practicable steps to avoid any risks the employer will not be held liable and will not be responsible to pay damages. In that case, the onus will be on the employee to ensure that they had taken reasonable care of themselves and of other employees. This was one of the main provisions that the Act strived to achieve as employees were entrusted with the duty to take reasonable care of not only their own health and safety but of the other employees at the workplace and to be liable for their own actions.

2.5 Duty not to misuse

The duty not to misuse or interfere with anything provided during the course of employment for health, safety or welfare, is a key provision introduced by the 1974 Act. The provision states that no person shall intentionally or recklessly interfere with any article or equipment provided in the interest of health, safety or welfare. The most intriguing aspect of this provision is that this duty does not apply only to employers, employees and those in control of the premises but to “all persons”. For instance, it can apply to a member of the general public who is at a hospital, fairground or at a leisure centre, or to passengers on a public transport system. This duty widened the scope of the law as it was no longer confined to conventional industrial premises. As the public was now covered by law, growing concerns about health and safety came before the health and safety inspectors, which required them to improve the maintenance, safety and standards of leisure centre and fairground rides.

2.6 Duties of the manufacturers and suppliers

The 1974 Act imposes a duty on manufacturers and suppliers to ensure, as far as it is reasonably practicable, that articles of PPE are designed and constructed in a manner that is safe and without any risks to the health of the consumer. Furthermore, the employer must ensure that the equipment is cleaned and maintained by the employees and it must arrange necessary examinations and testing to ensure that the equipment is free of defects and would be safe and without risks to operate. These duties represent another advancement in the health and safety at work legislation.

3. A new hope

Providing a safe working environment was the core aim that the 1974 Act strived to achieve. In furtherance of that aim, the 1974 Act created the Health and Safety Commission and the Health and Safety Executive. The above statutory duties enable workplaces to ensure that they comply with the law to protect the health and safety of workers. In addition to the above key duties, the 1974 Act introduced new features into practice to foster a culture of responsibility and accountability among workers, deviating from an apathy culture. For instance, a self-regulating system was adopted by the UK under the enactment of the Health and Safety at Work Act 1974.[284] Rather than having prescriptive standards, a goal-oriented approach enables workplaces to adopt a self-regulating system where responsibilities and duties are consulted on by both employers and employees. The Act also provided extensive powers to inspectors which enabled them to maintain a health and safety standard across all sectors of employment. Finally, this section will discuss how other rules and regulations assist in upholding the health and safety of workers.

3.1 Health and Safety Executive

The Health and Safety Executive is an agency introduced in order to oversee the enforcement of workplace health, safety and welfare. The HSE carries out routine checks and assists employers. Its introduction was advantageous to employers as the HSE provided guidance on how to manage risks correctly. When the 1974 Act first came into force, it was feared that the excessive load of new regulations and guidelines on health and safety could promote apathy, which would result in the reoccurrence of workplace accidents.[285] In order to move away from this continuing cycle of apathy towards workplace health and safety, which would inevitably lead to the rising number of accidents, the HSE worked in partnership with employers which had the worst risk management record.

The HSE requires that every business employing more than five workers needs to have in place a health and safety policy in accordance with the 1974 Act. The HSE directs employers to frame their policy in three separate sections. The first should set out the general health and safety policy at work and the steps taken by the business to achieve them. The second

[284] David Eves, ‘’Two steps forward, one step back’ A brief history of the origins, development and implementation of health and safety law in the United Kingdom, 1802-2014’ (History of Occupational Health and Safety) <https://www.historyofosh.org.uk/brief/index.html> accessed 12 February 2021.
[285] Christopher Sirrs, ‘Accidents and apathy: the construction of the ‘Robens Philosophy’ of occupational safety and health regulation in Britain, 1961–1974’ (*Social history of medicine*29, no. 1 2016).

should designate a set of people responsible for the specific actions within the business. Finally, in order to achieve the first objective, the third section should identify the practical steps that need to be taken in order to meet the aims of the health and safety policy.[286] These three sections provide a guide to employers on how to frame and adapt policies in order to preserve and maximise workers' health and safety.

Although the HSE was conducting inspections to prevent work-related deaths, injury and ill health, in recent years the HSE has faced numerous challenges in its attempt to regulate workplace health and safety. One of the main problems that limit the opportunities for inspections is the severe budget cuts experienced by the HSE. Starting from the year 2010, the HSE has gone from £228m grant-in-aid funding to only £126m in the year 2019.[287] The underfunding results in the inability to conduct effective investigations, which results in making the workplace less safe and depriving victims of justice, as those at fault for a workplace accident go unpunished.[288] While, in the most recent years, funding increased up to £185m in the year 2022, when inflation is factored in, funding is significantly lower compared to 2010,[289] especially as the HSE came across unique challenges as a result of the Covid-19 pandemic. Inspections had to be conducted in workplaces such as shops and offices that were traditionally deemed low risk, as they were facing a contagious disease. Workplaces that continued to operate during the pandemic were required by the law to use PPE, which was commonly used by the construction or healthcare sector. In addition to the physical health risks, the concept of working from home resulted in white-collar workers struggling to create boundaries between work and non-work time when making arrangements to work from home.[290]

In order to ensure that HSE inspectors are able to navigate through these new circumstances and provide assistance to avoid workplace injury they require adequate training. However, due to the lack of adequate funding for training purposes, inspectors are having to cut corners which result in lack of satisfactory health and safety standards within the workplace. This is due to the declining number of HSE inspectors within the UK. There was a staggering 41%

[286] 'Writing a health and safety policy' (Health and Safety Executive) <https://www.hse.gov.uk/toolbox/managing/writing.htm> accessed 18 February 2021.
[287] 'HSE under pressure: A perfect storm Prospect Union's report on the long term causes and latent factors' (Prospect, 2023) <https://library.prospect.org.uk/id/2023/April/24/HSE-under-pressure-perfect-storm> accessed 16 July 2024.
[288] 'Risks 1089- Cancelled HSE investigations HS2 tragedy overworked teachers' (Trades Union Congress, 2023) <https://www.tuc.org.uk/news/risks-1089-cancelled-hse-investigations-hs2-tragedy-overworked-teachers> accessed 16 July 2024.
[289] 'HSE under pressure: A perfect storm Prospect Union's report on the long term causes and latent factors' (Prospect, 2023) <https://library.prospect.org.uk/id/2023/April/24/HSE-under-pressure-perfect-storm> accessed 16 July 2024.
[290] A C L Davies and Lisa Rodgers, 'Towards a more effective health and safety regime for UK workplaces post Covid-19' (Industrial Law Journal, 2023).

reduction over the last 20 years.[291] Due to the lack of adequate pay, the experienced HSE inspectors are compelled to leave their roles resulting in an unexperienced and untrained cohort of HSE inspectors having to carry out inspections at a critical time, such as the Covid-19 pandemic. At a time when HSE inspections are crucial to maintain health and safety standards within workplaces, there is an alarming decline in the proactive inspections that are being carried out. In some high-hazard sectors, regular intervention plans should be agreed with inspectors. However, due to the shortage of regulatory and specialist inspectors it is difficult to oversee sites in accordance with health and safety regulations. With the degree of pressure that HSE inspectors were under during the pandemic, the demand to recruit and retain skilled staff is crucial. The inability to do so will result in employers overlooking their legal obligation and marginalising victims in the workplace.

The Robens Report sought to impose penalties on employers in the form of criminal sanctions to those who were breaching health and safety rules in a wilful, flagrant or reckless nature.[292] Although criminal sanctions were recommended in the Report, they did not appear in the 1974 Act. Nevertheless, employers were to be held criminally negligent if they were found to be failing to take reasonable care of their employees and others as a consequence of breaching health and safety legislation. At present, prosecution through the criminal courts for violating health and safety law is still possible in principle. Due to the HSE being under resourced, however, there is no prospect of the HSE enforcing the law through criminal prosecution. Instead, most proceedings appear before the civil courts. Some employees have successfully brought civil claims for damages.

3.2 Self-regulating system

As briefly mentioned above, the 1974 Act introduced a new system that encouraged employers to consult with their employees to ensure they understood how to carry out their duties whilst complying with health and safety laws.[293] This system of consulting employees not only involves giving them workplace information but more importantly it involves the employer actively listening to employees' issues and concerns and taking into account their ideas before formulating workplace health and safety policies. The main objective of introducing a system where employers were encouraged to consult employees is to improve

[291] 'HSE under pressure: A perfect storm Prospect Union's report on the long term causes and latent factors' (Prospect, 2023) <https://library.prospect.org.uk/id/2023/April/24/HSE-under-pressure-perfect-storm> accessed 16 July 2024.
[292] R.C Browne, "Safety and Health at work: The Robens Report" (British Journal of Industrial Medicine, 1973).
[293] 'Consulting employees on health and safety, A brief guide to the law' (Health and Safety Executive) <https://www.hse.gov.uk/pubns/indg232.pdf> accessed 20 April 2021.

the efficacy of health and safety policies and regulations.[294] The 1974 Act created a structure that enabled employers to co-operatively engage with employees to manage a more self-regulating system of work and move away from the more prescriptive and general goal-setting system.[295] The law also sets out two different regulations namely: the Safety Representative and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996 that require employers to discuss health and safety with their workforce. The former regulations will apply in the instances where the employer is able to recognise trade unions and the latter will apply where employees are not in a trade union.[296] Some of the instances where employers should consult their employees include when a new system of work, technology or equipment is being introduced, as alterations and substitutions may need to be made to the standards of health and safety at work. The most important of these is the organising and planning of health and safety training, as this would provide employees the opportunity to identify the risks at their workplace and practices to reduce and avoid risks.

3.3 Health and safety experts

The very first factory inspectors were appointed by King William IV, under the Factory Act 1833.[297] Initially four inspectors were appointed and under the Act they were given the power to make regulations, powers to enter premises and question workers and the enforcement powers of the Magistrates. These inspectors frequently worked independently, and their main responsibility was to report to the Home Secretary on their work within the region they oversaw. These individuals were the first to hold an inspectorate title and they had little experience or guidance to follow. This demanding job resulted in overworking the inspectors often leading them to death, as some factory inspectors were given the responsibility of working the whole of the Scotland and the North of England. Having seen that the system needed change, in 1844 the successors structured a system which had a committed and a more professional role in the discharge of their duties. This included educating the employers about their new responsibilities and prohibiting children from

[294] Sarah Fullick, Kelly Maguire, Katie Hughes and Katrina Leary, 'Employers; motivations and practices: A study of the use of occupational health services' (Department of Work and Pensions Research Report, 2019).
[295] Christopher Sirrs, 'Risk, Responsibility and Robens: The Transformation of the British System of Occupational Health and Safety Regulation, 1961-1974' (Governing Risks in Modern Britain: Danger, Safety and Accidents, c. 1800-2000, 2016).
[296] 'Consulting employees on health and safety, A brief guide to the law' (Health and Safety Executive) <https://www.hse.gov.uk/pubns/indg232.pdf> accessed 20 April 2021.
[297] David Eves, ''Two steps forward, one step back' A brief history of the origins, development and implementation of health and safety law in the United Kingdom, 1802-2014' (History of Occupational Health and Safety) <https://www.historyofosh.org.uk/ brief/index.html> accessed 18 April 2021.

engaging in dangerous trade. These minor changes helped promote higher standards of welfare for employees.[298]

According to the 1974 Act, inspectors were to be elected by the HSE. These inspectors were known as health and safety experts who checked if work premises complied with the law. The inspectors were allowed to conduct these checks by legal authority given to them under the 1974 Act.[299] Under Section 19(2) of the 1974 Act, the inspectors are required to have a warrant, which is a written instrument of appointment that mentioned the powers bestowed on an inspector.[300] An inspector is only allowed to exercise the powers granted under the warrant. Having acquired such a warrant, a health and safety inspector can visit workplaces for several reasons including routine inspection and/or following up on reported complaints and reported incidents. Through these visits, if an inspector believed that a health and safety law was breached during the course of the business or that it may seem likely to occur in the future, he has the choice of several enforcement options. Some common enforcement methods that inspectors apply are giving advice in the event where infringements are minor and prosecution in the event of serious accidents that occur as a result of the failure to comply with legislation.

3.4 Additional legislation and codes of practice

In addition to the HSWA and consequent regulations, other legislation has relevance to questions of health and safety at work. For example, the Equality Act 2010 protects individuals from discrimination at work on grounds ranging from age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.[301] Chapters five and six below will further explain how the legal framework of the Equality Act 2010 strives to protect workers from the time of application for jobs to their retirement and how it can be engaged by health and safety matters.

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[298] David Eves, ‘’Two steps forward, one step back’ A brief history of the origins, development and implementation of health and safety law in the United Kingdom, 1802-2014’ (History of Occupational Health and Safety) <https://www.historyofosh.org.uk/ brief/index.html> accessed 18 April 2021.
[299] ‘Guidance on the appointment of local Authority inspectors to enforce the Health and Safety at Work etc. Act 1974’ (Health and Safety Executive) <https://www.hse.gov.uk/lau/lacs/22-8.htm> accessed 18 April 2021.
[300] Health and Safety at Work etc. Act 1974, s19(2).
[301] ‘Discrimination at work Discrimination and the Equality Act 2010’ (ACAS) <https://www.acas.org.uk/discrimination-and-the-law> accessed 18 April 2021.

The introduction of the Approved Codes of Practice (ACoP) originated with the Robens Report and currently there are over 50 ACoP in force that cover a wide range of health and safety matters.[302] According to the Robens Report, ACoP should be put in place to achieve a system where the enactment of new statutory regulations should be considered a last resort and not used as a preliminary solution; rather, it should be considered whether a non-statutory code of practice or standard could be used to adequately achieve the objective in question. As mentioned above, before the introduction of the 1974 Act, one of the main issues that employers had was that there was too much law regulating workplace health and safety which often led towards apathy. However, in order to counteract such uncertainties and to manage the influx of new laws being enacted, the ACoP was introduced. The ACoP's main goal was to clarify ambiguities in the health and safety law as there were areas that needed substitutions to the general prescriptive legislation.[303] For instance, 'reasonably practicable' is one of the terms often used in the 1974 Act that created various ambiguities in the workplace. ACoP provides suitable advice, practical examples and suggests methods that can be used in order to understand such terms and how to comply with the duties cast on employers by the 1974 Act.[304] ACoP provided flexibility when regulations were necessary to be updated rather than amending legislation or creating new ones as it was easier to be done without lowering standards in order to match the introduction of new innovations and technological advancement.

4. The influence of European Union health and safety law in the UK

The European Union has always been a front runner in establishing the basic guidelines and rules to protect the health and safety of workers across all sectors. Since the establishment of the European Economic Community (1957) which derived from the Treaty of Rome, occupational health and safety has been considered a key objective of the EU. The Member States of the EU were required to abide by the various Directives that the EU created in order to prevent and compensate the number of work-related injuries and deaths across all Member States. In the year 1973 UK became a member of the EU and was entrusted to implement EU Directives into its national legislation.

[302] Ragnar Lèfstedt, 'Reclaiming health and safety for all: An independent review of health and safety legislation' (Great Britain Department for Work and Pensions, 2011).
[303] 'Legal status of HSE guidance and ACOPs' (Health and Safety Executive) <https://www.hse.gov.uk/legislation/legal-status.htm> accessed 17 April 2021.
[304] 'Workplace Health, safety and welfare, Workplace (Health, Safety and Welfare) Regulations 1992' (Health and Safety Executive, 2013) <https://www.hse.gov.uk/pUbns/priced/l24.pdf> accessed 19 April 2021.

Prior to the UK implementing the EU Directives the country had a set of several key health and safety rules. The main piece of legislation being the Health and Safety at Work Act 1974 alongside other statutory regulations. The 1974 Act mainly focused on alleviating different types of risks. However, EU law Directives assisted the UK in managing risks that arise in various sectors of work premises rather than merely focusing on types of risks. As a result, the substantive content of the UK legislation began to be heavily shaped by EU Directives and legislation.

4.1 European Union and Health and Safety Regulations

The EU has played a crucial role in promoting labour rights and encouraging the improvement of health and safety of workers since the mid 1970s.[305] However, it was the enactment of the Single European Act 1986, the backbone of health and safety directives, which significantly aided the EUs initiative. Amongst many, the most significant initiative behind the Single European Act was to enable the free movement of persons, services and capital and to abolish any obstacles to harmoniously achieve economic activities within the Member States.[306] The Single European Act facilitated workers' free movement within a single market. In order to achieve a unified Single Market, the Member States of the EU were to cooperate without prejudice to the powers of the Community.[307]

As the first step towards promoting the safety and health of workers Article 118A specifically obliged and encouraged Member States to improve the working conditions of the workers for the betterment of their health and safety.[308] Under Article 118A the first ever health and safety framework directive (Directive 89/391) was introduced.[309] Directive 89/391/EEC is the most significant directive introduced by the Council of the European Community in the field of occupational health and safety.[310]

[305] 'EU membership and Health and Safety- The benefits for UK workers' (Trades Union Congress) <https://www.tuc.org.uk/sites/default/files/EU_Health_Safety_Report_0.pdf> accessed 25 April 2021.
[306] Aaron Schidhaus, '1992 and the Single European Act' (1989).
[307] SL Greer, TK Hervey, JP Mackenbach and M McKee, 'Health law and policy in the European Union' (The Lancet, 2013).
[308] Glaesner Hans-Joachim, 'The Single European Act: Attempt at an Appraisal' (Fordham Int'l LJ, 1986).
[309] JE Kineke, 'The EEC Framework Directive for Health and Safety at Work' (1991).
[310] Judith Hackitt, 'A guide to health and safety regulation in Great Britain' (Health and Safety Executive) <https://www.hse.gov.uk/pubns/hse49.pdf> accessed 12 May 2021.

4.2 Health and Safety Framework Directive (89/391/EEC)

The Directive adopted in 1989 provided Member States with a framework that required them to improve workers' health and safety at work, whilst the legislative implementation was left in the hands of the Member States' national governments. The Directive was to be implemented through measures such as conducting risks assessments, eliminating risks and accident factors, prevention of risks, training workers and highlighting the importance of safety and health.[311]

The objective of the Directive was to encourage and enhance basic health and safety principles in preventing and protecting the workers against diseases and occupational accidents at work.[312] The implementation of the Directive required a number of changes in national legislation and effort from Member States as they were obliged to enforce new laws in line with the Directive in order to comply with the EU guidelines and provisions. The Member States were given a deadline as to when the Directive was to be enforced into the countries' national legislation and to comply with the Directive by the 31 December 1992. Due to the complex nature of the adaptation process, very few countries managed to bring the new laws and regulations into practice. However, the UK was able to enforce the new Directive into the national legislation in the year 1992 before the deadline set by the EU.[313]

4.3 UK and its approach to occupational health and safety at work

The United Kingdom joined the European Union after much deliberation in the year 1973 which commenced the implementation of various new Directives and frameworks into the UK legislation.[314] Different laws and regulations began to revolve around the topic on how best to manage and secure this vital part of life to protect workers from injury, sickness and disease. The first Directive on the issue of occupational health and safety that the UK implemented into its national legislation was the 89/391/EEC Directive.[315] One of the most prominent features of EU law is that it adopts a goal-oriented approach, where clear and

[311] 'Directive 89/391/EEC- OSH 'Framework Directive' (European Agency for Safety and Health at Work, 2021) <https://osha.europa.eu/en/legislation/directives/the-osh-framework-directive/1> accessed 11 May 2021.
[312] Ma Dolores Martínez Aires, Ma Carmen Rubio Gámez, and Alistair Gibb, 'Prevention through design: The effect of European Directives on construction workplace accidents' (Safety Science, 2010).
[313] Ma Dolores Martínez Aires, Ma Carmen Rubio Gámez, and Alistair Gibb, 'Prevention through design: The effect of European Directives on construction workplace accidents' (Safety Science, 2010).
[314] 'The EEC and the Single European Act' (UK Parliament, 2013) < https://www.parliament.uk/about/living-heritage/evolutionofparliament/legislativescrutiny/parliament-and-europe/overview/britain-and-eec-to-single-european-act/> accessed 17 May 2021.
[315] Judith Hackitt, 'A guide to health and safety regulation in Great Britain' (Health and Safety Executive) <https://www.hse.gov.uk/pubns/hse49.pdf> accessed 12 May 2021.

precise general obligations are set out in their legal texts but however, the autonomy to devise the rules and regulations are left to individual parties.[316]

Whilst the general guidelines on occupational health and safety were introduced by the 89/391/EEC Directive, the more detailed individual Directives that provided attention in specific areas were adopted under the authority of the Framework Directive and were known as the "Daughter Directives".[317]

There were six key Directives known as the "six pack" which were significant under the topic of occupational health and safety.[318] Some of the main directives are the use of Personal Protective Equipment Directive (89/656/EEC), the Workplace Directive (89/654/EEC), the Display Screen Equipment Directive (90/270/EEC), the Manual Handling of Loads Directive (90/269/EEC) and the Work Equipment Directive (89/655/EEC).

As the directives were more prescriptive and detailed than the 1974 Act, the UK legislation needed to be extended. The Daughter Directives were implemented by the UK under Section 15 of the 1974 Act which enables the Secretary of State to introduce secondary legislation in specific areas and six new regulations known as the six pack together with the Approved Codes of Practice and Guidance Notes was enacted. They are the Management of Health and Safety at Work Regulations 1999, Health and Safety (Display Screen Equipment Regulations 1992, Manual Handling Operations Regulations 1992, Personal Protective Equipment at Work Regulations 1992, Provision and Use of Work Equipment Regulations 1998 and Workplace (Health, Safety and Welfare) Regulations 1992. These regulations together strived to achieve necessary minimum health and safety requirements for workplaces.[319] In the following section I will elaborate how the EU Directives were influential in assisting the UK shape its existing health and safety legislation.

[316] Kai Liu, and Wen Liu, 'The development of EU law in the field of occupational health and safety: a new way of thinking' (Management and Labour Studies, 2015).
[317] MA Hanson, KM Tesh, SK Groat, PT Donnan, PJ Ritchie, RJ Lancaster, 'Evolution of the Six Pack Regulation 1992' (HSE, 1998) <https://www.hse.gov.uk/research/crr_pdf/1998/crr98177.pdf> accessed 15 May 2021.
[318] Matthais Beck and Charles Woolfson, 'The regulation of health and safety in Britain: from old Labour to new Labour' (Industrial Relations Journal 31, No1, 2000).
[319] 'Section 1 The Health and Safety Law- School Management' <https://schools.bracknell-forest.gov.uk/wp-content/uploads/section-1-health-and-safety-law.pdf> accessed 14 May 2021.

4.4 EU law influence in the UK

The new regulations helped UK law focus more on managing risks that exist in different types of work premises rather than focusing on particular types of risks. The main legislative response from the UK to the Framework Directive 89/391/EEC, 1989 was the Management of Health and Safety at Work Regulations 1999 (MHAW). Under the MHAW tackling risks to health and safety at the workplace is given a lot of emphasis. For instance, regulation 3(1) states that it is a duty of the employer to undertake a risk assessment.[320] This risk assessment should ensure that the employees are not exposed to risks whilst they are at work. If due to the negligence of the employer, the employee sustains injury because of the employer failing to fulfil this duty the employer will be breaching his duty and the employee will be able to take an action for compensation. This implementation is an indication that British legislation has been shaped and guided by EU Directives and requirements.[321]

It is further evident under Schedule 1 of the MHSW Regulation that the employers are required to abide by "general principles of prevention" which are considered as the basis for employer protective measures. Schedule 1 is an influence of Article 6(2) of the Framework Directive 89/391/EEC, 1989 which was initially introduced to alleviate monotonous work in the workplace. Although general principles of prevention are seen under the health and safety legislation, the MHSW requires employers to ensure that preventive measures are to be included in all aspects of work. For example, in construction work, preventive measure should be required under all stages of design, planning and preparation of a project. It is evident from the above that EU Directives has been the driving force of the UK health and safety legislation. Although at the time when the UK joined the EU the country had a specific set of rules and regulations that dealt with key principles such as the prevention of risks, the protection of safety and health, the assessment of risks, the elimination of risks and accident factors, consultation and training of workers these substantive regulations began to take the shape of EU Directives as the UK had to adopt different Directives into their national legislation.

[320] Management of Health and Safety at Work Regulations 1999, Reg 3(1).
[321] Mark Bell, 'Occupational health and safety in the UK: at a crossroads?' (2013).

5. Health and safety policy within the NHS

It will be recalled that the 1974 Act places a legal duty on all employers to take practical steps to ensure that staff work within a healthy and safe workplace environment.[322] The National Health Service has underpinned his legal duty with an undertaking that all employees should enjoy the privileges of the "NHS Health and Safety Policy". According to that policy, all employees of the NHS should not only take reasonable care of their own health and safety but of the people who may be affected by their work.[323] This is both difficult and problematic to achieve in an environment where healthcare employees work. This is due to the fact that HCWs are involved in workplaces that are prone to cause high levels of stress and at times they risk their own lives in order to treat patients and to ensure that patients are well looked after. From the outset, it can be seen that there are shortcomings within the legislation when certain laws are set in line with a 'one size fits all' approach. The prevailing reason that the general health and safety legislation has not been adequate for the protection of HCWs is due to the unique nature of work that they have to carry out. For instance, healthcare professionals are expected to take care of patients and to abide by the code "duty of care" despite the circumstances that they have to face. The duty of care is an issue that especially concerns HCWs when they are expected to provide care even during global pandemics as medical professionals. According to the Royal College of Nursing, HCWs "cannot refuse to be involved in the care of patients because of their condition or the nature of their health problems".[324] When considering this duty of care that the HCWs hold, it is necessary to consider if in the normal course of their work a healthcare professional would be able to permissibly deny treatment to a patient if they are met with a health and safety risk to themselves or other members.

Nonetheless the NHS has taken several steps in order to administer this policy in a manner that ensures all NHS employees are well equipped to understand and apply their legal duties in practice. One of the methods that they utilise is the use of the staff intranet to make available the health and safety laws and regulations that are applicable to the NHS and the procedures, guidance and protocol on how to meet those requirements.[325] This method is one of the most helpful ways which enables the NHS staff to understand and comprehend the

[322] Steve Tombs and David Whyte, 'Transcending the deregulation debate? Regulation, risk and the enforcement of health and safety law in the UK' (Regulations & Governance, 2013).
[323] Health and Safety Manager, NHS England, 'Health and Safety Policy: Policy & Corporate Procedures, 2015' <https://www.england.nhs.uk/wp-content/uploads/2017/04/pol-1002-health-safety-policy.pdf> accessed 16 February 2021.
[324] 'Refusal to treat' (Royal Collage of Nursing, 2020) <https://www.rcn.org.uk/get-help/rcn-advice/refusal-to-treat> accessed 04 September 2020.
[325] Ibid.

legal duties that they need to fulfil. This method not only summarises the provisions that the healthcare staff need to adhere to but also explains them in layman's terms. Another method the NHS staff utilise is to ensure that sufficient risk assessments are carried out by management.[326] Risk assessment ensures that the worker is satisfied that a careful examination of what they are doing has been carried out to keep themselves and others safe in whatever activity that they are engaged in. As risks are an everyday part of life, this enables the employees to first identify the risks and then eliminate them wherever possible. One of the most effective ways in which the NHS policy is imparted to employees is through health and safety training. The key resource used to deliver this training is through the NHS Learning Management System (LMS). This online learning system enables employees to engage in courses and assess their understanding of the health and safety awareness. Alongside this method, through the use of advertising materials, seminars, questionnaires and communications, the NHS policy strives to promote health, safety and welfare of all employees. Furthermore, in order to ensure that the policy is being practised and implemented by employees, progress is monitored by managers.

Conclusion

The Robens Committee of Inquiry on Safety and Health at Work provided recommendations on how best to protect workers which lead to the enactment of the 1974 Act. The recommendations provided by this Act enabled the UK to be a front runner in the field of occupational health and safety. The Robens committee provided guidance in understanding ambiguities in the legislation and on how to interpret statutory regulations. It introduced inspectors who were responsible for making sure that both employers and employees were aware of their responsibilities and cautious of the environment in which they carry out their work. In essence, it introduced a more self-regulating system between employers and employees, moving away from the alienated and fragmented system to one which was more adaptable and comprehensive. While the HSWA has many strengths, the regulation of health and safety has suffered a great deal due to the significant budget cuts within the HSE.

Over time, the employers became accustomed to their legal responsibilities and duties towards their employees and the consequences they had to face in the form of penalties and criminal chargers if these duties were breached. The 1974 Act strived to include the rights

[326] 'Health and Safety Core Skills Booklet' (James Paget Univeristy Hospital NHS Foundation Trust) <https://www.jpaget.nhs.uk/media/329158/Health-and-Safety-Booklet-v2-Workbook.pdf> accessed 17 February 2021.

and duties not only of the employer and employee but of all individuals involved in employment and the general public. Having mentioned the various duties assigned to the employers, the 1974 Act attempts to achieve a sense of impartiality by providing a defence to the employers. The employers are entrusted to comply with the above-mentioned duties as far as it is reasonably practicable to do so. The test used to determine whether an employer has complied with their duties as far as it is "reasonably practicable" is to show that the employer outweighed the sacrifices that they made either in the form of time or money against the degree of risk they undertook and that necessary precautions were taken to uphold the health and safety of employees within the workplace. If an employer is able to show that they took necessary precautions, then the measure will be considered reasonably practicable.

Despite the nature of risks being unique from one occupation to the other, the UK provides an all-encompassing health and safety regulation through the HSWA. This blanket provision on health and safety legislation creates difficulty for numerous occupational sectors including the healthcare sector. It is no surprise that enforcement of the health and safety legislation aided the UK in reducing workplace accidents and safeguarding workers' physical health and safety at work. However, with the passage of time, workers were not only engaged in more physically demanding jobs, but they were also employed in psychologically challenging work sectors. As a result, the legislation has overlooked occupations such as healthcare, education & hospitality industry that require a more tailored, sector specific health and safety provisions. Due to this lack of sector specific health and safety regulations, occupational sectors such as healthcare have implemented supplementary regulations that are more suitable and practical for NHS workers. The Health and Safety Policy of the NHS assesses the health and safety of workers at work to be of paramount importance and emphasises that compliance with the Health and Safety at Work etc. Act 1974 is not a matter of choice but a legal requirement. Although this might be considered as an innovative solution, it however, creates deep rooted problems across the NHS workforce. This is due to the fact that these supplementary regulations are drafted by various NHS trusts and as a result they will be distinctive from one trust to the other. Although the Health and Safety at Work etc. Act 1974 is a revolutionary piece of legislation that contributed to a number of positive changes in the British labour law, it still falls short as a legal instrument that provides clarification and certainty in the complex area of workers' health and safety, especially to workers engaged in the healthcare sector. The legislation having put a blanket provision on how employers should protect workers' health and safety, makes it difficult for workplaces such as hospitals and care homes to follow and adapt to the legal requirements. As was especially evident during the global Covid-19 pandemic, the 1974 Act alone is

unable to address occupational health and safety adequately within workplaces in the healthcare sector. For that, an amalgamation of different legislation would be needed such as the Equality Act 2010 which assists workers from being discriminated at work. In the next chapter I consider the important role played by trade unions during the Covid-19 pandemic and the collective bargaining power used by the unions to protect the rights of workers. This is a crucial component in developing answers to my research question. It highlights the proactive and influential role played by trade unions in protecting the health and safety of workers rather than relying solely on legislation.

Chapter 4 Trade Union Membership and Collective Bargaining in the NHS

Introduction

Trade unions play a crucial role in enhancing working conditions by advocating for equal opportunities, adequate pay, safe workplaces, protection from discrimination, paid leave, better employment terms and access to legal advice. Trade unions negotiate on these matters on behalf of members and strive to secure improved working environments for workers. Throughout the years, trade unions have played an important role in handling serious issues that workers face whilst at work. If not for the collective bargaining power of trade unions, individual workers would not be able to achieve the same level of influence at work. This chapter highlights the importance of trade unions and their bargaining power with regards to HCWs within the NHS and examines as to whether trade union membership contributed to the improvement of health and safety of HCWs during the pandemic. While this chapter focuses on the role of trade unions, the operations of union activity can significantly vary across different sectors. It is important to highlight that the primary focus is on the trade union structure and activities only within the NHS and its regulatory environment and unique structure. Consequently, the findings of this study on NHS trade unions will be limited to its generalisability beyond this sector when compared with other industries.

The first section of the chapter provides a brief introduction to trade unions in the UK and the functions that they perform, elaborating on the immediate benefits that employees might obtain being a member of a trade union in the form of greater job security and access to legal advice. Across the wider sector, trade unions also prioritise activities such as providing assistance to improve quality of public services, political campaigning, industrial action and collective bargaining. Section one will explore the function of collective bargaining and the reasons as to why collective bargaining is an important feature for NHS HCWs. I will also discuss how trade unions conduct negotiations with the NHS and the procedure which they need follow. Lastly, section one focuses on the importance of collective bargaining during the Covid-19 pandemic. Specifically, how the NHS trusts used partnership agreements in order to achieve its cooperate objectives during the Covid-19 pandemic. Throughout the chapter I will make reference to how trade unions have assisted HCWs during the Covid-19 pandemic to better manage their health and safety and negotiate policies to mitigate occupational health hazards during the unprecedented times.

The second section focuses mainly on two major trade unions, namely the Royal College of Nursing and the British Medical Association and how they utilised collective bargaining during the Covid-19 pandemic, to mitigate the added pressures faced by HCWs during the pandemic. These unions represent the NHS nurses and NHS doctors respectively and are among the largest in the UK in terms of membership. It is important to note that trade unions such as the RCN urged and pressured the government to recognise the importance of providing adequate PPE to HCWs. RCN later campaigned on the overuse of PPE as it was starting to cause distress amongst HCWs. This shows that trade unions, as democratic organisations, tend to be responsive to members' interests and can utilise the power of collective bargaining to further those interests, whatever they are. Lastly, section two will briefly discuss how trade unions have adapted to collective bargaining in the aftermath of the Covid-19 pandemic. Finally, the chapter will conclude by stating that trade union membership did lead towards the improvement of health and safety, encouraging stability in employment relations by regulating the health and safety of HCWs through collective bargaining.

1. Trade unions

In the UK as elsewhere, employer-employee relations have changed over time in response to broader socio-economic changes, from the decline of workers in dangerous trades that used heavy machinery to the mass entry of female workers into the labour market and to more individuals attaining higher levels of education, improving skills and knowledge within the workforce.[327] In more recent years there had been a shift from more traditional employment, the so-called 'standard employment model' to more flexible and often precarious forms or work. Labour market trends seemed to accelerate in the aftermath of the pandemic with ever-increasing numbers of workers being hired for short-term commitments in the 'gig' economy and more employers willing to create remote working opportunities by enabling workers to work from home.[328] These changes in the labour market required trade unions to diversify and alter their bargaining strategies.[329]

Trade unions, also referred to as labour unions, are groups of employees who work together to protect their professional rights and interests in order to maintain and improve their

[327] Paul Nowak, 'The past and future of trade unionism' (Employee Relations, 2015).
[328] 'Post-pandemic economic growth: UK labour markets' (House of Commons Business, Energy and Industrial Strategy Committee, 2023) <https://publications.parliament.uk/pa/cm5803/cmselect/cmbeis/306/report.html> accessed 01 April 2023.
[329] Hazel Conley, 'Trade unions, equal pay and the law in the UK' (Economic and Industrial Democracy, 2014).

conditions of employment.[330] Employees join trade unions in the knowledge that the trade unions will act on their behalf, by, for example, raising members' concern with employers, negotiating agreements with employers on pay, accompanying members to grievance and disciplinary meetings and discussing large scale redundancy issues.[331] Since the employer is in a considerably dominant position when compared with an individual worker and the relationship between an employer and employee is fundamentally unequal, collective bargaining plays an important role in this instance by reducing if not completely removing this imbalance of power. Furthermore, trade unions may provide members with health and safety training, additional to whatever the employer has provided.[332] This adds a supplementary layer of protection when it comes to preventing workplace accidents and supporting those with mental and physical health problems.

NHS workers are represented by several trade unions including UNISON and Unite the Union and by several organisations that are both professional bodies and trade unions: these include the RCN, British Medical Association (BMA) and Hospital Physicists' Association. Members of these bodies range from doctors, nurses, student nurses, midwives, health visitors, healthcare assistance, paramedics, catering staff, medical secretaries, clerical, admin, scientific and technical staff and hospital cleaners.[333] The above trade unions represent a significant number of HCWs. The RCN represents close to half a million HCWs which includes nurses, student nurses, midwives and nursing support workers.[334] UNISON has over 400,000 members who work in the NHS.[335] The BMA also has 173,000 members ranging from doctors, junior doctors to doctors in training.[336] Unite the Union represents over 100,000 NHS workers.[337] The individual data for these trade unions is supported by the 2021 National Statistics. The trade union density in terms of the number of members within the 'human health and social work' was 39.2% which was the second largest percentage of employees that belonged to a trade union.[338] This significantly high number of HCWs who

[330] Trade Union and Labour Relations (Consolidation) Act 1992, section 1(1).
[331] 'Joining a trade union' (GOV.UK) <https://www.gov.uk/join-trade-union/trade-union-membership-your-employment-rights> accessed 27 September 2022.
[332] 'Why join a trade union' (Trade Union Congress) <https://www.tuc.org.uk/why-join-union> accessed 17 March 2023.
[333] 'Representing you' (UNISON, 2023) <https://www.unison.org.uk/at-work/health-care/representing-you/> accessed 02 February 2023.
[334] 'What the RCN does' (Royal College of Nursing) <https://www.rcn.org.uk/About-us/What-the-RCN-does> accessed 02 April 2023.
[335] 'In your work place' (UNISON) <https://london.unison.org.uk/about/in-your-work-place/> accessed 02 April 2023.
[336] Tim Tonkin, 'BMA Membership surpasses 173,000' (British Medical Association) <https://www.bma.org.uk/news-and-opinion/bma-membership-surpasses-173-000> accessed 01 April 2023.
[337] 'Unite announces consultations on government's offer to NHS workers in England' (Unite the Union, 2023) <https://www.unitetheunion.org/news-events/news/2023/march/unite-announces-consultation-on-government-s-offer-to-nhs-workers-in-england/> accessed 01 April 2023.
[338] 'Trade Union Membership, UK 1995-2021: Statistical Bulletin' (National Statistics, 2022) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1077904/Trade_Union_Membership_UK_1995-2021_statistical_bulletin.pdf >accessed 02 April 2023.

remain as trade union members despite the nation-wide decline suggests that they value this membership.[339]

1.1 Trade unions and collective bargaining

The concept of collective agreements and negotiations existed since the establishment of trade unions in Britain and collective bargaining became quite common already in the nineteenth century.[340] Collective bargaining is the process by which voluntary negotiations are made between employers and trade unions concerning employees' working conditions, pay, reducing workload and other issues that affect workers during the course of their employment.[341] Discussions are held between both parties in order to reach a consensus by reciprocal trade-offs. The ideal result of these negotiations is collectively to reach an agreement that regulates the terms and conditions of the workers in question.

In the UK, the general rule is that employers are free to choose whether or not to recognise a trade union, regardless of the 'representativeness' of the union in question. If a trade union requests recognition and the employer refuses, the union can threaten or organise industrial action. According to UNISON, there are three key features that all formal recognition agreements should comply with to satisfy the parties involved in the agreement. Firstly, it should be a comprehensive agreement that will contribute to the improvement of the relationship between unions and management. Secondly, encourage the participation of employees in decision making and, finally, strive to achieve effectiveness when dealing with problems and organisational changes.[342] Since 2000, employers may exceptionally come under a legal obligation to recognise a trade union for collective bargaining which includes pay, working time and holiday.[343] The Employment Relations Act 1999 (ERA 1999) introduced a new statutory recognition procedure, which came into effect in June 2000. Broadly speaking, an obligation to recognise a trade union will arise when a union that can demonstrate majority support for recognition among a group of workers ('the bargaining

[339] 'Trade Union Membership, UK 1995-2021: Statistical Bulletin' (National Statistics, 2022) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1077904/Trade_Union_Membership_UK_1995-2021_statistical_bulletin.pdf >accessed 02 April 2023.
[340] Virginia Doellgast and Chiara Benassi, 'Collective bargaining' (In Handbook of research on employee voice, 2020).
[341] Trade Union and Labour Relations (Consolidation) Act 1992, section 178.
[342] 'Recognition Agreements: A negotiator's guide to recognition agreements' (UNISON, 2019) <https://www.unison.org.uk/content/uploads/2019/03/Recognition-Agreements-Guide-03-2019.pdf> accessed 20 October 2022.
[343] Employment Relations Act 1999 (ERA 1999), Schedule 1, 'Employers: recognise a trade union' (GOV.UK) <https://www.gov.uk/trade-union-recognition-employers> accessed 09 October 2022.

unit'), makes a formal application for recognition to the Central Arbitration Committee (CAC).[344]

Collective bargaining takes many forms, including single-employer bargaining and multi-employer bargaining. Single-employer bargaining is where an individual employer negotiates agreements at the company or workplace level with a trade union or unions.[345] Multi-employer bargaining enables one or more unions to conduct negotiations with two or more employers.[346] Successful collective bargaining negotiations have the potential to resolve important social and economic issues and to deal with crisis situations in an effective way. As a result, the collective bargaining coverage that a country has, indicates the extent to which employment is influenced by collective negotiation. In the year 2019, the UK had a collective bargaining coverage rate of 26.9%.[347] When compared with the country that has the highest rate, Italy, with a percentage of 99.0%, the UK appears as a country where only relatively few workers are covered by a collective agreement.

The Covid-19 pandemic showed how certain sectors of workers were crucial to the functioning of the society while also exposing the weak health and safety protection in place to protect these workers. This put to the test the trade unions' ability to negotiate effectively on behalf of its members. Unions acted as intermediators in protecting workers' rights during an unprecedented time. It is no surprise that there was a plethora of pre-existing issues that trade unions were negotiating with employers prior to the pandemic, yet the pandemic starkly illustrated how complicated employer-employee relations can be and, therefore, the potential benefits of robust collective bargaining arrangements.[348] During the pandemic, collective agreements were sometimes more important for workers than statutory rights and regulations, not least because the statutory rights of workers were not always respected by employers. Moreover, health and safety legislation were ineffective in preventing the increasing numbers of workers contracting coronavirus.[349] In such instances of regulatory failure, trade unions rose to the occasion to regulate these issues with employers by means of effective collective bargaining.

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[344] Lourie Julia, 'Trade Unions Recognition' (House of Commons Library, 2000) <https://researchbriefings.files.parliament.uk/documents/RP00-55/RP00-55.pdf> accessed 09 October 2022.
[345] Edmund Heery and Mike Noon, 'A dictionary of human resource management' (Oxford, 2008).
[346] Lewis Emery, 'Multi-employer bargaining in the UK: does it have a future' (Wage bargaining under the new European Economic Governance, Brussels, 2015).
[347] 'Statistics on Collective Bargaining' (International Labour Organization, 2022) <https://ilostat.ilo.org/topics/collective-bargaining/> accessed 21 May 2022.
[348] John Hendy and Keith Ewing, 'The Covid Crisis Makes the Case for Collective Bargaining' <https://tribunemag.co.uk/2020/11/the-covid-crisis-makes-the-case-for-collective-bargaining> accessed 20 October 2022.
[349] John Hendy and Keith Ewing, 'The Covid Crisis Makes the Case for Collective Bargaining' <https://tribunemag.co.uk/2020/11/the-covid-crisis-makes-the-case-for-collective-bargaining> accessed 20 October 2022.

1.2 Trade unions, collective bargaining and the NHS

Prior to describing how trade unions operated during the Covid-19 pandemic it is important to understand the relationship between the NHS and trade unions. NHS trusts recognise the right of trade unions to negotiate with the employers on issues that impact their members.[350] According to the *NHS Terms and Conditions of Service Handbook* Annex 1, NHS employers include NHS Trusts, Foundation Trusts, Special health authorities, NHS England, Clinical commissioning groups, The Health and Social Care information Centre, National Institute for Health and Care Excellence and Health Education England.[351] For the purposes of this chapter, the 'employer' will be understood to be an NHS trusts and NHS Foundation trusts.

Across the NHS, the recognition process has been standardised in the form of a formal agreement made between the NHS trusts and relevant trade unions.[352] This is known as the 'Recognition and Local Collective Bargaining Arrangements', which sets out the objectives by which the employer seeks to improve the effectiveness and relationship between the employer and trade unions in order to achieve the best interests of its patients and staff through joint consultation and negotiations. Trade unions retain the right to negotiate singularly on issues where union members' views are in opposition to the collective staff side position.[353] Under UK law, all workers have the right to join a trade union, remain as a member of the union, belong to a union of their choice and to choose and be a member of one or more trade unions.[354] It is therefore important for NHS employees to understand that the NHS organisations only recognise certain trade unions. These trade unions are recognised upon the joint agreement between the Chair of the Management Side and the Chairperson of the Trust Joint Staff Side.[355] A staff side representative is an employee

[350] 'Recognition and Local Collective Bargaining Arrangements: A formal Agreement made between the University Hospital of North Midlands (NHS) Trust and the Trade Unions representing the Workforce' (NHS University Hospital of North Midlands, 2023) <https://www.uhnm.nhs.uk/media/ehvp32sk/20230801-hr06-recognition-and-local-collective-bargaining-foi-ref-262-23.pdf> accessed 09 October 2023.
[351] 'NHS Terms and Conditions of Service handbook' (NHS Employers, 2024) <https://www.nhsemployers.org/publications/tchandbook> accessed 17 April 2024.
[352] 'Trade union facilities recognition agreement' (University Hospital Bristol NHS Foundation Trust, 2014) <https://www.uhbristol.nhs.uk/media/3194393/18_-_407_-_foi_response-attachment_redacted.pdf> accessed 27 September 2022.
[353] 'Policy for the Recognition and Local collective Bargaining Arrangements' (University Hospitals of North Midlands NHS Trust, 2017) <https://www.uhnm.nhs.uk/media/2052/20180709-hr06-recognition-and-local-collective-bargaining-final-foi-ref-191-1819-2-of-2.pdf> accessed 27 August 2022.
[354] 'Joining a trade union' (GOV.UK) <https://www.gov.uk/join-trade-union/trade-union-membership-your-employment-rights> accessed 27 September 2022.
[355] 'Recognition and Local Collective Bargaining Arrangements: A formal Agreement made between the University Hospital of North Midlands (NHS) Trust and the Trade Unions representing the Workforce' (NHS University Hospital of North Midlands, 2023) <https://www.uhnm.nhs.uk/media/ehvp32sk/20230801-hr06-recognition-and-local-collective-bargaining-foi-ref-262-23.pdf> accessed 09 October 2023.

accredited by the trust and elected to represent their members.[356] Under the above-mentioned Recognition and Local Collective Bargaining Arrangements, a list of matters relevant to collective bargaining are mentioned as defined under the Trade Union and Labour Relations (Consolidation) Act 1922 (TULRCA). Although these recognition agreements are trust-specific, the scope of collective bargaining in each one is virtually the same. Under s.178(2) TULRCA, collective bargaining can cover the physical conditions of work, suspension, termination, engagement, non-engagement of employment or the duties related to employment, allocation of work, matters related to discipline, employees' membership with trade unions or non-membership and facilities for trade union officials.[357] In the NHS, some matters are negotiated at the level of the individual trust while others, such as pay, equal opportunities, terms and conditions of service and employee relations, are negotiated at an NHS-wide level.

1.3 Trade unions, collective bargaining, the NHS and partnership agreements

In line with the above-mentioned collective bargaining arrangements, policy development can also be achieved through so-called 'partnership agreements'. The use of partnership working agreements was important and prominent during the Covid-19 pandemic. Partnership agreements aim to build joint approaches on working together and solving problems between trusts and trade unions and professional organisations. The agreement sets out the framework on how the partners intend to work together by understanding the respective responsibilities and to delegate work to different partners in order to harness the best outcome. Trade unions play a vital role as they represent the NHS staff and give expression to their priorities for change at both national and local level. This reassurance they provide to NHS staff is essential as it indicates their voices are heard in processing policies and conducting negotiations. NHS trusts/foundation trusts often formulate its own working in partnership agreements and framework and as a result the agreements are trust specific.

The recent Covid-19 pandemic has put partnership agreements to the test. One of the partnership agreements that achieved stability during this period whilst HCWs were under immense pressure from the Covid-19 pandemic was the South West Yorkshire Partnership

[356] 'Staff Side' (South West Yorkshire Partnership NHS Foundation Trust, 2018) <https://www.southwestyorkshire.nhs.uk/work-for-us/staff-side/> accessed 27 September 2022.
[357] Trade Union and Labour Relations (Consolidation) Act (TULR(C) Act) 1992. S. 178(2).

NHS Foundation Trust (SWYP NHS Foundation Trust).[358] The trust states that the partnership agreement strived to improve the working relationship between management and unions by prioritising employee engagement in decision making and adequately responding to challenging situations.[359] The SWYP NHS Foundation Trust claimed that it sought to provide the best patient care despite facing the unprecedented nature of the Covid-19 pandemic whilst also protecting the health and wellbeing of the HCWs. It made several key changes with the aim of achieving this difficult balance.

Due to social distancing rules and regulations in England, the trust ensured that, for everyone's safety, meetings were moved to virtual platforms which in turn massively increased participation and effectiveness. Urgent policies and processes were agreed within days as opposed to months, which were crucial during this period. As a result, these partnership agreements enabled decisions to be made quickly when necessary. The trust appointed a full-time staff side Covid-19 lead.[360] Staff side members were appointed to represent the interests of the HCWs, particularly to recover and rebuild from the pandemic.

SWYP NHS Foundation Trust also ensured that staff side members and Human Resources held weekly meetings. This was to make sure the trust was aware of any potential issues as they surfaced. One of the main benefits achieved by doing so was that in the 2020 NHS staff survey 69% of staff that participated recommended the trust as a progressive workplace. Yet 31% of staff did not think that it was a progressive workplace. However, the affirmative percentage was a significant increase compared to 61.5% in the preceding year and a score above the national average.[361] This result indicated improved working conditions, with the commitment to true partnership enabling better decision-making and policy development. Moreover, a partnership approach allows for a more engaged workforce. For instance, once the Covid-19 vaccination was available to staff, staff engagement within the trust was strong as they felt safe attending to work and carrying out their work effectively.[362] The general principles of this recognition agreement can be applied across other trusts as there are no concrete rules or regulations that they have to adhere to.

[358] 'Partnership working at its best: South West Yorkshire Partnership NHS Foundation Trust' (Social Partnership Forum, 2021) <https://www.socialpartnershipforum.org/case-studies/partnership-working-its-best> accessed 27 September 2022.
[359] 'Partnership working at its best: South West Yorkshire Partnership NHS Foundation Trust' (Social Partnership Forum, 2021) <https://www.socialpartnershipforum.org/case-studies/partnership-working-its-best> accessed 27 September 2022.
[360] Ibid.
[361] Ibid.
[362] Ibid.

1.4 Summary

Trade unions have played a crucial role in providing improved job security and better terms and conditions of employment to members. The negotiations they conduct by way of collective bargaining either single-employer bargaining or multi-employer bargaining and partnership agreements enable workers to bring to light issues within the workplace that could improve the working conditions. These collective agreements can also serve to strengthen weak legislation. The NHS has a formal Recognition and Local Collective Bargaining Arrangement which lays out the consultative framework design. Although all NHS trusts have this document it is trust specific and each trust can tailor the framework accordingly.

2. NHS trade unions during the Covid-19 pandemic

Throughout the pandemic, protecting frontline workers was one of the main priorities of many of the NHS unions. Many workers were in occupations where they were directly exposed to the virus. Trade unions utilised collective bargaining as a regulatory tool in order to mitigate these issues. For instance, during the early stages of the pandemic, a good working partnership between trade unions and employers was crucial in order to ensure that re-negotiations and policy making were successfully conducted during challenging times.[363] With the assistance of the NHS staff council, NHS trade unions agreed to jointly revise the NHS Terms and Conditions of Service (TCS), specifically section 33 of the handbook. The NHS staff council is responsible for the agenda and change of pay system within the NHS. This revision enabled NHS staff to consider flexible working conditions and encourage workers to consider their work/life balance. According to the new changes which came into effect on 13th September 2021, section 33.5 grants any healthcare worker a contractual right to request flexible working from the commencement of employment. Section 33.6 further states that there is no limit on the number of requests that can be made to grant the above flexible working right.[364] These new changes go beyond the statutory minimum requirements on flexible working set out by the Employment Rights Act 1996.[365] Collective

[363] 'Guidance for joint union-employer partnerships on reviewing flexible working policies' (NHS Staff Council Working in Partnership, 2021) <https://www.nhsemployers.org/system/files/2021-08/Joint%20negotiating%20guidance%20-%20reviewing%20flexible%20working%20policies_July2021.pdf> accessed 20 October 2022.
[364] 'Guidance for joint union-employer partnerships on reviewing flexible working policies' (NHS Staff Council Working in Partnership, 2021) <https://www.nhsemployers.org/system/files/2021-08/Joint%20negotiating%20guidance%20-%20reviewing%20flexible%20working%20policies_July2021.pdf> accessed 20 October 2022.
[365] 'NHS Terms and Conditions of Service Handbook' (NHS Employers, 2022) <https://www.nhsemployers.org/publications/tchandbook> accessed 20 October 2022.

bargaining is essential in these instances as joint partnerships recognise the challenges faced by the NHS workforce and how staffing and service obligations intensified during the pandemic. Section 33.10 of the TCS further reiterates the importance of trade unions and employers working together to optimise flexible working.[366] In addition to the above, collective bargaining can contribute tremendously to the inclusive and effective governance of work. One such example is that collective bargaining provides a responsive set of guidelines, which enables the affected parties to tailor their rules in order to adapt to particular situations. Collective bargaining was utilised as a regulatory tool during the Covid-19 pandemic in order to safeguard frontline workers' health and safety.[367]

During the pandemic, trade unions raised issues of concern such as the insufficiency of proper PPE, staff shortages, dissatisfaction with wages and the sheer intensity of the work, which put the lives of frontline workers at risk.[368] Negotiations with the governments of each of the devolved nations were held throughout the pandemic on the importance of providing adequate PPE to HCWs, access to vaccines and increased paid sick leave during quarantine periods.[369] Many compromises achieved through collective bargaining later progressed into long term solutions. Nursing profession is one of the main sectors of healthcare professionals that is undervalued in the UK.[370] Nurses are amongst the lowest paid health workers despite the level of care and commitment that they provide which goes unrecognised.[371] Nonetheless, the RCN has been striving to change this unfair treatment to nursing staff by advocating for better working conditions through the 'fair pay for nursing' campaigning.[372]

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[366] 'Guidance for joint union-employer partnerships on reviewing flexible working policies' (NHS Staff Council Working in Partnership, 2021) <https://www.nhsemployers.org/system/files/2021-08/Joint%20negotiating%20guidance%20-%20reviewing%20flexible%20working%20policies_July2021.pdf> accessed 20 October 2022.
[367] 'Social Dialogue report 2022. Collective bargaining for an inclusive, sustainable and resilient recovery' (International Labour Organisation, 2022) < https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_842807.pdf> accessed 02 November 2022.
[368] 'Lack of PPE for health and social care staff is "a crisis within a crisis", unions warn ministers' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/lack-ppe-health-and-social-care-staff-crisis-within-crisis-unions-warn-ministers> accessed 03 November 2022.
[369] 'The public health response by UK governments to Covid-19' (British Medical Association, 2022) <https://www.bma.org.uk/media/5980/bma-covid-review-report-4-28-july-2022.pdf> accessed 03 November 2022.
[370] Rachael McIlory, 'Nurses have been invisible and undervalued for far too long' (The Guardian, 2020) <https://www.theguardian.com/society/2020/jan/29/nurses-invisible-devalued-women-inequality-change> accessed 17 May 2022.
[371] Alba Llop-Girones, et al., 'Employment and working conditions of nurses: where and how health inequalities have increased during the COVID-19 pandemic?' (Human Resources for Health, 2021).
[372] 'Fair pay for nursing' (Royal College of Nursing, 2023) <https://www.rcn.org.uk/Get-Involved/Campaign-with-us/Fair-Pay-for-Nursing> accessed 02 February 2023.

2.1 Royal College of Nursing

First founded on 27 March 1916, the RCN aims to support nurses by promoting the fundamental importance of the nursing staff in the healthcare occupation.[373] In 1976, the RCN was registered as a trade union and currently has close to half a million members, which makes it the biggest nursing union in the world. One of the key dates in RCN history is 1919, when for the first time, having successfully campaigned for the Nurses' Act, a register for nurses was established. This enabled the public to be confident that the newly registered nurses had been trained to a professional standard.[374]

Whilst the RCN advocates for the health and safety of nurses, for instance in the aftermath of Covid-19, by promoting the use of suitable and adequate PPE, it has recently initiated a new campaign labelled "the gloves are off".[375] This is an instance where a trade union is utilising their authority to initiate incentives to encourage nursing staff to be conscious of the occasions that they use gloves and to consider if it is necessary to do so. During the years 2020 to 2022, 12.7 billion gloves were used by the NHS and social care in England compared to 1.7 billion in the year 2019.[376] While this staggering increase contributes to climate change and environmental pollution, the risk associated with overusing PPE has been revealed by recent research.[377] Research has indicated that in many cases the use of PPE, particularly gloves, was necessary, for instance when in contact with blood or body fluids, harmful drugs or chemicals and broken skin. However, the use of gloves was not necessary when taking blood pressure, giving vaccinations and helping patients eat or drink.[378] Although during the Covid-19 pandemic the use of gloves, face masks and gowns was mandatory, the RCN initiative has provided a risk assessment tool kit that can help the workforce to think whether it is absolutely necessary to operate safely in line with health and safety laws.

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[373] 'Our history: The RCN from 1916 to the present' (Royal College of Nursing, 2022) <https://www.rcn.org.uk/About-us/our-history> accessed 17 May 2022.
[374] 'Our history: The RCN from 1916 to the present' (Royal College of Nursing, 2022) <https://www.rcn.org.uk/About-us/our-history> accessed 17 May 2022.
[375] 'Reducing glove use protects hands and saves the planet, says Royal College of Nursing' (Royal College of Nursing, 2022) <https://www.rcn.org.uk/news-and-events/Press-Releases/reducing-glove-use-protects-hands-and-saves-the-planet> accessed 17 May 2022.
[376] 'Glove awareness week: make one change for sustainability' (Royal College of Nursing, 2022) <https://www.rcn.org.uk/news-and-events/news/uk-glove-awareness-week-make-one-change-for-sustainability-020522> accessed 17 May 2022.
[377] Vidua K Raghvendra, Vivek K. Chouksey, Daideepya C. Bhargava, and Jitendra Kumar, 'Problems arising from PPE when worn for long periods' (Medico-Legal Journal, 2020).
[378] Reducing glove use protects hands and saves the planet, says Royal College of Nursing' (Royal College of Nursing, 2022) <https://www.rcn.org.uk/news-and-events/Press-Releases/reducing-glove-use-protects-hands-and-saves-the-planet> accessed 17 May 2022.

In the past, RCN have been involved in providing their input into many crucial NHS legislative frameworks. Recently, the RCN, in partnership with over one hundred other organisations, had been supporting the advancement of Safe staffing saves lives: Health and Social Care Bill 2022. The RCN called for the Secretary of State for Health and Care to have legal accountability for providing safe and effective care for nursing staff. This was eventually agreed upon and was within the final version of the bill.

However, RCN also highlights the limitations of what unions are able to achieve. Currently the staffing situation is unsustainable and urgent action is needed to avoid overworking and overstretching nursing staff as they are unable to deliver efficient and effective care that the patients deserve. As of now, there are approximately 40,000 vacancies for registered nurses in the NHS in England. The RCN was unable to lobby the UK Government to address this workforce crisis within the bill and are continuing to push for efforts to recruit more staff in order to cope with demand and provide safe care.[379]

2.2 British Medical Association

The BMA is a trade union representing and negotiating on behalf of doctors within the UK, with over two thirds of practising UK doctors being members. At national level, the BMA bargains in respect of all its members. Negotiations relating to the conditions of service for the NHS medical staff are held between the BMA and the Department of Health.[380] In addition, it holds discussions as appropriate with ministers, members of both parliaments, the national assemblies, government departments and other influential bodies. Local negotiations are held in a manner similar to the above, where local negotiating committees are formed. They hold consultations regularly in order to identify any pressing issues that require negotiations with local managers.[381]

3. NHS trade unions since the Covid-19 pandemic

In the aftermath of the Covid-19 pandemic, trade unions are still striving to assist NHS workers. For instance, UNISON has voiced its concerns regarding long Covid-19. According

[379] 'Safe staffing saves lives: Health and Social Care Bill 2022' (Royal College of Nursing, 2022) <https://www.rcn.org.uk/About-us/Our-Influencing-work/Health-and-Care-Bill> accessed 17 May 2022.
[380] 'BMA as a trade union' (British Medical Association, 2021) <https://www.bma.org.uk/about-us/about-the-bma/how-we-work/bma-as-a-trade-union> accessed 18 May 2022.
[381] 'BMA 'utterly dismayed' as Health and Care Bill passes without workforce guarantees' (British Medical Association, 2022) <https://www.bma.org.uk/bma-media-centre/bma-utterly-dismayed-as-health-and-care-bill-passes-without-workforce-guarantees> accessed 20 May 2022.

to the Office for National Statistics, as of June 2022, an estimated two million people in the UK were experiencing long Covid.[382] In correlation to these distressing numbers of long Covid-19 patients, it is likely that there are thousands of NHS workers who are affected by the Covid-19 pandemic.[383] According to the NHS, most people who contract the virus are expected to make a full recovery within twelve weeks, however, for some, ongoing health concerns may continue for weeks and months resulting in suffering from long Covid symptoms.[384] Due to the fear of losing employment, workers would return to work despite feeling unwell only to relapse. In a survey conducted by UNISON during April 2022, around 1,900 NHS workers reported symptoms of having had or still experiencing long Covid.[385] The survey indicated that 68% of workers attended work despite suffering from Covid symptoms and 8% of workers were unable to return to work.[386]

In this instance, UNISON advises that NHS union representatives need to be aware that employees who have been absent from work for long periods of time might require reassurance from their employers that they are allowed to return to work. Support could be offered in the form of providing suitable workplaces or working hour adjustments and providing assistance and reassurances throughout the recovery process that may impact their work.[387]

Strict guidelines are set by the Advisory, Conciliation and Arbitration Service (ACAS) on how employers should conduct themselves where an employee who has been off sick due to reoccurring symptoms of Covid-19 is hoping to return to work. The employer should discuss getting an occupations health assessment (this indicates to the employer that the employee is fit to return to work and carry out his/her work), a staggered return to work (this will ensure that the employee does not push himself/herself to have a relapse), make adequate changes to the workplace or how the affected employee works (for instance flexible working

[382] 'Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 7 July 2022' (Office for National Statistics, 2022) <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/7july2022> accessed 21 October 2022.
[383] 'Guidance on supporting members with long Covid or post Covid-19 syndrome' (UNISON, 2022) <https://www.unison.org.uk/content/uploads/2022/05/Bargaining-to-support-those-who-have-long-COVID-v4.pdf> accessed 15 October 2022.
[384] 'Long term effects of Coronavirus (Long Covid)' (NHS, 2022) <https://www.nhs.uk/conditions/coronavirus-covid-19/long-term-effects-of-coronavirus-long-covid/> accessed 15 October 2022.
[385] 'Staff with long Covid will feel forced out of the health service if managers don't treat them fairly, warns UNISON' (UNISON, 2022) <https://www.unison.org.uk/news/2022/04/staff-with-long-covid-will-feel-forced-out-of-the-health-service-if-managers-dont-treat-them-fairly-warns-unison/> accessed 16 October 2022.
[386] 'Staff with long Covid will feel forced out of the health service if managers don't treat them fairly, warns UNISON' (UNISON, 2022) <https://www.unison.org.uk/news/2022/04/staff-with-long-covid-will-feel-forced-out-of-the-health-service-if-managers-dont-treat-them-fairly-warns-unison/> accessed 16 October 2022.
[387] 'Staff with long Covid will feel forced out of the health service if managers don't treat them fairly, warns UNISON' (UNISON, 2022) <https://www.unison.org.uk/news/2022/04/staff-with-long-covid-will-feel-forced-out-of-the-health-service-if-managers-dont-treat-them-fairly-warns-unison/> accessed 16 October 2022.

hours as mentioned above) and finally, how in-depth if at all the affected employees would like to tell other colleagues about their illness.[388]

While the extent of which the NHS trade unions advocated for their workforce was remarkable, the findings impose several limitations. There are several factors that shape NHS trade union activities that are unique when compared to other industries. NHS trade unions prioritise fair pay and improved working conditions for their members, however, since NHS trade unions operate within the public sector, the negotiations are often subjected to budgetary constraints and more importantly, government policy. While their resource allocations are subject to public policy, due to the highly regulated nature of the healthcare sector, unions are able to leverage patient safety and workforce shortages, which ultimately gives the unions the upper hand when conducting negotiations. This prompts the question on whether NHS trade unions have greater power when conducting collective bargaining when compared to other private sector trade unions.

While it is not entirely definitive, some of the most notable instances that would give NHS unions significant strength is due to the NHS providing essential and comprehensive healthcare to the public. In the instance where the NHS were to undertake industrial action, the impact it would have on public health and safety would be significant which would in turn create substantial pressure on the government. Influencing speedier dispute resolution in order to appease the public interest is a strength when compared with other private sector trade unions. Similarly, the NHS represents a significantly large workforce which is often diverse including an array of different professional groups, which requires a tailored approach when conducting negotiations. While these complexities are not often found in other private industries, a high union density strengthens NHS union mandates. These features shape the NHS trade union activities in ways that are either not applicable or cannot be compared to other sectors.

It is crucial to acknowledge and recognise the extraordinary circumstances that the pandemic imposed on the NHS trade union activity and the limitations it would impose on the generalisability of the findings. The extraordinary circumstances would have created an environment that required NHS trade unions to focus on providing immediate crisis responses with regards to staff shortages, workforce burnout and rapidly changing health and safety policies, influencing the ways in which they responded to and operated to certain

[388] 'Long Covid- Advice for employers and employee' (ACAS, 2022) <https://www.acas.org.uk/long-covid> accessed 02 November 2022.

activities. Consequently, the activities conducted by trade unions during the pandemic might not represent an accurate picture of their undertakings in the absence of pandemic conditions making it difficult to generalise these findings under normal circumstances.

As mentioned above, during the pandemic, trade unions shifted their priorities to address issues with regards to the supply of PPE. The unprecedented demand for PPE caused due to the panic buying and stockpiling by the general public and limited manufacturing capacity for PPE in the UK created a strain in the overall supply. The additional need to properly fit test respiratory equipment such as the FFP3 masks created an added layer of complexity within the workforce amidst the rapidly evolving guidance. NHS trade unions were able to raise public awareness by directly appealing to the government, providing media statements and press releases of the risks faced by frontline workers due to the lack of PPE. Furthermore, the direct appeal to the government included a demand for clear guidance and consistency on the use of PPE. These actions pressured the government to secure adequate PPE supplies in order to reduce the risks of unsafe practices such as reusing single use PPE or using equipment that did not meet the fit test standards. These unique activities of NHS trade unions might not be directly transferable to other trade unions and some findings limit the generalisability to non-pandemic times. Prior to the pandemic, workers were aware of the use of PPE with regards to infection risks and the various procedures on the safe use of PPE as there was a well-established protocol and guidance. The pandemic was an anomaly that created a surge in the use of PPE however, if applied to non-pandemic times the supply chain would have been more stable and predictable. This chapter provides valuable insight of the NHS trade unions activity and structure nevertheless, the findings are not directly applicable to trade unions of other industries as they might not have experience the severity of the pandemic to the same scale as the NHS.

Conclusion

I have explored some of the instances where NHS trade unions have used their collective bargaining power to assist members to provide support and advice for better conditions of work and pay. Trade unions have indicated that they are able to match the strength of the employers by standing together as one collective body. This chapter highlights that collective bargaining initiated by trade unions strives to achieve the improved job security and terms and conditions that its members desire. It was through trade union negotiations that adequate PPE was provided to NHS frontline workers and it was through negotiations initiated by

trade unions that flexible working arrangements were made available for NHS workers. These initiatives implemented by trade unions indicate that membership of trade unions can help to ensure that workers are treated with respect within the workplace and that their health and safety is safeguarded. During the Covid-19 pandemic, trade unions rose to the occasion by providing assistance to workers during an unprecedented time. Trade unions were able to collectively bargain on issues that were unfamiliar to NHS HCWs and provide quick solutions albeit temporary. It is interesting to note that while health and safety legislation strives to protect workers, in the instance where the Covid-19 pandemic transpired, the law was unable to provide rapid responses to protect the workers due to the unprecedented nature of the pandemic. However, trade unions were able to utilise collective bargaining and assist workers in instances where they sought support to protect their health and safety. While this chapter provides an in-depth understanding of the NHS trade union activity and structure, the findings of the study is limited to the internal workings and actions exclusively. This restricts its generalisability when comparing with unions in other sectors. Chapters five and six below will explore the extent to which these rights are protected by conducting a thorough analysis of the data gathered. The analysis will be conducted with the use of a socio-legal methodology and thematic qualitative analysis to determine the effectiveness of the existing legal framework.

Chapter 5 Healthcare Workers' Mental Health

Introduction

Having conduced an initial collection of data relating to HCWs' work experiences during the Covid-19 pandemic, it became evident that these workers had encountered both physical and mental distress as a consequence of those experiences.[389] In order to analyse the data, five key overarching themes were identified and highlighted within the data pool. The first, *prejudicial treatment of Black Minority Ethnic workers* represents the systematic discrimination that transpired within the NHS and the extent of the unfair treatment towards these workers during the pandemic.[390] People of colour and racialised minorities collectively make up the ethnic minority population within the NHS workforce and the term BME workers is used in this chapter to refer to them.[391] *The lack of support for migrant workers* emphasizes the harsh immigration and visa rules in the UK, which weigh heavily on the mental health of HCWs and created an added burden of working during the pandemic.[392] *The supply of PPE* signifies the importance of protecting HCWs as they are the most valued resource within the healthcare system and providing them with the necessary safeguard measure in order to meet increased demands.[393] *Inconsistent advice across the NHS workforce* showed the government's careless approach to policy reform that undermined the confidence of HCWs working during the pandemic.[394] *The intention to leave the healthcare profession* highlights how the NHS is dealing with a chronic workforce crisis due to inadequate workforce planning, lack of well-trained staff and the government's inability to take accountability for years of insufficient investment.[395]

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[389] Anika R Petrella, Luke Hughes, Lorna A Fern, et al., 'Healthcare staff well-being and use of support services during Covid-19: a UK perspective' (General Psychiatry, 2021).
[390] Rebecca Rhead, Lisa Harber-Aschan, Juliana Onwumere, et al, 'Ethnic inequalities among NHS staff in England-workplace experiences during the Covid-19 pandemic' (medRxiv, 2023) <https://www.medrxiv.org/content/10.1101/2023.04.13.23288481v1.full.pdf> accessed 17 February 2024.
[391] 'Glossary and Key Concepts' (NHS England) <https://www.england.nhs.uk/midlands/wrei/glossary-and-key-concepts/#:~:text=BME%20–%20Black%20and%20Minority%20Ethnic&text=In%20this%20strategy%2C%20we%20have,at%20work%20in%20the%20NHS> accessed 21 January 2024.
[392] Marina Fernandez Reino, 'The health of migrants in the UK' (The migrant observatory at the University of Oxford, 2020) <https://migrationobservatory.ox.ac.uk/wp-content/uploads/2020/08/Briefing-The-Health-of-Migrants-in-the-UK.pdf> accessed 15 January 2024.
[393] Charlotte Gordan and Abigail Thompson, 'Use of personal protective equipment during the Covid-19 pandemic' (British Journal of Nursing, 2020).
[394] 'Chronic neglect of the NHS and flawed Government policy contributed to the harrowing death toll of Covid-19, says BMA' (British Medical Association, 2021) <https://www.bma.org.uk/bma-media-centre/chronic-neglect-of-the-nhs-and-flawed-government-policy-contributed-to-the-harrowing-death-toll-of-covid-19-says-bma> accessed 17 January 2024.
[395] 'NHS medical staffing data analysis' (British Medical Association, 2024) <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis> accessed 17 February 2024.

My presentation of the analysis of the collected data will be divided into two chapters. In chapter five, I will address the question whether the health and safety laws pertaining to mental health were properly deliberated and utilised by the employers within the NHS to support and safeguard the mental health of HCWs during the Covid-19 pandemic. Certain issues that HCWs faced during the pandemic were already prevalent in the healthcare system.[396] However, the pandemic interrupted the normal rhythm of work life balance and the added pressures of working during a worldwide pandemic intensified the working conditions of NHS workers. These workers encountered new challenges such as having to adapt to the constantly changing use of PPE guidelines, increased workload, relocating to different sectors of work, having to take on new responsibilities and the risk of infection to oneself and close family.[397] Although the physical impairments associated with working in the frontline are apparent as it affects the state of the physical body, it can be difficult to recognise the mental health effects as they can be easily concealed.[398] Protecting workers' mental health is important since failure to do so will mean higher rates of sickness within the NHS and could impact the quality of care provided for patients.[399]

In order to address my research question, I will focus on three of the five themes mentioned above. The two themes – *prejudicial treatment of BME workers* and *the lack of support for migrant workers* – are dealt with together since they both focus on the ethnic minority workforce within the NHS and the data emphasised the psychological impact these minority workers faced due to their nationality and race. The final theme – *supply of PPE* – will be explored under the current chapter to identify the mental health impact on workers and in the subsequent chapter to identify the effects to workers' physical health.

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[396] 'The mental health and wellbeing of the medical workforce- now and beyond Covid-19' (British Medical Association, 2020) <https://www.bma.org.uk/media/2475/bma-covid-19-and-nhs-staff-mental-health-wellbeing-report-may-2020.pdf> accessed 15 February 2024, 'Workforce burnout and resilience in the NHS and social care' (UK Parliament, 2021) <https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/22/2207.htm> accessed 15 February 2024, 'Covid-19 and the health and care workforce supporting our greatest asset' (NHS Confederation, 2020) <https://www.nhsconfed.org/system/files/media/NHS-Reset-COVID-19-and-the-health-and-care-workforce_4.pdf> accessed 15 February 2024.

[397] Rachel Gemine, Gareth R. Davies, Suzanne Tarrant, et al., 'Factors associate with work-related burnout in NHS staff during Covid-19: a cross- sectional mixed methods study' (BMJ, 2021) <https://bmjopen.bmj.com/content/11/1/e042591> accessed 15 January 2024.

[398] 'BMA Covid Review 2 The impact of the pandemic on the medical profession' (British Medical Association, 2022) <https://www.bma.org.uk/media/5620/20220141-bma-covid-review-report-2-the-impact-of-the-pandemic-on-the-medical-profession-final.pdf> accessed 11 March 2023, Norha Vera Juan San, David Aceituno, Nehla Djellouli, et al., 'Mental health and well-being of healthcare workers during the Covid-19 pandemic in the UK: contrasting guidelines with experiences in practice' (BJPsych open, 2021).

[399] Neil Greenberg, 'Our moral obligations: supporting the mental wellbeing of healthcare workers' (King's College London, 2022) < https://www.kcl.ac.uk/news/our-moral-obligation-supporting-the-mental-wellbeing-of-healthcare-workers> accessed 15 February 2023, Lara Shemtob and Alice Woolley, 'We should protect NHS staff against mental illness just as we protect them against Covid-19' (Occupational Medicine, 2021).

Before delving into the main discussion of this chapter, it is important to consider how the individual themes directly link to workers' mental health well-being.

Firstly, many BME workers experience racial discrimination at the workplace, in the form of bullying, abuse, harassment and in extreme instances, these workers are denied promotions and training.[400] Although workers may be familiar to these discriminatory behaviours within the workplace, over time the accumulation of these experiences will severely harm workers' mental health.[401] Several studies have highlighted that racial discrimination significantly affects mental health, instigating the rise of depression, anxiety and psychological stress.[402] This strong link between racial discrimination and poor mental health is not merely theoretical, as the neurological changes can lead to dysregulation in a victim's brain.[403] The impaired function of the prefrontal cortex and the anterior cingulate cortex resembles chronic stress, anxiety, depression and psychosis.[404] Racism at work could take the form of sudden, unexpected abuse, but could also be microaggressions encountered over a long time period. Both of these actions significantly contribute towards stress. [405] If workers are distressed at work, it not only affects their mental health but also affects the quality of care they provide to patients, putting the patients safety at risk.[406] Racism has been a long-standing issue within the NHS workforce and while the NHS acknowledges the systemic racism that transpires, the initiatives implemented to tackle racism are short lived due to the deep rooted cultural norms.[407] Nonetheless, the underlying mental health issues are persistent not only due to racial discrimination but also because of the unfair treatment towards BME workers. Workers are unjustly denied promotions and are underrepresented in leadership roles, these uncertainties in career progression can lead to significant stress and anxiety.[408] Consequently, the link between racial discrimination, unfair treatment and mental disorders is undisputable.

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[400] 'Is racism real? A report about the experiences of Black and minority ethnic workers – polling findings' (Trades Union Congress, 2017) <https://www.tuc.org.uk/sites/default/files/Is%20Racism%20Real.pdf> accessed 11 May 2025.
[401] 'Still rigged: racism in the UK labour market' (Trade Union Congress, 2022) <https://www.tuc.org.uk/research-analysis/reports/still-rigged-racism-uk-labour-market#:~:text=Over%20time%2C%20these%20experiences%20build,people%20and%20even%20physical%20assault> accessed 10 November 2023.
[402] Yin Paradies, Jehonathan Ben, Nida Denson, et al., 'Racism as a determinant of health: a systematic review and meta-analysis' (PloS one, 2015).
[403] Maximus Berger and Zoltán Sarnyai, 'More than skin deep: stress neurobiology and mental health consequences of racial discrimination' (Stress, 2015).
[404] Ibid.
[405] 'Racism and mental health' (Mind, 2021) <https://www.mind.org.uk/information-support/tips-for-everyday-living/racism-and-mental-health/#TalkingAboutRaceAndRacismAccordions> accessed 11 May 2025.
[406] Ashitha Nagesh, 'NHS racism making doctors 'anxious and depressed'' (BBC, 2022) <https://www.bbc.co.uk/news/uk-61792140> accessed 11 May 2025.
[407] 'Tackling racism and other types of discrimination' (NHS) <https://www.england.nhs.uk/midlands/wrei/tackling-racism-and-other-types-of-discrimination/> accessed 11 May 2025.
[408] Cecile Guillaume and Gill Kirton, 'Unions defending and promoting nursing and midwifery: workplace challenges, activates and strategies' (2019), Riz Hussain, 'An alarming rise in the number of BME workers in insecure work' (TUC, 2023) <https://www.tuc.org.uk/blogs/alarming-rise-number-bme-workers-insecure-work> accessed 11 May 2025.

Secondly, the correlation between migrant workers and their mental health is not a novel concept.[409] This matter has been deliberated by scholars over the years due to multiple reasons. While some studies state that migrant workers have good mental health, with low levels of anxiety and depression due to the excitement of new opportunities and better living conditions following migration,[410] these initial feelings often weaken overtime if these aspirations are not met. Other external variables such as poor social networks and extreme weather conditions, along with job dissatisfaction and discrimination at work have an adverse effect on workers' mental health.[411] Migrants who experience discrimination and harassment while at work have a lower job satisfaction and the subsequent anxiety and depression can lead to workers taking long periods of sickness absence.[412] Furthermore, migration often leads towards a culture shock when adjusting to a different life style and work environment in a new country. These socio-environmental variables show an increase of anxiety and post-traumatic disorder.[413] This feeling is further exaggerated having to separate from ones family and community which creates an overwhelming amount of anxiety and stress.[414] In addition to having to adopt to these new changes, migrant workers need to withstand and be attentive to the implementation and/or change of government immigration policies. Migrant workers often face a considerable financial burden when dealing with these immigration hurdles. Moreover, the high cost of living, working conditions and housing significantly impact the mental health of immigrant workers.[415] Having to fulfil the countless requirements and policies proclaimed by the Home Office on the route to achieving permeant residency in the UK is extremely difficult.[416] The uncertainties surrounding immigration policies, therefore have an adverse effect on the mental health of workers.[417]

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[409] Siti Idayu Hasan, Anne Yee, Ariyani Rindaldi, et al., 'Prevalence of common mental health issues among migrant workers: A systematic review and meta- analysis' (PloS one, 2021).
[410] Martijn Hendriks, 'The happiness of international migrants: A review of research findings' (Migration studies, 2015).
[411] Ehinomen Jude Imoisili and Russell Kabir, 'Self-reported mental health effects of changing migration policies on immigrant health and allied care professionals in the UK' (World Journals of Biology Pharmacy and Health Sciences, 2024).
[412] Rebecca D Rhead, Zoe Chui, Ioannis Bakolis, et al., 'Impact of workplace discrimination and harassment among National Health Service staff working in London trusts: results from the TIDES study' (BJPsych open, 2021).
[413] Munyi Shea and Y Joel Wong, ' A two-way street: immigrants' mental health challenges, resilience, and contributions' (One Earth, 2022), Nicola Mucci, Veronica Traversini, Gabriele Giorgi, et al., 'Migrant workers and psychological health: A systematic review' (Sustainability, 2019).
[414] Munyi Shea and Y Joel Wong, ' A two-way street: immigrants' mental health challenges, resilience, and contributions' (One Earth, 2022).
[415] Ariadna Font, Salvador Moncada and Fernando G Benavides, 'The relationship between immigration and mental health: what is the role of workplace psychosocial factors' (International archives of occupational and environmental health, 2021).
[416] Samitha Udayanga, 'Challenges in navigating the education-migration pathways, an subjective well-being of highly educated immigrants: the case of Indian student immigrants in the United Kingdom' (Frontiers in Sociology, 2024).
[417] Ehinomen Jude Imoisili and Russell Kabir, 'Self-reported mental health effects of changing migration policies on immigrant health and allied care professionals in the UK' (World Journals of Biology Pharmacy and Health Sciences, 2024).

Third and finally, while the use of PPE is a physical barrier that provides a sense of security to HCWs when providing care to patients, it is in essence a psychological buffer to these workers.[418] Consequently, in the event that there is a lack of protective equipment readily available at the workplace, it can directly affect workers' physical and mental health.[419] While the physical health aspect is discussed under chapter 6 below, the current chapter will focus on the supply of PPE and the direct effect it had on the mental health of HCWs. Through the pandemic the major concern surrounding PPE was the shortage of PPE and the confusing guidelines given by the government in its use.[420] The lack of adequate PPE persisted within the NHS for a long period. This in turn created anxiety and stress among workers as they were reluctant to provide care to patients without appropriate protection.[421] At times this anxiety and stress was rooted in donning and doffing PPE. Workers who lived with vulnerable individuals were cautious of avoiding the transmission of the virus.[422] The exposure to the risk of contracting the virus remained a significant cause of anxiety amongst HCWs.[423] This feeling was warranted as the lack of suitable PPE created an unsafe work environment, putting workers' safety in jeopardy. Managing workers' mental health while navigating the constantly changing guidelines created distrust and confusion.[424] Adverse mental health issues were directly linked to the lack of suitable PPE available to workers.

Having justified the links between the individual themes and the effects on workers' mental health, in section one of the chapter, I will explain the prejudicial treatment that BME workers endured working during the pandemic, highlighting how this disproportionately impacted them. Having to experience racism while at work can be extremely distressing. While the unfair treatment that they endured was not new for the BME workers, the impact of it was highlighted and exacerbated during the pandemic.[425] This section will make

[418] Katarina Hoernke, Nehla Djellouli, Lily Andrews, et al., 'Frontline healthcare workers' experiences with personal protective equipment during the Covid-19 pandemic in the UK: a rapid qualitative appraisal' (BMJ, 2021).
[419] Christopher A Martin, Daniel Pan, Joshua Nazareth, et al,. 'Access to personal protective equipment in healthcare workers during the COVID-19 pandemic in the United kingdom: results from a nationwide cohort study (UK-REACH)' (BMC Health Service Research, 2022).
[420] 'The supply of personal protective equipment (PPE) during the Covid-19 pandemic' (National Audit Office, 2020) <https://www.nao.org.uk/wp-content/uploads/2020/11/The-supply-of-personal-protective-equipment-PPE-during-the-COVID-19-pandemic-Summary.pdf> accessed 21 July 2023.
[421] Hui Yun Chan, 'Hospitals' liabilities in times of pandemic: Recalibrating the legal obligation to provide personal protective equipment to healthcare workers' (Liverpool Law Review, 2021).
[422] Robert McCarthy, Bruno Gino, Philip d'Entremont, et al., 'The important of personal protective equipment design and donning and doffing technique in mitigating infectious disease spread: a technical report' (Cureus, 2020).
[423] Imrana Siddiqui, Marco Aurelio, Ajay Gupta, at al,. 'COVID-19: Causes of anxiety and wellbeing support needs of healthcare professionals in the UK: A cross-sectional survey' (Clinical medicine, 2021).
[424] Katarina Hoernke, Nehla Djellouli, Lily Andrews, et al., 'Frontline healthcare workers' experiences with personal protective equipment during the Covid-19 pandemic in the UK: a rapid qualitative appraisal' (BMJ, 2021).
[425] Shilpa Ross, 'Life in the shadow of the snowy white peaks: race inequalities in the NHS workforce' (The Kings Fund, 2019) <https://www.kingsfund.org.uk/insight-and-analysis/blogs/race-inequalities-nhs-workforce> accessed 11 February 2023.

reference to the legal duties that employers have towards protecting the wellbeing of workers. In section two of the chapter, I will explore how migrant HCWs in the NHS survived during the Covid-19 pandemic with minimum support from the government. The NHS and social care in the UK heavily rely on the support of migrant workers.[426] However, the hostile immigration and visa laws severely affect the mental health of these workers.[427] Section two will also discuss recent case law that emphasised the legal duties of employers and their failure to meet the health and safety standards within the workplace.

Section three of this chapter will focus on the use of PPE and explore whether the NHS was successful in complying with its legal duty to provide suitable protective equipment and training in its usage.[428] During the Covid-19 pandemic, HCWs were strongly advised to exercise the use of PPE by the UK government and the NHS. However, these workers were not aware of the scale and the severity of the Covid-19 virus as they never experienced having to wear full protective equipment for a prolonged time-period. The prolonged use of PPE took a heavy toll on workers. It could be especially challenging for female HCWs, who had to provide care to patients while wearing ill-fitting PPE. The workforce within the NHS is female-dominated yet the default sizing of the protective equipment available to the workers is male-centric.[429] The ill-fitting protective equipment is not only hazardous when used by female workers but it is also unsafe for the patient as the protective barrier between the patient and the healthcare provider would not be at a standard that is adequate to protecting both parties from transmitting the virus. Female HCWs had no choice but to adhere to the guidelines and use ill-fitting protective equipment exacerbating the risk of infection. PPE was essential to control infection yet, due to the lack of training on donning and doffing protective equipment, it actually added to the mountain of problems that HCWs faced during the pandemic. The incorrect use of PPE resulted in higher risk of infection and worsened the shortage of PPE. Although the NHS urged workers to practise the safe use of PPE, the line managers of workers did not always take proactive measures to provide in-depth training to these workers, especially during a novel pandemic.

[426] 'Racial inequalities in health and social care workplaces' (Trades Union Congress, 2021) <https://www.tuc.org.uk/research-analysis/reports/racial-inequalities-health-and-social-care-workplaces> accessed 30 June 2023.
[427] Zinovijus Ciupijus, Chris Forde, Rosa Mas Giralt, et al., 'The UK National Health Service's migration infrastructure in times of Brexit and Covid-19: Disjunctures, Continuities and Innovations' (International migration, 2023).
[428] 'Do employers have to provide personal protective equipment (PPE)?' (Health and Safety Executive) <https://www.hse.gov.uk/contact/faqs/ppe.htm> accessed 30 June 2023.
[429] Caroline Criado Perez, 'Another truth from the Covid inquiry: women were being ignored over ill-fitting PPE long before the pandemic' (The Guardian, 2023) <https://www.theguardian.com/commentisfree/2023/nov/03/covid-inquiry-women-ill-fitting-ppe-pandemic-unisex-healthcare> accessed 30 January 2024.

Taking the above into consideration, this chapter concludes that the NHS as an employer failed in its duties to support and protect HCWs during the Covid-19 pandemic. The NHS failed to fulfil its legal responsibilities. The lack of support and care provided to the BME NHS workers was highlighted due to the systematic racism they face within the NHS and its negative effects on the mental health of BME workers. Furthermore, the NHS failed to support migrant NHS workers who were mentally distressed having to navigate the harsh visa and immigration rules whilst providing care in the NHS. Additionally, the lack of training opportunities that were available to workers worsened the mental health of HCWs. The majority of the issues were pre-existing and the NHS were aware of the harsh reality that the HCWs were facing during the pandemic yet failed to mitigate these issues to protect the health and safety of HCWs.

1. Prejudicial treatment of Black Minority Ethnic workers

1.1 Mental health and racial discrimination

During the Covid-19 pandemic, pre-existing inequalities within workplaces were highlighted and deepened. Among others, one group of workers impacted during the pandemic by these underlying inequalities were BME workers. During the first wave of the pandemic, the TUC published a survey, which suggested that one in five BME workers in the NHS believed they were being treated unfairly during their employment due to their ethnicity.[430] The TUC sought to delve into this issue as they called for evidence for BME workers to share first-hand experience of working during the Covid-19 pandemic. A staggering number of more than 1,200 workers responded. This testifies to the point made in Chapter four above regarding the importance of being a member of a trade union and how trade unions can bring to light issues such as discrimination and inequality within the workforce.

The evidence revealed that a fifth of the workers believed that due to their ethnicity they received unfair treatment at work.[431] This incites low workplace engagement and employee

[430] 'One in five BME workers treated unfairly at work during Covid-19- TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 30 January 2023.
[431] 'One in five BME workers treated unfairly at work during Covid-19- TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 30 January 2023.

dissatisfaction, ultimately resulting in greater staff turnover.[432] Scholarly articles have also indicated that racially and ethnically minoritized individuals experience difficulty with career progression, disciplinary actions, workplace exclusion and recruitment.[433] These claims are reinforced by data presented under the 'NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts'. With the intention of reforming and improving equality within the workforce and to help employers understand their staff experience, the NHS provided a detailed analysis through the WRES report. It should be noted that the report includes data gathered between 2016 and 2022, which is the most up to date report produced by the NHS.

The data shows that there was an increase of over 27,500 BME workers from the year 2021 compared to 2022. Taking that increase of workers into consideration, Figure 1 below depicts that the percentage of workers experiencing harassment, bullying or abuse from other members of staff during those 12 months was twice as high for BME workers compared to their white colleagues in the year 2022. Although the overall percentage between the year 2021 and 2022 reduced, 28.8% and 27.6% BME workers and 23.3% and 22.5% for white workers, the gap between the two groups of workers still remains significant. It is also important to mention that in the year 2019, 29.3% of BME workers experienced harassment, bullying or abuse from staff. This figure is striking as the Covid-19 pandemic first appeared in the UK in the year 2020.[434] However, the harassment and bullying was prominent prior to the Covid-19 pandemic. Moreover, across the seven years that the data was collected for the WRES report, 2019 was the year that had the highest percentage of BME workers who believed that they were subjected to harassment and bullying at the workplace by staff. These figures indicate that although Covid-19 highlighted pre-existing issues within the NHS, there was already a culture of prejudice treatment towards BME workers.

[432] Charlotte Woodhead, Nkasi Still, Hannah Harwood, et al, 'They created a team of almost entirely the people who work and are like them': A qualitative study organisational culture and racialised inequalities among healthcare staff' (Sociology of Health & Illness, 2022).
[433] Mor Barak, Michalle E, 'Inclusion is the key to diversity management, but what is inclusion?' (Human Service Organizations: Management, Leadership & Governance', 2015).
[434] 'Covid-19 timeline' (British Foreign Policy Group) <https://bfpg.co.uk/2020/04/covid-19-timeline/> accessed 30 January 2024.

Figure 1: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

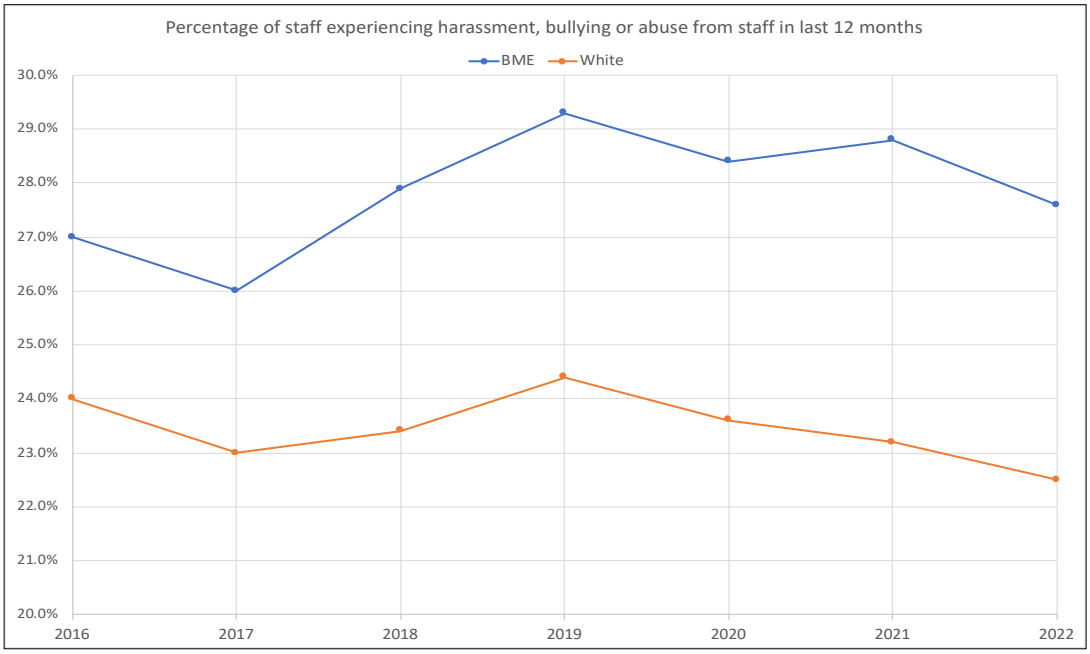

Figure 1 [435]

[435] 'NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts' (NHS England, 2023) <https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/> accessed 30 March 2023.

When looking at the data collected for the research, the HCWs who experienced harassment, bullying and abuse whilst at work during the Covid-19 pandemic were predominately workers who classified as BME workers. These workers believed that they received unfair treatment at work due to the colour of their skin. Unfair treatment at work creates an uncomfortable and hostile environment at work for these workers. Midwife Estelle, who worked as a healthcare home visitor, experienced unfair treatment when she realised that a disproportionate number of black workers compared to white workers were being sent on home visits.[436] At this point in time, research indicated that BME people were more at risk of contracting the Covid-19 virus, becoming seriously unwell and dying of the virus.[437] Although workers including Estelle raised concerns about this issue, the majority of workers who conducted home visits continued to be black.[438]

This unfair treatment of black workers had a direct impact on their health and safety. Whilst workers' physical health was always under pressure and unsafe working during the pandemic, the indirect effect that it had on workers' mental health was substantial. HCW Estelle's employer had a legal duty to ensure that her health, including her mental health, was protected while she was at work. Similar to other health and safety hazards at work, workers' mental health issues, whether they are caused by work or aggravated by work, should be taken into consideration and assessed to measure the associated risks.[439] Employers are responsible to identify such risks and take reasonably practicable steps in order to remove or reduce such risks. Section 2 of the HSWA places a general duty of care to ensure that the health, safety and welfare of employees is protected by employers.[440] Carrying out risk assessments, safeguarding workers from discrimination within the workplace, and providing a safe work environment for staff, are all crucial aspects of the duty of care to make sure that employees' mental health is treated as equally important as their physical health.

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[436] 'One in five BME workers treated unfairly at work during Covid-19- TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 30 January 2023.
[437] 'Beyond the data: Understanding the impact of Covid-19 on BAME groups' (Public Health England, 2020) <https://assets.publishing.service.gov.uk/media/5ee761fce90e070435f5a9dd/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf> accessed 11 January 2023.
[438] Ibid.
[439] 'Mental health conditions, work and the workplace' (Health and Safety Executive) <https://www.hse.gov.uk/stress/mental-health.htm> accessed 19 January 2023.
[440] Health and Safety at Work etc. Act 1974. Section.2 (Legislation. Gov.UK) <https://www.legislation.gov.uk/ukpga/1974/37/section/2> accessed 30 January 2023.

Although the HSWA is the primary legislation that encourages the protection of health and safety of workers, when it comes to the mental health of workers, the Equality Act 2010 (EqA 2010) also places a legal duty on employers to protect the mental health of workers. The underlying premiss of the EqA 2010 is to protect workers from being discriminated against at their workplace.[441] Under section 4 of the EqA 2010, there are nine protected characteristics namely age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.[442] If a person is treated less favourably due to having any of the above protected characteristic they are subjected to disadvantages compared to an individual who does not have the protected characteristic. Although the law does not provide a legal definition for what constitutes 'disadvantages' it could include causing financial loss to a worker, causing an individual emotional loss, excluding a person from benefits or opportunities which makes it harder for them to continue with their job. When applying this law to the case of Estelle, it could be argued that she was treated unfairly while working during the Covid-19 pandemic due to her race. This was evident as the majority of the HCWs who were allocated to go on home visits were black HCWs, while white workers were not made to do so. Repeatedly making Estelle attend home visits caused emotional distress as she was concerned about contracting the virus and this overlooked her concerns of working in high-risk environments. The racial group that Estelle belongs to have been repeatedly treated unfairly, which aligns with the TUC survey data mentioned above.

BME HCW Sarah, Gabriella and Precious all faced similar situations where they were treated unfairly when compared to their white colleagues.[443] Sarah was required to treat suspected Covid-19 patients without any of her white colleagues being put into the rota to minimise the spread of the virus. Gabriella was required to work in the 'Covid red zone', while white colleagues were working in the 'Covid blue zone', which carried very different risks of becoming infected by the virus. Precious had to wash deceased Covid-19 patients, while white colleagues were never required to do so. Each of these BME HCWs believed that they received this unfair treatment at work due to the colour of their skin being black and to their employers having a pre-conceived notion that HCWs in this racial group would comply willingly due to the colour of their skin. The unfair treatment these workers faced

[441] 'Equality Act 2010: guidance' (Government Equalities Office and Equality and Human Rights Commission, 2013) <https://www.gov.uk/guidance/equality-act-2010-guidance> accessed 21 January 2023.
[442] Equality Act 2010. Section.4 (Legislation. Gov.UK) <https://www.legislation.gov.uk/ukpga/2010/15/section/4> accessed 21 January 2023.
[443] 'One in five BME workers treated unfairly at work during Covid-19- TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 30 January 2023.

during the pandemic was due to the protected characteristic of race and as a result these workers faced racial discrimination at work. This discrimination at work causes deeper mental issues for these workers as they were often faced with the decision of having to leave the workplace due to the stress of working in high-risk environments or having to endure the burden of continuing to work when mentally distressed.[444] It is generally easier to recognise physical health and risks associated with it, however, emotional wellbeing of workers is often overlooked and rarely talked about due to the longstanding stigma associated with mental health.[445] Over and above any legal obligations that they are under for taking reasonably practicable steps to protect workers' health and safety, employers should be proactive in developing a culture that encourages workers to speak up about their mental health struggles and provide a safe working environment for all staff.[446]

1.2 Conquering the snowy white peaks of the NHS

The mental health of BME HCWs was further strained due to the challenges faced with regards to perceived career progression and the lack of equal opportunities provided to them within the NHS.[447] The increased number of BME workers joining the NHS highlighted the underrepresentation of BME workers at senior levels and executive positions.[448] As mentioned above, the WRES is one of the major progress monitoring tools for NHS trusts in England. Figure 2 below depicts the percentage of staff who believed that their trust provided equal opportunities for career progression or promotion.[449] The gap between BME and white workers is striking. In the year 2022 while 58.7% of white workers believed the above, only 44.4% of BME workers shared this belief.

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[444] Rebecca Rhead, Lisa Harber-Aschan, Juliana Onwumere, et al, 'Ethnic inequalities among NHS staff in England-workplace experiences during the Covid-19 pandemic' (medRxiv, 2023) <https://www.medrxiv.org/content/10.1101/2023.04.13.23288481v1.full.pdf> accessed 17 February 2024.
[445] 'Mental health in the workplace' (NHS Employers, 2024) <https://www.nhsemployers.org/articles/mental-health-workplace> accessed 30 January 2024.
[446] 'The mental health and wellbeing of the medical workforce- now and beyond COVID-19' (British Medical Association) <https://www.bma.org.uk/media/2475/bma-covid-19-and-nhs-staff-mental-health-wellbeing-report-may-2020.pdf> accessed 11 June 2023.
[447] Irtiza Qureshi, Mayuri Gogoi, Amani Al-Oraibi, et al., 'Factors influencing the mental health of an ethnically diverse healthcare workforce during Covid-19: a qualitative study in the United Kingdom' (European journal of psychotraumatology, 2022).
[448] 'Race for Equality Challenging racism in the NHS' (UNISON) <https://www.unison.org.uk/content/uploads/2022/07/27435_Race_for_Equality_Career_Dev.pdf> accessed 11 June 2023.
[449] 'Summary of key evidence on barriers to and initiatives to support career progression for ethnic minority doctors' (British Medical Association, 2022) <https://www.bma.org.uk/media/5747/bma-summary-of-key-evidence-report-15-june-2022.pdf> accessed 11 June 2023.

Figure 2: Percentage of staff believing that trust provides equal opportunities for career progression or promotion

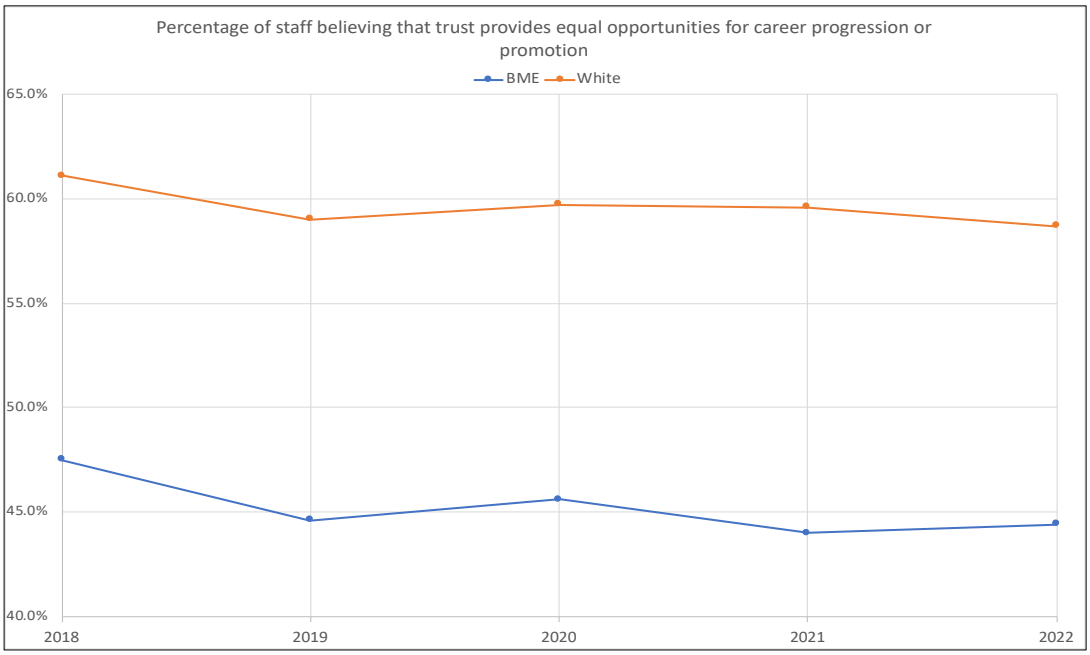

Figure 2 [450]

[450] 'NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts' (NHS England, 2023) <https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/> accessed 30 March 2023.

The slogan 'the snowy white peaks of the NHS' was first used in 2014 in connection with a survey conducted of the discrimination faced by NHS workers in governance and leadership positions and its effect on patient care in England.[451] The survey highlighted that within the NHS, the most senior positions were held by white males.[452] This survey emphasised the racial discrimination and the culture that promotes this behaviour in the NHS. Although, over the years, the NHS has tried to 'melt' these snowy peaks to improve the discriminatory treatment towards BME workers, it remains stagnant nearly a decade after the survey was conducted. Consequently, BME staff members were over-represented across medical roles as opposed to managerial positions. According to the NHS workforce: ethnicity facts and figures, in the year 2022, 88.7% of white workers were in senior manager positions compared to 3.4% of black NHS workers in senior managerial roles.[453]

In order to understand why BME workers face inequality with regards to career progression, it is important to ask the question, what are the factors that affect the career progression of BME workers when compared to their white counterparts? It is possible that some BME workers have a mental barrier that restrains them from pursuing career aspirations due to the rarity of role models and 'people like me' in senior positions within the workplace.[454] Even in instances where workers overcome this hurdle and self-doubt, the support that BME workers receive from their line managers that influence a person's career are poor.[455] Although they play an important part in career development, often line managers limit the access that ethnic workers have towards training and development opportunities that might help boosts their career progression. Workers do not feel supported when talking to their managers about possible career development opportunities due to preconceived notions of the lack of support from their line managers.[456] BME workers can also feel the need to

[451] Roger Kline, 'The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England' (2014).
[452] Roger Kline, 'After the speeches: What now for NHS staff race discrimination?' (NHS Providers, 2020) <https://nhsproviders.org/news-blogs/blogs/after-the-speeches-what-now-for-nhs-staff-race-discrimination#:~:text=Six%20years%20ago%2C%20The%20Snowy,more%20needs%20to%20be%20done> accessed 11 June 2023.
[453] 'Ethnicity facts and figures: NHS workforce' (GOV.UK 2023) <https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest/> accessed 21 May 2023.
[454] 'Addressing the barriers to BAME employee career progression to the top'(CIPD, 2017) <https://www.cipd.org/globalassets/media/knowledge/knowledge-hub/reports/addressing-the-barriers-to-BAME-employee-career-progression-to-the-top_tcm18-33336.pdf> accessed 21 March 2023.
[455] 'Identifying and Removing Barriers to Talented BAME Staff Progression in the Civil Service' (GOV.UK, 2014) <https://assets.publishing.service.gov.uk/media/5a74b356e5274a3f93b48174/Ethnic_Dimension_Blockages_to_Talented_BAME_staff_Progression_in_the_Civil_Service_Final_16.12.14__1_.pdf> accessed 10 November 2023.
[456] 'Addressing the barriers to BAME employee career progression to the top' (CIPD, 2017) <https://www.cipd.org/globalassets/media/knowledge/knowledge-hub/reports/addressing-the-barriers-to-BAME-employee-career-progression-to-the-top_tcm18-33336.pdf> accessed 10 November 2023.

change certain aspects of their behaviour and culture to fit into the workplace due to the stereotypes and organisational biases that are widespread within the workplace.[457] This culture of prejudice that marginalises BME workers can create extremely distressing work environments which result in impairing their mental health.[458]

Racial discrimination concerns are often swept under the rug by employers within the organisation and the psychological ramifications of these issues are overlooked. However, a recent landmark case highlighted this unfair treatment and race discrimination at work and succeeded in raising awareness of the severity of racial discrimination within the NHS.[459] Michelle Cox, BME healthcare manager, was employed in the NHS where her employer subjected her to discrimination, harassment and victimisation. During the course of her employment, she faced discrimination on several occasions in different forms. She was often excluded purposefully from team events, and team away-days were deliberately organised on occasions when she could not attend.[460] Even if she was able to disregard this as coincidence, Cox was taken by surprise when she was made aware after the fact that a junior member of her team had been promoted without the fair recruitment procedure having been followed.[461] This unfair racial discrimination was further evident when her manager excluded her from being able to apply for a senior post within her team. The blatantly unfair treatment towards Cox was persistent. Personal and private information that Cox told her manager in confidence was discussed with other team members. Even in the instance where concerns were raised by Cox they were dismissed by her manager. Due to the psychological impact of these events, she could not work in an organisation that subjected workers to racial discrimination.[462] Cox raised a claim of race discrimination before the employment tribunal with the help of the RCN supporting her and representing her case. The tribunal found in her favour.[463] This case highlighted how blatant racial discrimination can be within the NHS and

[457] 'Still rigged: racism in the UK labour market' (Trades Union Congress, 2022) <https://www.tuc.org.uk/research-analysis/reports/still-rigged-racism-uk-labour-market> accessed 10 November 2023.
[458] 'No more tick boxes' (NHS East of England, 2021) <https://www.england.nhs.uk/east-of-england/wp-content/uploads/sites/47/2021/09/NHSE-Recruitment-Research-Document-FINAL-2.2.pdf> accessed 10 November 2023.
[459] 'Apology to North West Black nurse follows publication of poor performance report for BME health staff' (Royal College of Nursing, 2023) <https://www.rcn.org.uk/news-and-events/news/090323-nw-wres-results> accessed 21 January 2024.
[460] 'North West nurse wins landmark case against NHSE&I for racial discrimination' (Royal College of Nursing, 2023) <https://www.rcn.org.uk/news-and-events/news/220223-nw-michelle-cox-tribunal#:~:text=The%20tribunal%20heard%20how%20Ms,occasions%20she%20couldn%27t%20attend> accessed 18 August 2023.
[461] Ibid.
[462] Lynne Pearce, 'Imagine a world without race discrimination' (Royal College of Nursing, 2023) <https://www.rcn.org.uk/magazines/Action/2023/Oct/Michelle-Cox-Imagine-a-world-without-race-discrimination> accessed 20 March 2023.
[463] 'Apology to North West Black nurse follows publication of poor performance report for BME health staff' (Royal College of Nursing, 2023) <https://www.rcn.org.uk/news-and-events/news/090323-nw-wres-results> accessed 30 January 2024.

set a precedent that workers should not be expected to go to work and endure unfair treatment due to their race.[464]

During the Covid-19 pandemic, this racial discrimination towards the BME community was put under the spotlight as a disproportionate number of minority workers were occupied on the frontline compared to white colleagues.[465] Several HCWs in the data pool disclosed their experience working during the pandemic as a black NHS worker. Nurse Efe Obiakor recounts that during the height of the Covid-19 pandemic when patients began to flood the NHS she knew that black NHS workers would be put on the frontline. "It's us again", she thought, alluding to the fact that black workers are always treated as "cannon fodder".[466] Obiakor has no faith in the system that systematically discriminates against black nurses on a daily basis. Community nurse Monifa Thompson felt similarly aggrieved as she believes that she is unable to take any action to change the system.[467] During the pandemic, the number of patients for whom she provided care increased dramatically. She experienced racism and was apprehensive of speaking up as she feared being labelled as "a lazy nurse" despite feeling overwhelmed having to work beyond her capability.[468] Black agency nurse Neomi Bennett tried unsuccessfully to beat the odds of speaking up about unfair treatment during work, as she felt unsafe attending to patients in a high risk Covid-19 environment without proper PPE.[469] When she raised concerns about being uncomfortable treating patients, she was bullied and was made to work in these environments. Since she worked as an agency nurse and worked in multiple hospitals, she experienced harassment and discrimination in varying degrees. She later recognised these patterns and developed strategies to cope with it during work.

The gap between white and BME workers under the Agenda for Change (AfC) pay band is significant. On the one hand, the non-clinical staff who receive the most basic pay level, known as Band 2, approximately 16.6% of the staff are BME workers compared to 78.8% of white workers.[470] At Band 9, which is the highest level, only 9.9% BME workers fall

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[464] Ibid.
[465] Suzie Bailey and Michael West, 'Ethnic minority deaths and Covid-19: what are we to do?' (The Kings fund, 2020) <https://www.kingsfund.org.uk/insight-and-analysis/blogs/ethnic-minority-deaths-covid-19> accessed 21 March 2023.
[466] Salma Abdelaziz, 'From the front lines, Black nurses battle twin pandemics of racism and coronavirus' (CNN, 2020) <https://edition.cnn.com/2020/07/10/europe/black-nurses-nhs-discrimination-gbr-intl/index.html>accessed 10 March 2022.
[467] Salma Abdelaziz, 'From the front lines, Black nurses battle twin pandemics of racism and coronavirus' (CNN, 2020) <https://edition.cnn.com/2020/07/10/europe/black-nurses-nhs-discrimination-gbr-intl/index.html>accessed 10 March 2022.
[468] Ibid.
[469] Ibid.
[470] 'Agenda for change- pay rates' (NHS) <https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates> accessed 30 March 2023.

within the band while a staggering 83.6% of white workers represent Band 9 which is shown below in Figure: 3.[471] Separately, Figure: 4 exhibits the AfC pay band of clinical staff, where Band 2 and under, BME workers represent 24.0%, while 72.2% is represented by white NHS staff. In comparison 12.0% of BME workers fall within Band 9 while 85.4% of white staff are represented within the same band.[472]

[471] 'NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts' (NHS England, 2023) <https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/> accessed 30 March 2023.
[472] [472] 'Apology to North West Black nurse follows publication of poor performance report for BME health staff' (Royal College of Nursing, 2023) <https://www.rcn.org.uk/news-and-events/news/090323-nw-wres-results> accessed 30 January 2024.

Figure 3: Percentage representation by ethnicity at each AfC pay band, amongst non-clinical staff in NHS trusts

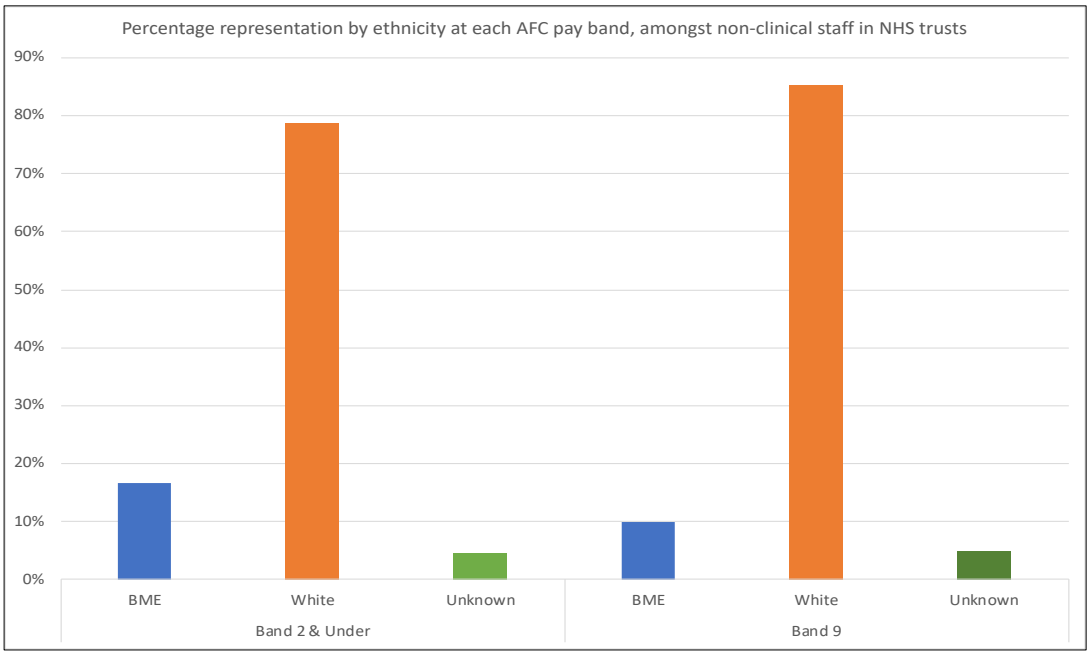

Figure 3 [473]

[473] 'NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts' (NHS England, 2023) <https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/> accessed 30 March 2023.

Figure 4: Percentage representation by ethnicity at each AfC pay band, amongst clinical staff in NHS trusts

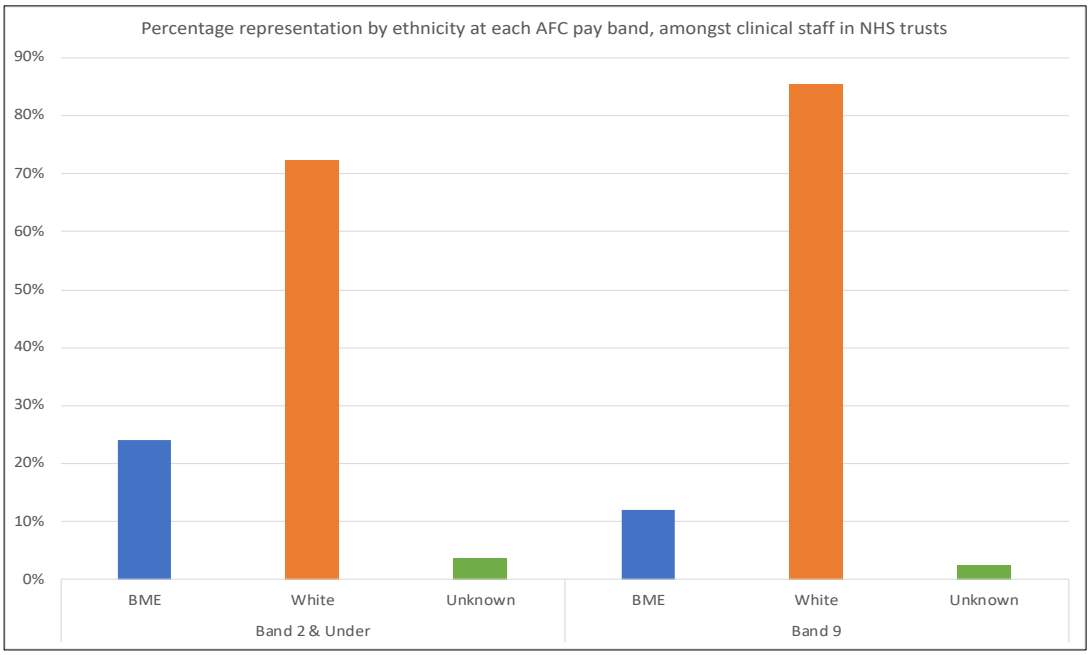

Figure 4 [474]

[474] 'NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts' (NHS England, 2023) <https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/> accessed 30 March 2023.

These figures show that minority groups are systematically overrepresented at lower levels compared to the higher levels of work within the NHS. Even within the NHS recruitment process, research has indicated that a considerable number of white applicants are more likely to be appointed from shortlisting even if potential applicants from BME backgrounds have similar qualifications.[475]

The data pool highlighted one reason why it is important to represent minority workers within different sectors of the NHS. Deputy sister Anu Agboola, who worked at a mental health hospital, emphasised that having someone from her background in sectors such as human resources would help her feel more confident when raising issues. Similarly, if she was referred to consult an occupational therapist, she felt that a worker from her background would be more likely to understand what her struggles were and how to navigate them.[476] As a result, when minority workers are rare in positions of authority, it is more difficult for BME workers' struggles to be recognised and for their voices to be heard. In order to change the experience of the BME staff there is still significant room for improvements to be made.[477] This unequal representation remains a major concern as BME workers will continue to work in the shadow of the snowy white peaks.

1.3 Conducting risk assessment

The discriminatory treatment that BME NHS workers endured during the early stages of the pandemic was brought to light when the first ten doctors who died from Covid-19 were identified as ethnic minority workers.[478] TUC evidence also indicated that one in six BME workers felt that during the Covid-19 pandemic they were put at more risk of exposure to the virus. They believed that due to their ethnic background they were forced to work in the frontline while their white colleagues had the option to refuse.[479] For instance, 28% of BME

[475] Shereen Hussein, 'Low-paid ethnic minority workers in health and social care during COVID-10: A rapid review' (2022).
[476] 'Discrimination' on frontline of coronavirus outbreak may be factor in disproportionate BAME deaths among NHS staff' (ITVX, 2020) <https://www.itv.com/news/2020-05-13/discrimination-frontline-coronavirus-covid19-black-minority-ethnic-bame-deaths-nhs-racism> accessed 18 January 2023.
[477] 'New figures show NHS workforce most diverse it has ever been' (NHS, 2023) <https://www.england.nhs.uk/2023/02/new-figures-show-nhs-workforce-most-diverse-it-has-ever-been/#:~:text=The%20analysis%20shows%20more%20than,Black%20and%20minority%20ethnic%20backgrounds> accessed 11 March 2023.
[478] Christine Ro, 'Coronavirus: Why some racial groups are more vulnerable' (BBC, 2020) <https://www.bbc.com/future/article/20200420-coronavirus-why-some-racial-groups-are-more-vulnerable> accessed 11 March 2023.
[479] 'One in five BME workers treated unfairly at work during Covid-19 – TUC reveals' (Trades Union Congress, 2020) <https://www.tuc.org.uk/news/one-five-bme-workers-treated-unfairly-work-during-covid-19-tuc-reveals#research-analysis> accessed 18 October 2023.

men, which is nearly three in ten male workers, were employed in a field of occupation with a higher male mortality rate. Only 18% of white male workers, which is less than one in five workers, were subjected to working in the same hazardous conditions. Similar to BME men, 20% of female workers, which is one in five female BME workers, were employed in a higher mortality rate context when compared to white female workers, of whom only 14%, nearly one in seven workers, were employed in such a context.

Although all HCWs faced risks during the Covid-19 pandemic, the data suggest that the BME workers suffered these risks more deeply. According to the Office for National Statistics the deaths related to Covid-19 by ethnic group during the 2nd of March 2020 to 15th May 2020 indicated that there were 255.7 black ethnic male deaths per 100,000 population and only 87.0 white male deaths per 100,000. This supports the conclusion that there was an increased mortality risk from Covid-19 for black workers.[480] A substantial amount of evidence indicated the reasons for this disproportionate impact on ethnic minority workers.[481] These include the overrepresentation of BME workers in the frontline as discussed above, shortages of PPE which will be discussed in the following chapter and failing to conduct a suitable risk assessment and act upon it.[482]

Employers are under a legal duty to conduct risk assessments on a regular basis in order to ensure that their employees are protected from stress at work.[483] Assessing the risk of stress is important as it could impact a worker's physical and mental health, adversely affecting the quality of care they provide.[484] According to the HSE, stress is defined as the negative reaction to excessive pressure and demands on workers during work.[485] The main piece of legislation on health and safety, the HSWA, places a duty of care on employers to safeguard workers from experiencing risk of stress at work and to take reasonably practicable steps to

[480] 'Coronavirus (Covid-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020' (Office for National Statistics) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbyethnicgroupenglandandwales/2march2020to15may2020> accessed 18 October 2023.
[481] Youssof Oskrochi, Samir Jeaj, Robert Aldridge, et al., 'Not by choice – the unequal impact of the COVID-19 pandemic on disempowered ethnic minority and migrant communities' (Race Equality Foundation, 2023) <https://www.doctorsoftheworld.org.uk/wp-content/uploads/2018/11/Not-by-choice.pdf> accessed 08 November 2023, 'Disparities in the risk ad outcomes of COVID-19' (Public Health England, 2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf> accessed 08 June 2023.
[482] Akaninyene Out, Bright Opoku Ahinkorah, Edward Kwabena, et al., 'One country, two crises: what Covid-19 reveals about health inequalities among BAME communities in the United Kingdom and the sustainability of its health system?' (International journal for Equity in Health, 2020).
[483] 'What is the Health and Safety at Work Act? (Trades Union Congress, 2022) <https://www.tuc.org.uk/guidance/what-health-and-safety-work-act> accessed 08 June 2023.
[484] 'Stress' (UNISON) <https://www.unison.org.uk/get-help/knowledge/health-and-safety/stress/#:~:text=Key%20facts,work%20or%20other%20working%20conditions> accessed 08 November 2023.
[485] 'Work-related stress and how to manage it' (Health and Safety Executive) <https://www.hse.gov.uk/stress/overview.htm> accessed 08 November 2023.

manage and reduce the risk.[486] The Management of Health and Safety at Work Regulations 1999 require employers to assess risk associated with stress at work and protect workers' health and safety by creating a suitable and sufficient assessment similar to any other hazard at work.[487]

When carrying out risk assessments, employers are required to identify risk factors with the use of Management Standards (MS). According to the HSE, MS are tools that can be used by employers to conduct risk assessment to properly manage the health and wellbeing of employees.[488] The MS cover six key areas that can lead to work related stress; firstly, *demands*, which was one of the most prevalent difficulties HCWs experienced during the Covid-19 pandemic.[489] *Control* takes different forms within a workplace, especially for NHS workers during the Covid-19 pandemic as they did not have any control of how the virus affected individuals nor their work schedules when treating patients.[490] *Support* indicates that having a supportive work environment, supportive colleagues and managers is crucial in the healthcare system which was frighteningly scarce during the Covid-19 pandemic.[491] *Relationships* can be important, whether it is with their patients, line managers, colleagues or people outside of their work who could affect a workers' stress which was complicated during the Covid-19 pandemic.[492] *Job role* constantly evolved during the pandemic as HCWs were required to work in unique and unfamiliar ways and work beyond their existing roles.[493] *Change* affected almost all HCWs in the NHS as the pandemic challenged workers to work in an unprecedented environment and adopt to new strategies when treating patients.[494]

Having identified the risks, it is important for employers to determine how to reduce and remove those risks, in order to manage an employee's stress. This is an important stage, as when conducting a risk assessment, the HSE encourages employers to work alongside their

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[486] 'Understanding the law Managing work- related stress' (ACAS, 2023) <https://www.acas.org.uk/managing-work-related-stress/understanding-the-law#:~:text=By%20law%2C%20employers%20must%20carry,remove%20or%20reduce%20the%20risks> accessed 08 February 2024.
[487] 'Managing work-related stress as part of prevention culture' (Health and Safety Executive, 2018) <https://books.hse.gov.uk/gempdf/Managing_WRS_as_part_of_a_prevention_culture.pdf> accessed 08 February 2024.
[488] 'What are the Management Standards' (Health and Safety Executive) <https://www.hse.gov.uk/stress/standards/#:~:text=The%20Management%20Standards%20are%3A,organisation%2C%20line%20management%20and%20colleagues> accessed 08 February 2024.
[489] Rachel Gemine, Gareth R. Davies, Suzanne Tarrant, et al., 'Factors associated with work-related burnout in NHS staff during Covid-19: a cross-sectional mixed methods study' (BMJ, 2021).
[490] Ibid.
[491] Kristina Newman, Yadava Jeve and Pallab Majumder, 'Experiences and emotional strain of NHS frontline workers during the peak of the Covid-10 pandemic' (International Journal of Social Psychiatry, 2022).
[492] Anthony Lloyd, Daniel Briggs, Anthony Ellis, et al., 'Critical Reflections on the Covid-19 Pandemic from the NHS Frontline' (Sociological Research Online, 2023).
[493] Elisa Liberati, Natalie Richards, Janet Willars, et al., 'A qualitative study of experiences of NHS mental healthcare workers during the Covid-19 pandemic' (BMC psychiatry, 2021).
[494] Rachel Barr-Keenan, Tayla Fay, Aleksander Radulovic and Sanja Shetty, 'Identifying positive change within the NHS as a result of the Covid-10 pandemic' (Future Healthcare Journal, 2021).

employees to identify and assess the gap between the current implementations used to reduce work-related stress alongside the MS.[495] The system that the NHS utilised prior to the Covid-19 pandemic needed to be updated in order to bridge the gap of the new and unique vocational risks that affected HCWs' stress at work.[496] Having identified the gaps it is important that employers take necessary actions to alleviate the risks associated with stress at work. When making changes employers should have a record of their findings and actions should be clearly communicated with the employee to make them aware of the potential risks that they could face and the necessary precautions they need to take in order to maintain their stress levels. Lastly, the employer has an obligation to regularly review how the employee is dealing with the action that was designed to reduce their stress at work. According to the HSE, stress related risk assessments require continuous improvements and should not be considered as one-off exercises.[497] This is due to the constantly evolving nature of the work environment and varying types of work activities that employers have to face.

Due to the increased risk of BME individuals contracting the Covid-19 virus and facing extreme consequences it was important to conduct individual risk assessments on a case by case basis.[498] As a means to control the disparities between BME and white NHS workers who were at high risk of infection working in the frontline, employers were advised to conduct a risk assessment and make appropriate arrangements to reduce risks to their health.[499] Risk assessment involved workers having meetings with managers and discussing ways to reduce risks. However, workers felt that there was no consistency in the advice given to workers across the trusts.[500] Workers often had to urge managers to have these meetings and in some instances, they did not consider all the factors that might affect a worker in order to safely carry out their role.[501] It is important to note that on the one hand giving additional attention to workers because of their ethnicity implies that there is an imbalance of worker representation in high-risk work settings. On the other hand, the timing of conducting risk

[495] Robert Kerr, Marie McHugh and Mark McCrory, 'HSE Management Standards and stress-related work outcomes' (Occupational medicine, 2009).
[496] 'Coronavirus (Covid-19)-Advice for workplaces (Health and Safety Executive, 2022) < https://www.hse.gov.uk/coronavirus/> accessed 18 July 2023, Kamlesh Khunti, Amanda Griffiths, Azeem Majeed, et al., 'Assessing risk for healthcare workers during the Covid-19 pandemic' (BMJ, 2021).
[497] 'Work-related stress, A toolkit for organising around work related stress' (UNISON, 2022) <https://www.unison.org.uk/content/uploads/2022/10/27039_stress.pdf> accessed 18 October 2023.
[498] Christopher A Martin, Katherine Woolf, Luke Bryant, et al., 'Coverage, completion and outcomes of Covid-19 risk assessments in a multi-ethnic nationwide cohort of UK healthcare workers: a cross-sectional analysis from the UK-REACH Study' (Occupational and Environmental Medicine, 2023).
[499] A Abbas, S.F Kattab, NAbbas, et al, 'Covid-19 risk assessments: shortcomings in the protection of Black, Asian and Minority Ethnic healthcare workers' (Journal of Hospital Infection, 2020).
[500] 'Experiences of minority ethnic health workers during the Covid-19 pandemic' (Nursing times, 2023) <https://www.nhsbmenetwork.org.uk/wp-content/uploads/2023/06/230508-Experiences-of-minority-ethnic-health-workers-during-the-Covid-19-pandemic.pdf> accessed 18 January 2024.
[501] 'Dying on the job Racism and risk at work' (Trades Union Congress, 2020) <https://www.tuc.org.uk/sites/default/files/2020-06/Dying%20on%20the%20job%20final.pdf> accessed 18 January 2024.

assessments is crucial as some workers had already caught the Covid-19 virus by the time managers wanted to conduct meetings. Serious harm and death could have been avoided if these workers were aware of what risks they were exposing themselves to and how they could have reduced those risks.[502]

1.4 Summary

As mentioned above, BME NHS workers are a substantial group of workers in the UK healthcare system and it is vital to include this group in the research in order to evaluate how the Covid-19 pandemic affected the health and safety of these workers and what the system did to protect them. In this part of the chapter, I aimed to assess whether the mental health of BME workers was supported and safeguarded by the NHS according to health and safety laws during the Covid-19 pandemic. The data analysed above suggests that the NHS failed to protect the health and safety of Black Minority Ethnic workers during the Covid-19 pandemic due to their race. The unfair treatment that BME workers received at work was highlighted due to the disproportionate number of BME workers like Estelle, Sarah, Gabriella and Precious undertaking work in the frontline and the NHS disregarding concerns about their safety at work. Employers should have paid closer attention to these concerns as they were aware of the discrimination that BME workers faced within the NHS, as the organisation formulated the WRES in order to improve equality within the NHS. Employers failed to apply the law that protects the health and safety of workers when it was needed the most. Primary legislation that protects workers' wellbeing at work such as the EqA 2010 and HSWA was overlooked. In the terms used in the EqA 2010, BME workers were treated less favourably due to their race and they were subjected to disadvantages within the work when compared to their white colleagues. The data pool indicated this, showing for example that workers such as Precious had to wash deceased Covid-19 patients while white colleagues were never required to do so. It seems highly doubtful that the employer took reasonably practicable steps, as required by section 2 HSWA, to protect BME workers' health and safety. The employers failed to fulfil their legal duties by failing to conduct adequate risk assessments needed to safeguard workers despite BME workers being more susceptible to contracting the virus and becoming unwell. Although the pandemic affected the lives of all NHS workers, it is clear that the BME community faced added psychological distress due to their ethnicity. This added burden could be the consequence of the underrepresentation of

[502] Anandi Ramamurthy, Sadiq Bhanbhro, Faye Bruce, et al, 'Nursing Narrative: Racism and the Pandemic' (Anti-Racism Research Group, Centre for Culture Media and Society. Sheffield Hallam, 2020) <https://nursingnarratives.com/report-and-press/> accessed 07 February 2023.

BME workers in senior levels and executive positions. Due to this imbalance of worker representation, minority employees are represented at low levels in the NHS grade hierarchy. This is a barrier to their voices being heard and their concerns being echoed up the hierarchy chain as white senior workers in authority are less able to empathise with the unfair discrimination they face within the NHS.

2. Lack of support for migrant workers

"It is often those who contribute to the NHS the most that find themselves at a disadvantage".[503]

The pledge made by the NHS in 1948 to provide accessible healthcare to the whole population required an unprecedented number of HCWs, which inclined the NHS to rely upon the support and contribution of a migrant workforce.[504] Skilled doctors, nurses and auxiliary workers migrated to compensate for staff shortages within the NHS.[505] According to the most recent 2023 NHS workforce statistics, 19% of the HCWs currently identify as non-British nationals. Out of the 1.5 million staff recorded in the NHS, 265,000 are migrant workers, which amounts to approximately one in five HCWs being categorised under a different nationality.[506] The most common nationalities amongst NHS staff are Asian, India having around 60,533 staff followed by Filipino workers having over 34,652 staff.[507] Overall Asian nationals' amount to approximately 8.6% of NHS staff. Workers from African countries are also quite prominent, with Nigeria having around 22,851 workers, followed by Zimbabwean and Ghanaian workers having around 5,917 and 6,134 workers respectively.[508] Over the years, the population of both Asian and African NHS staff has risen drastically, for instance 4.0% of NHS staff had an Asian nationality in 2016 which has risen to 8.6% as of June 2023. Similarly, staff with African nationality rose from 1.8% in 2016 to 3.8% in 2023.[509]

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[503] Mariri Niino, Lauren Brown and Zehui Qiu, 'Migrants in and out of the National Health Service' (The University of Oxford, 2021) <https://www.compas.ox.ac.uk/2021/migrants-in-and-out-of-the-national-health-service/> accessed 08 July 2023.
[504] 'Heart of the Nation' (Migration Museum, 2023) <https://heartofthenation.migrationmuseum.org/on-the-frontline/> accessed 15 July 2023.
[505] Julian M Simpson, Aneez Esmail, Virinder S Kalara, Stephanie J Snow 'Writing migrants back into NHS history: addressing a 'collective amnesia' and its policy implications' (Journal of The Royal Society of Medicine, 2010)
[506] Carl Baker, 'NHS staff from overseas: statistics' (House of Commons Library, UK parliament, 2022) <https://commonslibrary.parliament.uk/research-briefings/cbp-7783/> accessed 08 March 2023.
[507] Ibid.
[508] Christopher A Martin, Katherine Woolf, Luke Bryant, et al., 'Coverage, completion and outcomes of Covid-19 risk assessments in a multi-ethnic nationwide cohort of UK healthcare workers: a cross-sectional analysis from the UK-REACH Study' (Occupational and Environmental Medicine, 2023).
[509] Ibid.

2.1 Immigration hurdles in the race for a successful visa application

The rise in labour migration has continued despite the constantly evolving, increasingly exasperating and stringent restrictions on the immigration of migrant health professionals.[510] There are different hurdles that these migrant workers have to overcome in order to merely qualify to apply for an employment visa to work in the UK. The points-based system (PBS) is one such immigration hurdle that was introduced by the Labour Government in 2008 where non-EU immigrants were given the opportunity to apply for work visas based on their qualifications and personal characteristics rather than only requiring a job offer.[511] Under the PBS an applicant can score a total of seventy points; however, in order for an applicant to be eligible for this category of visa, they must show that the applicant has a job offer that pays the relevant minimum salary, which is normally around £26,200.[512] The sponsor must be a Home Office licensed organisation that offers a job at the appropriate skill level for the applicant and finally the applicant must speak English at level B1 which is the intermediate proficiency.[513] These are some of the basic requirements that will enable an applicant to get the required seventy points. Having obtained the necessary points, a worker would be qualified to apply for a skilled worker visa.[514] Over the years, this system has evolved. Since 2021, both EU and non-EU immigrants are governed by the same rules and subjected to more restrictive immigration rules[515]

The psychological impact a person endures when undergoing the potentially overwhelming process of accurately completing a visa application and anticipating its decision is significant. Some of the main factors that affect this psychological burden include *anxiety and stress related to visa application fees*. The costs of applying for a UK visa depend on

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[510] Marina Fernandez-Reino and Ben Brindle, 'Migrants in the UK Labour Market: An Overview' (The Migration Observatory at the University of Oxford, 2024) <https://migrationobservatory.ox.ac.uk/resources/briefings/migrants-in-the-uk-labour-market-an-overview/> accessed 08 February 2024.

[511] Melanie Gower, CJ McKinney and Georgina Sturge, 'The UK's new points-based immigration system' (House of Commons Library, UK parliament, 2022) <https://commonslibrary.parliament.uk/research-briefings/cbp-8911/> accessed 08 March 2023.

[512] 'The UK's points- based immigration system: An introduction for EU, EEA and Swiss workers' (UK Government, 2021) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1015796/The_UK_s_points-based_immigration_system_-_An_introduction_for_EU_EEA_and_Swiss_workers.pdf> accessed 08 March 2023.

[513] 'The UK's points-based immigration system: information for EU citizens' (GOV.UK, 2021) <https://www.gov.uk/guidance/the-uks-points-based-immigration-system-information-for-eu-citizens#working-in-the-uk> accessed 08 March 2023.

[514] Tom Edgington, 'UK visas: How does the points-based immigration system work?' (BBC, 2023) <https://www.bbc.co.uk/news/uk-48785695> accessed 08 March 2023.

[515] Mihena V Cuibus, 'EU immigration to and from the UK' (The Migration Observatory at the University of Oxford, 2023) <https://migrationobservatory.ox.ac.uk/resources/briefings/eu-migration-to-and-from-the-uk/#:~:text=Before%20Brexit%2C%20free%20movement%20rules,citizens%20from%20non%2DEU%20countries> accessed 08 March 2023.

the visa route chosen by the HCW; for instance, a skilled worker visa application fee could range from £719-£1500. Additionally, an annual sum of £1,035 is required to be paid as the Immigration Health Surcharge (IHS), and in order to demonstrate that the worker can support themselves while in the UK, they need to show a bank balance of at least £1,270.[516] These are the minimum costs that a worker has to expend when applying for a basic level skilled worker visa. One of the HCWs within the data pool who had to expend a bill for a family of four is health care assistant Folasade.[517] She worked at the Midlands hospital as a night shift worker having migrated from Nigeria. Since Folasade has two children she had to pay for a dependant's visa and the IHS which takes a heavy toll on their family life. Having to live with the heavy burden of struggling to pay her monthly rent and trying to pay her loans on top of having to pay the Home Office visa fees has had a negative effect on her health.[518] The Covid-19 pandemic highlighted how unfair some of these costs are for migrant NHS workers, who have to pay these additional fees in order to live in the UK while also providing their unwavering support to patients during a crisis.[519]

The IHS is a payment that workers have to pay annually to access free health services when applying for a work visa. It has been heavily debated during the Covid-19 pandemic.[520] Workers who cannot afford this additional tax may end up leaving the country, which in turn creates staff shortages within the NHS that is already struggling with a chronic short staffing issue.[521] Some HCWs such as Eva Omondi and Jeri Lee had to work additional shifts in order to afford visa fees. Jeri Lee a care home manager who migrated from Jamaica was concerned about working during the pandemic as she was worried about contracting the Covid-19 virus and being unable to work. This catch-22 situation created a cycle where she was worried about getting unwell from the virus which would put a major toll on her wages but having to attend work as she needed to pay her visa fees. This dilemma had a massive psychological impact as she worked three hundred hours on overtime shifts in order to afford

[516] 'Skilled worker visa' (GOV.UK) < https://www.gov.uk/skilled-worker-visa/how-much-it-costs#:~:text=When%20you%20apply%20for%20a,usually%20£1%2C035%20per%20year> accessed 18 August 2023.
[517] Sarah Marsh and Harriet Grant, 'We feel insulted': migrant health workers on PM's refusal to scrap NHS surcharge' (The Guardian, 2022) <https://www.theguardian.com/society/2020/may/20/we-feel-insulted-migrant-health-workers-react-boris-johnson-refusal-to-scrap-nhs-surcharge> accessed 18 August 2023.
[518] 'MV members speak to Guardian about NHS surcharge' (Migrant Voice, 2022) <https://www.migrantvoice.org/press/mv-members-speak-to-guardian-260520102038> accessed 18 August 2023.
[519] Rachael Healy, 'Fighting an unfair fee' (Royal College of Nursing, 2020) <https://www.rcn.org.uk/magazines/Activists/2020/July-2020/Eva-Omondi-immigration-health-surcharge-campaign> accessed 18th August 2023, Steve Gulati, 'Migration- A Personal Story' (University of Birmingham, 2022) <https://www.birmingham.ac.uk/news/2022/migration-a-personal-story> accessed 18 August 2023.
[520] 'The health surcharge' (UNISON) <https://www.unison.org.uk/at-work/health-care/big-issues/more-campaigns/hostile-environment-nhs/the-health-surcharge/> accessed 18 August 2023.
[521] 'Increase in charges on migrant health workers in pay settlement "shameful" says BMA' (British Medical Association, 2023) <https://www.bma.org.uk/bma-media-centre/increase-in-charges-on-migrant-health-workers-in-pay-settlement-shameful-says-bma#:~:text="The%20Immigration%20Health%20Surcharge%20is,for%20abolishing%20this%20tax%20completely> accessed 18 August 2023.

the Home Office fees.[522] HCWs feel outraged by having to shoulder what they perceive to be an unfair financial burden on top of having to pay income tax and National Insurance payments.[523]

In order to alleviate some of the financial burden, the UK government introduced a new exemption scheme, which enabled NHS workers to apply for a reduced visa application fee and to be exempt from the IHS for themselves and their dependants.[524] Although the new exemption scheme eased the financial burden for Tier 2 visa holders working in the healthcare sector, the implementation of the exemption is deeply unfair because it does not apply to other HCWs, especially social care staff.[525] This leaves low paid migrant NHS workers at a disadvantage. Although the UK government agreed to reimburse the payment to workers who paid the IHS a month after 31 March 2020, these reimbursements have yet to be paid.[526] HCW Eva Omondi rejoiced at the government's pledge to discharge workers from this obligation, perceived to be an unfair burden.[527] Eva campaigned for this change since 2018 and many other HCWs supported her as they identified with the idea of a burden that they had to bear. Migrant HCWs are expected to withstand hardships without complaining, as they have little choice but to endure them.[528] However, only a migrant worker is able to understand the vulnerabilities of working in the NHS, having to deal with visa insecurities and financial uncertainties while working on the frontline. This added burden could certainly affect the mental health of workers.

Depression and loss of self-confidence having to isolate from family and friends. During the Covid-19 pandemic, almost all individuals experienced some form of isolation, as the government introduced strict guidelines to minimise the spread of the virus.[529] Lockdown and associated measures increased the levels of loneliness, stress and depression within the

[522] Sarah Marsh and Harriet Grant, 'We feel insulted': migrant health workers on PM's refusal to scrap NHS surcharge' (The Guardian, 2022) <https://www.theguardian.com/society/2020/may/20/we-feel-insulted-migrant-health-workers-react-boris-johnson-refusal-to-scrap-nhs-surcharge> accessed 18 August 2023.
[523] 'Scrap 'unjust' immigration health surcharge for nursing staff, College urges parties' (Royal College of Nursing) <https://www.rcn.org.uk/news-and-events/Press-Releases/surcharge> accessed 14 October 2023.
[524] Rebecca Gilroy, 'Government to scrap health service fees for overseas NHS staff' (Nursing Times, 2020) <https://www.nursingtimes.net/news/policies-and-guidance/breaking-government-scraps-nhs-fees-for-overseas-staff-21-05-2020/> accessed 14 October 2023.
[525] 'The health surcharge' (UNISON) <https://www.unison.org.uk/at-work/health-care/big-issues/more-campaigns/hostile-environment-nhs/the-health-surcharge/> accessed 18 August 2023.
[526] 'UNISON demands action on migrant worker health surcharge' (UNISON, 2023) <https://www.unison.org.uk/news/article/2023/01/unison-demands-action-on-migrant-worker-health-surcharge/> accessed 18 August 2023.
[527] Rachael Healy, 'Fighting an unfair fee' (Royal College of Nursing, 2020) <https://www.rcn.org.uk/magazines/Activists/2020/July-2020/Eva-Omondi-immigration-health-surcharge-campaign> accessed 18 August 2023.
[528] Catherine Vaillancourt-Laflamme, Jane Pillinger, Nicola Yeates, et al., 'Impacts of Covid-19 on migrant health workers: a review of evidence and implications for health care provision' (The Open University, 2022).
[529] 'Coronavirus (Covid-19): What is self-isolation and why is it important?' (GOV.UK, 2020) <https://ukhsa.blog.gov.uk/2020/02/20/what-is-self-isolation-and-why-is-it-important/> accessed 18 August 2023.

general population.[530] However, the extent to which migrant HCWs suffered the psychological effects of isolation was extreme. Having to live far away from 'home' in a new environment, without the people they have always found comfort in was challenging for these workers.[531] Although many HCWs were unable to reunite with their family and friends during the Covid-19 pandemic, many migrant HCWs could not afford to reunite with their families due to financial difficulties. Mictin Ponmala, who worked as a nurse in the NHS, is one of the workers within the data pool who highlighted the indirect effects of the hostile visa and immigration system.[532] Mictin migrated to the UK as a HCW in 2017. Upon his arrival, his visa and his travel fees were entirely covered by the NHS. Mictin was unaware, however, that, as his visa was about to expire, he would have to incur the costs of the renewal application and the IHS. Upon his wife's arrival to the UK, Mictin's visa costs doubled. When Mictin applied for Indefinite Leave to Remain in the UK, the couple had to sustain even higher costs on a single nurse's salary. Their family currently faces a financial dilemma since they are unable to afford a visit to India, along with their son who has never visited, on top of having to make visa payments.

In order to alleviate the distress HCWs face due to loneliness and isolation, the Queen's Nursing Institute launched a listening service 'TalkToUs'.[533] The service provides the opportunity for HCWs to talk with a trained listener in complete confidence about their work, life and difficulties in order to help ease their mental stress.

Paranoia and anxiety due to the uncertainties of visa and immigration laws. Complex and frequently changing immigration rules are shaped by political considerations. It has been argued that the government has failed to provide sufficient resources to support a well-functioning immigration system.[534] Following Brexit, in December 2020, the Tier 2 (General) visa was formally replaced by the Skilled Worker Visa. Although the overall process of applying for a visa is similar for both applications, some notable changes were made to make the long-winded visa process somewhat easier for migrant workers. It should be noted, however, that these changes came during the most challenging period of the Covid pandemic. Migrant workers had to familiarise themselves with these new changes and apply

[530] Kristina Newman, Yadava Jeve and Pallab Majumder, 'Experiences and emotional strain of NHS frontline workers during the peak of the Covid-10 pandemic' (International Journal of Social Psychiatry, 2022).
[531] Emma Baxey, ''The Lonely Professional- The outsider' : Loneliness in internationally recruited nurses' (Maudsley Learning, 2022) <https://maudsleylearning.com/insights/blogs/the-lonely-professional-the-outsider-loneliness-in-internationally-recruited-nurses/> accessed 18 August 2023.
[532] Doaa Khalifeh, 'It's not my story, its every migrant's story' (Migrant Voice) <https://www.migrantvoice.org/our-stories/its-not-my-story-its-280723101357> accessed 18 August 2023.
[533] 'TalkToUs The QNI's Listening Service' (The Queen's Nursing Institute) <https://www.qni.org.uk/wp-content/uploads/2020/12/Talk-to-Us-poster-download.pdf> accessed 18 August 2023.
[534] Colin Yeo, 'Welcome to Britain: Fixing our broken immigration system' (Biteback Publishing, 2022).

for visa extensions while working in the frontline. The government declared its commitment to support migrant workers who continued to work in the front line at an unprecedented time during the pandemic by extending visas free of charge for a year.[535] The initiative was put in place to extend visas that were due to expire before 1 October 2021.[536] The Government's instructions were to "complete a simple online form to verify their identity and for their employers to confirm their eligibility".[537] The procedure of extending visas of migrant workers was not straight forward, however, and the government's declaration to grant free visa extensions to frontline health workers and their dependants should have come with a caveat: since the government only covered workers who held Tier 2 (General) work visas, this excluded workers such as healthcare assistants, porters or cleaners.[538] Furthermore, even if workers did qualify, there was no guarantee of an extension, as there was no legal protection, since these changes were not supported by any statutory instruments.

The data pool included several HCWs who fell victim to this arrangement, which caused them psychological anguish as they desperately wanted to rely on the support of the government. A healthcare assistant from Nigeria dishearteningly stated that the worker did not qualify for the free visa renewal as her immigration status was under the 'wrong' type of visa.[539] As her husband was also a care worker, they had to incur added costs of visa and immigration fees. This financial burden of having to incur additional visa costs despite them paying tax and national insurance was draining as they did not qualify for the free renewal due to her visa expiring outside of the dates set by the Home Office.[540] Similar to the above, a hospital healthcare worker from Kenya failed to meet the criteria set by the Home Office for the free visa extension.[541] She was struggling financially during the pandemic as she became a full-time carer for her husband who fell ill prior to the pandemic. Having to prioritise her family's health over employment placed a heavy mental burden on the worker.

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[535] 'Home Office preparedness for Covid-19 (coronavirus): immigration and visas, Conclusions and recommendations' (Parliament. UK, 2020) <https://publications.parliament.uk/pa/cm5801/cmselect/cmhaff/362/36204.htm> accessed 11 March 2023.
[536] 'Migrant health and care workers- UNISON Briefing' (UNISON, 2020) <https://www.unison.org.uk/content/uploads/2020/10/26211_migrant_health_care_workers_briefing.pdf> accessed 11 March 2023.
[537] 'Visas extended for thousands of frontline health and care workers' (GOV.UK, 2021) <https://www.gov.uk/government/news/visas-extended-for-thousands-of-frontline-health-and-care-workers> accessed 10 March 2023.
[538] Jamie Grierson, 'MPs warned of gaps in plan to extend NHS workers' visas' (The Guardian, 2020) <https://www.theguardian.com/uk-news/2020/apr/21/mps-warned-of-gaps-in-plan-to-extend-nhs-workers-visas> accessed 10 March 2023.
[539] 'Frontline care and health workers face thousands of pounds of government visa charges' (UNISON, 2020) <https://www.unison.org.uk/news/2020/07/frontline-care-health-workers-face-thousands-pounds-government-%E2%80%8Bvisa-charges/> accessed 30 July 2023.
[540] Ibid.
[541] 'Frontline care and health workers face thousands of pounds of government visa charges' (UNISON, 2020) <https://www.unison.org.uk/news/2020/07/frontline-care-health-workers-face-thousands-pounds-government-%E2%80%8Bvisa-charges/> accessed 30 July 2023.

If she had qualified for the government visa renewal, this would have alleviated her financial burden and her mental health. Lastly, a HCW from the Philippines who also failed to qualify for the free government extension was distressed because she was struggling to make ends meet.[542] She was unable to attend work as she was pregnant and was shielding at home. Due to her immigration status, they did not qualify for any child benefits or state support which put her in a vulnerable position as she would have to incur visa costs and IHS for a family of four and bear the constantly increasing immigration charges.

Anxiety and worry of deportation risk. Despite migrant NHS workers risking their lives to provide adequate patient care during the Covid-19 pandemic, some faced the possibility of deportation. The uncertain nature of a migrant worker's immigration status can impact upon their ability to perform their role effectively due to the unnecessary stress and anxiety.[543] Arun Panabaka, a senior nursing assistant, migrated to the UK on a family visa in 2019.[544] When the Covid-19 crisis struck, Arun was working, like many other NHS migrant workers, on the frontline. He was redeployed to a Covid-19 ward where he worked in the intensive care unit. He was living in university accommodation for four months, isolated from his family. In addition to the challenging working conditions, not knowing if he might get infected with the virus, he was also preoccupied with the fear of his visa expiring and being deported from the country. Arun states that "on top of the mental and physical strain of working through the pandemic, I used to check the immigration rules every single day".[545] Arun was hopeful that his visa would be extended, as the government was having discussions about extending frontline NHS workers' visas. Arun further states that, "these immigration measures are punishing NHS patients. When there are so many vacancies, people are dying because there aren't sufficient staff. And even then, all the government wants to do is stop immigration".[546] It is important to note that during the critical period of the pandemic, discussions were held by the Migration Advisory Committee (MAC), which is an independent public body that advises the government regarding issues on migration.[547] The MAC put forward recommendations to renew visas of migrant workers and if they should be included on the shortage occupation list. These recommendations were rejected by the

[542] Ibid.
[543] Kitty Worthing, Marta Mojarrieta Galaso, Johanna Kellett Weight, et al., 'Patients or passports? The hostile environment' in the NHS' (Future healthcare journal, 2021).
[544] Janey Starling, 'How the Home Office is risking lives in the NHS' (UNISON, 2020) <https://magazine.unison.org.uk/2020/11/20/how-the-home-office-is-risking-lives-in-the-nhs/> accessed 08 March 2023.
[545] Ibid.
[546] 'Frontline care and health workers face thousands of pounds of government visa charges' (UNISON, 2020) <https://www.unison.org.uk/news/2020/07/frontline-care-health-workers-face-thousands-pounds-government-%E2%80%8Bvisa-charges/> accessed 10 March 2023.
[547] 'The Migration Advisory Committee' (GOV.UK, 2023) <https://www.gov.uk/government/organisations/migration-advisory-committee/about> accessed 08 March 2023.

then Home Secretary Priti Patel in October 2021, which resulted in workers who were professionally qualified and experienced leaving the NHS. In practice only about 14,000 visas of migrant workers were extended.[548] Despite the NHS being understaffed and having over 100,000 vacancies in health and social care, Arun was forced to return to India once his visa expired in October. The government failed to extend visas of migrant workers and was reluctant to employ additional workers leaving the NHS in a state that was worse than when the pandemic struck.

2.2 PPE required beyond this point

During the early stages of the Covid-19 pandemic, Dr Meenal Viz, a migrant healthcare worker, was a frontrunner in striving to achieve justice for the HCWs experiencing systemic challenges within the NHS. Born and raised in Gibraltar, Dr Viz became a doctor in 2018 and migrated to the UK to work for the NHS.[549] It was during this period that she experienced racism first- hand. Having to put up with comments such as "I don't want to be seen by an Indian doctor. I want a white doctor" complicated her opinion of the NHS.[550] When the pandemic hit, however, a lot of issues in the healthcare system regarding social injustice, inequalities, racism and sexual discrimination were brought to light. It was at this moment that Dr Viz decided to take action and to speak up, as HCWs of ethnic minority groups were dying at an alarming rate and their deaths were going unacknowledged.[551] Even in instances when she raised concerns to managers regarding the working conditions, the managers would disregard her concerns and shrug off their responsibilities.

Following the death of nurse Mary Agyapong, Dr Viz questioned the significance of the health and safety laws and their capacity to protect HCWs adequately in an instance such as the Covid-19 pandemic. Nurse Agyapong was a healthcare worker who was eight months pregnant working twelve-hour shifts during the Covid-19 pandemic. While at work, she contracted covid and she was faced with no choice but to have her baby delivered via emergency c-section. She later died whilst at the Intensive Treatment Unit (ITU). This

[548] 'Visas extended for thousands of frontline health and care workers' (GOV.UK, 2021) <https://www.gov.uk/government/news/visas-extended-for-thousands-of-frontline-health-and-care-workers> accessed 10 March 2023.
[549] 'I held a One-Woman Protest After the Death of a Nurse from Covid-19. Here's Why It Mattered' (Global Citizens, 2020) <https://www.globalcitizen.org/en/content/health-care-protests-meenal-viz/> accessed 18 June 2023.
[550] Ibid.
[551] Suzie Bailey and Michael West, 'Ethnic minority deaths and Covid-19: what are we to do?' (The King's Fund, 2020) <https://www.kingsfund.org.uk/insight-and-analysis/blogs/ethnic-minority-deaths-covid-19#:~:text=Of%20119%20NHS%20staff%20known,from%20an%20ethnic%20minority%20background> accessed 18 June 2023.

shocking incident highlighted the need for proper health and safety laws at work for HCWs and how they should be regulated during a global pandemic. Dr Viz found this information particularly distressing as she was herself pregnant whilst working in the Accident and Emergency (A&E). She states that no form of risk assessment was conducted and when concerns were raised regarding the infection of Covid-19 the managers stated that there was not sufficient evidence to show that pregnant women could get affected by Covid-19. This lead Dr Viz to conduct a protest at Downing Street in order to emphasise and remind politicians of the rights of HCWs.

© BBC[552]

Six days after nurse Agyapong's death on the 19th of April 2020, Dr Viz began her protest.[553] She states that "As a South Asian pregnant woman, I thought who would listen to me and take on my concerns? I've realised if you scream loud enough and for long enough, someone will hear you".[554] This was exactly what Dr Viz achieved, overnight her protests went viral over social media and started to gain a lot of interest and debate surrounding the topic of health and safety.[555]

The need for appropriate PPE for NHS staff and the concerns regarding the proper use of PPE during the pandemic provoked Dr Viz to file for judicial review in May. Her application concerned the government's guidance on PPE. She argued that unclear advice and guidance

[552] 'Coronavirus: Doctors hail progress after PPE legal Challenge' (BBC, 2020) <https://www.bbc.co.uk/news/uk-england-beds-bucks-herts-55497010> accessed 18 June 2023.
[553] David Keen, 'Does democracy protect? The United Kingdom, the United States, and Covid-19' (Disasters, 2021).
[554] Ibid.
[555] Carole Cadwalladr, 'They can't get away with this': doctor who took protest to No 10' (The Guardian, 2020) <https://www.theguardian.com/society/2020/apr/20/coronavirus-doctor-ppe-protest-downing-street-london> accessed 18 June 2023.

across the different NHS trusts exposed workers to greater risks of contracting the virus, especially BME workers. This risk was heightened by the failure to disclose the risk levels associated with the use of different PPE and the fact that the guidance did not align with either the health and safety legislation under the HSWA or the international standards set by the World Health Organisation.[556] This landmark protest brought about positive changes as NHS doctors were no longer required to reuse surgical masks. The judicial review was brought to a close without the need to attend court as both parties concluded that appropriate changes were made with regards to the use of PPE.[557]

2.3 Summary

It is beyond doubt that the NHS would struggle to provide sufficient and adequate patient care without the support of migrant HCWs. This was evident during the Covid-19 pandemic due to the alarming rise in patient care that was required by the NHS workforce. This section addressed the question whether the mental health of migrant workers was safeguarded and supported in line with health and safety laws pertaining to mental health during the Covid-19 pandemic. The data analysed above suggests that the NHS failed to fulfil its duty of care in return for the immeasurable service that migrant NHS workers provided during the Covid-19 pandemic. It is no surprise that the pandemic was detrimental and challenging to almost all NHS HCWs however, a migrant NHS HCW had the added burden of having to ensure that they were aware of the constantly evolving visa and immigration rules and were able to afford the extortionate visa fees. The psychological effects that these workers had to withstand were not always taken into consideration by the employers, which at times acted as if they believed that migrant workers were expendable. Workers suffered anxiety and stress due to the excessive visa charges that they had to pay and – somewhat ironically – were required to pay an annual fee to access free health service while the workers themselves were at the forefront providing free healthcare especially during the Covid-19 pandemic. Although the UK government introduced new measures to alleviate costs by exempting workers from paying the IHS, this exemption was not a blanket provision that applied to all migrant NHS workers which caused further discrepancies within the migrant worker community. This created confusion for migrant workers as they were unaware of the rules

[556] Clare Dyer, 'Doctors challenge legality of PPE guidance' (BMJ, 2020) <https://www.bmj.com/bmj/section-pdf/1026250?path=/bmj/369/8243/This_Week.full.pdf> accessed 08 June 2023, Basmah Sahib, 'Legal challenge against the UK government's guidance about personal protective equipment in hospitals' (Bindmans, 2020) <https://www.bindmans.com/knowledge-hub/news/legal-challenge-against-the-uk-governments-guidance-about-personal-protective-equipment-in-hospitals/> accessed 08 June 2023

[557] 'Coronavirus: PPE legal challenge doctors push for judicial review' (BBC, 2020) <https://www.bbc.co.uk/news/uk-england-beds-bucks-herts-52758517> accessed 08 June 2023.

that applied to individual workers. Although various trade unions voiced their concerns regarding this unfair treatment of migrant workers the NHS failed to take action to support its employees.

Sustaining good social and personal relationships was crucial during the Covid-19 pandemic as it provided emotional support, higher self-esteem and reduced stress which was necessary as it had a positive impact on workers' wellbeing. Since migrant workers were subjected to visa restrictions and in light of the added costs of airfare, it was often impossible for workers to find such comforts during the pandemic. Workers' emotional and mental wellbeing were not supported by their employers and minimum action was taken to mitigate such risks. The anxiety that workers' felt due to the fear of being deported from the country was problematic, as it not only affected the migrant workers, but it also put added pressure on the healthcare system jeopardising the quality of care provided to their patients. Despite this chain of events the NHS did not challenge the UK government's unfair treatment of migrant workers. Although the NHS failed to stand up and support this marginalised community, migrant workers took it upon themselves to ensure their safety whilst at work. Dr Meenal Viz protested regarding the right to adequate PPE as workers were not provided with the necessary resources to provide care and carry out their role. This is an indication of how powerful taking a stand can be as it led to change within the community. This begs the question of why an individual migrant NHS worker had to protest in order for her basic rights to be fulfilled and why did the NHS fail to provide adequate health and safety to its workers from the outset.

3. Supply of Personal Protective Equipment

Since the beginning of the pandemic, the use of PPE has attracted a lot of attention for a number of different reasons. These include the public panic-buying PPE, the hoarding and misusing of equipment and misinformation being spread amongst the public regarding the use of PPE, all of which caused a rise in demand.[558] This resulted in frontline workers, doctors and nurses having a shortage of supplies such as medical masks, gloves, face shields, gowns and aprons, which ultimately resulted in HCWs being dangerously ill-equipped to care for Covid-19 infected patients.[559]

[558] Fadela Chaib, 'Shortage of personal protective equipment endangering health workers worldwide' (WHO, 2020) <https://www.who.int/news/item/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide> accessed 21 May 2023.
[559] Ibid.

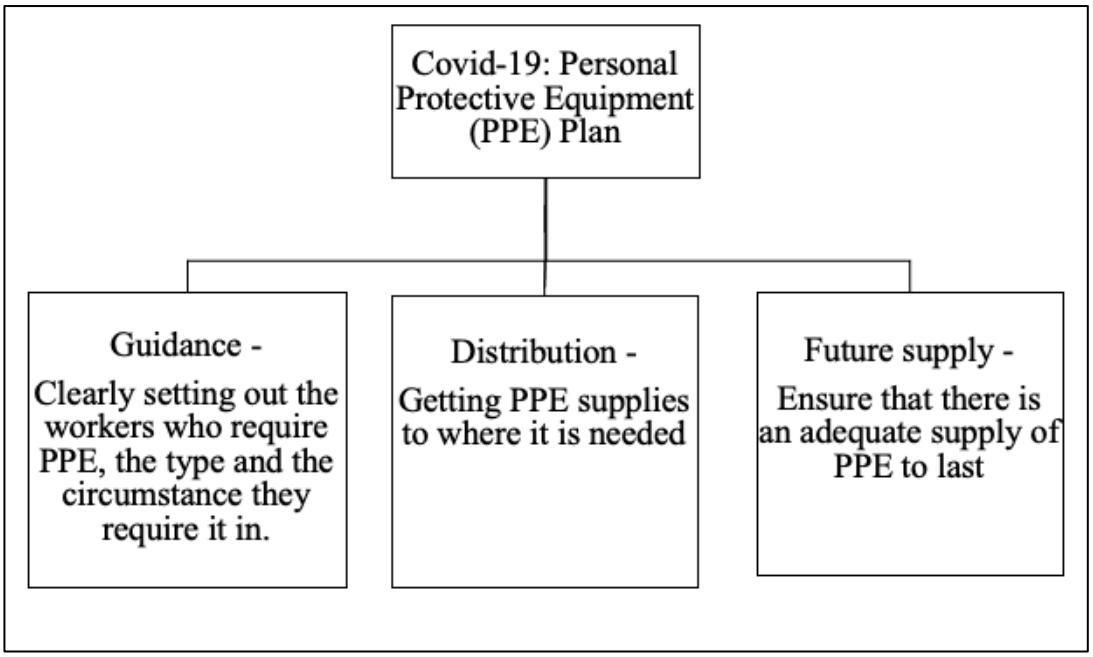
NHS workers who were at the receiving end of these shortages were pushed to their limits, having to work with the risk of contracting the virus in order to fulfil their contractual duties as HCWs. In a survey conducted by the Royal College of Nurses, with a questionnaire emailed to all RCN members, a third of the 5,023 respondents stated that they felt pressured to work during the Covid-19 pandemic without adequate PPE.[560] In a similar survey conducted by the British Medical Association, over half of the workers were unsure of their safety working in a covid infected environment.[561]

In order to ensure that the health and safety of HCWs are protected, so that they can provide satisfactory care to patients, access to high quality PPE is essential. Health and safety legislation places employers under a legal duty to ensure that their employees are protected from health and safety risks by conducting suitable and sufficient risk assessments and appropriate measures are put in place to minimise the risk of harm to employees as far as it is reasonably practicable.[562] Furthermore, the PPER 2022 entrusts duties on employers to ensure that PPE is used correctly by workers, maintained and stored properly, provided with instructions on how to use it safely and properly assessed before use to make sure it is fit for purpose.[563]

On 10th April 2020, the UK government published the 'Covid-19: Personal Protective Equipment Plan' with the intention of making sure that HCWs had access to proper PPE. The PPE plan had three distinctive pillars: guidance, distribution and future supply.[564]

[560] 'Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the Covid-19 pandemic' (Royal College of Nursing, 2020) <https://www.rcn.org.uk/professional-development/publications/rcn-second-ppe-survey-covid-19-pub009269> accessed 20 May 2023.
[561] 'BMA Covid Tracker Survey- repeated questions' (British Medical Association) <https://www.bma.org.uk/media/2513/bma-covid-surveys-tracker-tables.pdf> accessed 20 May 2023.
[562] 'Do employers have to provide personal protective equipment (PPE)?' (Health and Safety Executive) <https://www.hse.gov.uk/contact/faqs/ppe.htm> accessed 21 May 2023.
[563] 'Using personal protective equipment (PPE) to control risks at work' (Health and Safety Executive) <https://www.hse.gov.uk/ppe/overview.htm> accessed 21 May 2023.
[564] 'Covid-19: Personal Protective equipment (PPE) Plan' (Department of Health and Social Care, 2020) <https://assets.publishing.service.gov.uk/media/5f72097d8fa8f51890c6ba25/Coronavirus__COVID-19__-_personal_protective_equipment__PPE__plan.pdf> accessed 20 May 2023.

Figure 5: The three pillars of the Personal Protective Equipment Plan



Under the first strand the government guarantees that workers who are in the frontline will be provided with PPE to ensure that they carry out their work safely. Especially workers such as clinicians and care professionals were advised to wear eye protection, surgical masks, gloves and an apron when treating patients who are suspected or confirmed to have the Covid-19 virus. Moreover, as an added layer of security, clinicians who work in environments that generate airborne droplets were required to use additional protection in the form of disposable gowns, face shielding and filtering respirators. The guidance was put in place to provide clarity to HCWs and show how the government was trying to safeguard their health and safety. The government made every effort to ensure that the guidance was consistent with WHO guidance on health and safety.[565]

After providing guidance on who requires PPE, the government sought to deliver the PPE to the workers in a timely manner. The report states that the UK was well prepared with a national stockpile of PPE equipment reserved for a pandemic outbreak. Although intentions were set on providing PPE promptly to HCWs, however, in practice this was far from reality. As mentioned above by different trade unions, NHS HCWs did not have access to PPE in a timely manner. All sources of data point towards the same conclusion, that there was a PPE shortage across the UK.[566]

Finally, the last strand of the plan intended to ensure that there was an adequate stockpile of PPE for frontline workers to see them through the pandemic. The government contracted with more suppliers to coordinate procurement programmes. These negotiations were not always successful. For instance, during the first year of the pandemic, the UK government lost 4 billion pounds worth of PPE due to it being unusable.[567] The haphazard purchasing of PPE has undeniably turned the spotlight on government strategy, however, ultimately it was the frontline workers who were working during unprecedented times that reaped the consequences of the government's careless policy decisions.

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[565] 'Covid-19: Personal Protective equipment (PPE) Plan' (Department of Health and Social Care, 2020) <https://assets.publishing.service.gov.uk/media/5f72097d8fa8f51890c6ba25/Coronavirus__COVID-19__-_personal_protective_equipment__PPE__plan.pdf> accessed 20 May 2023.

[566] 'The supply of personal protective equipment (PPE) during the Covid-19 pandemic' (Department of Health and Social Care, 2020) <https://www.nao.org.uk/wp-content/uploads/2020/11/The-supply-of-personal-protective-equipment-PPE-during-the-COVID-19-pandemic-Summary.pdf> accessed 21 July 2023. David Oliver, 'Lack of PPE betrays NHS clinical staff' (BMJ, 2021) <https://www.bmj.com/content/372/bmj.n438> accessed 21 July 2023. Tim Tonkin, 'Let down' (British Medical Association, 2022) <https://www.bma.org.uk/news-and-opinion/let-down#:~:text=PPE%20failings,guidance%20once%20the%20pandemic%20began> accessed 21 July 2023.

[567] '£4 billion of unusable PPE bought in first year of pandemic will be burnt "to generate power" (UK Parliament, 2022) <https://committees.parliament.uk/committee/127/public-accounts-committee/news/171306/4-billion-of-unusable-ppe-bought-in-first-year-of-pandemic-will-be-burnt-to-generate-power/> accessed 21 June 2023.

3.1 One-size-'does not'-fit-all !

The Covid-19 virus affected everyone irrespective of their age, race/ethnicity, gender or social status.[568] Across the NHS, however, female HCWs were disproportionately exposed to the perils of the Covid-19 virus due to the ill-fitting PPE provided to them by their employers.[569] In a study conducted by the TUC, it was reported that, in general, PPE was intended to fit the characteristics of the male population and was designed to fit the size of an average European or white United States (US) male's face and body.[570] Consequently, not only female workers but male employees were affected by this biased protective equipment sizing.[571] The study also revealed NHS workers' experience with the use of PPE, the equipment of different extremes. For instance, on the one hand, safety boots were too large in size for female workers, on the other, clothing items such as T-shirts were often tight-fitting, unlike the male version. Workers' movements were constrained and they were unable to work when wearing form-fitting clothing at work. At times, the equipment appeared to have been manufactured with aesthetics rather than practicality in mind. The shape and size of PPE was problematic and unsuitable to female HCWs prior to the Covid-19 pandemic.[572] However, the relentless and prolonged use of PPE during the pandemic exacerbated the dormant issues that female HCWs associated with PPE.

The types of protective equipment used in the healthcare profession enable workers to minimise and prevent contact with infectious agents and bodily fluids.[573] Goggles provide protection to the workers' eyes, respirators and face masks protect the mouth and nose, the entire face is protected by face shields, gloves keep the hands protected and aprons and gowns provide protection to the skin and/or clothing.[574] Such protective equipment should be selected on an individual basis to ensure that the equipment fits the workers by

[568] Neeta Kantamneni, 'The impact of the Covid-19 pandemic on marginalized populations in the United States: A research agenda' (Journal of vocational behaviour, 2020).
[569] Lauren Sproule, 'From pay gap to ill-fitting PPE, female workers highlight challengers in U.K health care' (CBC News, 2020) < https://www.cbc.ca/news/world/uk-health-care-gender-bias-1.5741670> accessed 21 May 2023.
[570] D J Janson, B C Clift and V Dhokia, 'PPE fit of healthcare workers during the Covid-19 pandemic' (Applied ergonomics, 2022), 'Personal protective equipment and women' ((Trades Union Congress, 2017) <https://www.tuc.org.uk/sites/default/files/PPEandwomenguidance.pdf> accessed 21 May 2023.
[571] 'Personal protective equipment and women' ((Trades Union Congress, 2017) <https://www.tuc.org.uk/sites/default/files/PPEandwomenguidance.pdf> accessed 21 May 2023.
[572] Caroline Criado Perez, 'Another truth from the Covid inquiry: women were being ignored over ill-fitting PPE long before the pandemic' (The Guardian, 2023) <https://www.theguardian.com/commentisfree/2023/nov/03/covid-inquiry-women-ill-fitting-ppe-pandemic-unisex-healthcare> accessed 30 January 2024.
[573] Jos H Verbeek, Blair Rajamaki, Sharea Ijaz, et al., 'Personal protective equipment for preventing highly infectious diseases due to exposure to contaminated body fluids in healthcare staff' (Cochrane database of systematic reviews, 2020)
[574] 'Public Health England Covid-19: infection prevention and control guidance' (Public Health England, 2020) < https://webarchive.nationalarchives.gov.uk/ukgwa/20200623134104/https://madeinheene.hee.nhs.uk/Portals/0/COVID-19%20Infection%20prevention%20and%20control%20guidance%20v3%20%2819_05_2020%29.pdf> accessed 21 May 2023, 'Personal Protective Equipment (PPE): Protect the Workers with PPE' (National Institute for Occupational Safety and Health, 2017) <https://www.cdc.gov/niosh/learning/safetyculturehc/module-3/7.html> accessed 21 May 2023.

considering the fit, size, compatibility and weight of the PPE against the physical characteristics of the employee.[575]

The data highlighted the experience of acute medicine doctor Amun Sandhu who worked during the Covid-19 pandemic in NHS East London. She recalls that during the inception of the pandemic, in order to ensure that the PPE was satisfactory for HCWs, the PPE was fit-tested. The aim of the test was to determine the reliability and suitability of the PPE for health workers. The test involved mimicking the virus by spraying a fine mist over the workers' faces. The PPE was deemed reliable if the workers could not smell or taste the spray. However, healthcare worker Sandhu along with many other female workers were able to taste a bitter taste in the back of their throats and an orange smell through their PPE.[576] This indicates that the protective masks that they were wearing were ill-fitting for female HCWs. Sandhu states that the employer failed to take into consideration the female workers' safety during a time period where suitable PPE was necessary.[577] Female workers had to resort to using tape to alter the extra, extra-large scrubs and when there was a shortage of surgical caps, workers used the excess material from the gowns as replacements. In theory, HCWs should not be required to alter protective equipment as the employers have a legal duty according to Regulation 4 of the PPER 2022 to ensure that suitable PPE is provided to the workers.[578] Sandhu's right to appropriate PPE was breached by her employer during the Covid-19 pandemic which had a direct effect on her mental health as she felt unprotected providing care without suitable PPE to potentially Covid infected patients.

Female HCWs were given hardly any options on how to handle the issues with regards to ill-fitting PPE. They either had the option of sharing respirators, with the risk of infection due to the lack of proper cleaning or wearing ill-fitting protective equipment.[579] Female workers were required to provide care to patients regardless of the improper PPE and prompted to put the patients above their own safety.

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[575] 'Using personal protective equipment (PPE) to control risks at work' (Health and Safety Executive) <https://www.hse.gov.uk/ppe/selection-and-use.htm#:~:text=Select%20equipment%20that%20suits%20the,if%20sleeves%20are%20too%20long> accessed 21 May 2023.
[576] Lauren Sproule, 'From pay gap to ill-fitting PPE, female workers highlight challengers in U.K health care' (CBC News, 2020) <https://www.cbc.ca/news/world/uk-health-care-gender-bias-1.5741670> accessed 21 May 2023.
[577] Lauren Sproule, 'From pay gap to ill-fitting PPE, female workers highlight challengers in U.K health care' (CBC News, 2020) <https://www.cbc.ca/news/world/uk-health-care-gender-bias-1.5741670> accessed 21 May 2023.
[578] Personal Protective Equipment at Work (Amendment) Regulations 2022, Regulation 4.
[579] Abhijoy Chakladar and Anna Ascott, 'Personal protective equipment' (BMJ, 2021) <https://blogs.bmj.com/bmj/2021/03/09/personal-protective-equipment-is-sexist/#:~:text=Covid%2D19%20has%20highlighted%20concerns,well%20as%20their%20males%20colleagues> accessed 21 May 2023.

This treatment within the workplace is discriminatory towards female HCWs. Discrimination law encompasses nine protected characteristic and under the Equality Act 2010 sex is one of the nine protected characteristics.[580] The law simply states sex discrimination is where a male or a female worker is treated less favourably at work because of their sex.[581] This includes direct and indirect discrimination, harassment and victimisation. In this instance where female HCWs were routinely expected to work with ill-fitting PPE and expected to provide care to patients without adequate protection amounts to indirect sex discrimination. The Equality Act 2010 defines indirect sex discrimination as a situation where a working practice, policy or rule is applied to everyone, yet it places a person or group of people at a disadvantage due to their sex.[582] In this instance, PPE is provided to all the staff regardless of their sex, however, due to the design of the PPE predominately being favourable for the male body it places women at a particular disadvantage.

Female HCWs were at a disadvantage having to work during the pandemic with ill-fitting protective equipment when compared to male HCWs.[583] Female HCWs reported that protective equipment such as goggles were constantly slipping as they were too big for their face, gowns were long, respirators did not fit the female faces and face shields pushed against their breasts.[584] The biological features of female workers were not taken into consideration when manufacturing protective equipment which resulted in less favourable treatment towards female workers. Women make up almost three-quarters of the NHS in England, yet these workers had to withstand working in a covid-infected environment with unsuitable protective equipment. Dr Fidler who works as a consultant gastroenterologist stated that PPE not being available in smaller sizers was discriminatory towards female NHS workers as it is uncomfortable to work a twelve-hour shift with ill-fitting PPE.[585]

The primary purpose of using PPE is to protect the workers from the hazards that they are exposed to at work. In the context of HCWs, protective equipment is used to create a barrier

[580] Equality Act 2010. Section 11, 'Discrimination: your rights' (GOV.UK, 2010) <https://www.gov.uk/discrimination-your-rights> accessed 11 August 2023.
[581] Equality Act 2010. Section 13(1).
[582] 'Sex discrimination Types of sex discrimination' (ACAS, 2024) <https://www.acas.org.uk/sex-discrimination/types-of-sex-discrimination> accessed 11 January 2024.
[583] Carlie Porterfield, 'A lot of PPE doesn't fit women – and in the Coronavirus Pandemic, it puts them in danger' (Forbes, 2020) <https://www.forbes.com/sites/carlieporterfield/2020/04/29/a-lot-of-ppe-doesnt-fit-women-and-in-the-coronavirus-pandemic-it-puts-them-in-danger/> accessed 11 August 2023.
[584] Anna Ascott, Paul Crowest, Eleanor de Sausmarez, et al., 'Respiratory personal protective equipment for healthcare workers: impact of sex differences on respirator fir test results' (British Journal of Anaesthesia, 2021).
[585] Maya Oppenheim, 'Female NHS staff at risk due to not being able to 'access protective gear correctly sized for women' (Independent, 2020) <https://www.independent.co.uk/news/uk/home-news/coronavirus-ppe-women-wrong-size-doctors-nurses-uk-cases-a9476766.html> accessed 11 August 2023.

to safeguard the workers and the patients from contamination.[586] Ill-fitting protective equipment defeated this purpose as workers reported having difficulty communicating with patients when wearing surgical masks and visors.[587] The suggestion that female HCWs encountered discriminatory treatment was further reinforced in a study conducted by Loughborough University and the University Hospitals of Leicester NHS Trusts. There, a significantly higher number of female workers had issues with protective equipment when compared to male workers. In the study of over 400 clinician responses, 292 women reported that they had problems with protective equipment.[588] This significant difference implies that NHS female HCWs may have required special training on how to manage the prolonged use of PPE, overheating and fatigue.[589]

3.2 Mind the training gap

The Covid-19 pandemic reiterated the importance of the use of PPE, which provided the protective barrier necessary to restrain the airborne droplets of saliva loaded with the virus.[590] While the use of PPE was crucial when caring for the potentially Covid infected patients, it was equally important to receive appropriate training on the proper use of protective equipment. Training enables workers to know when and what type of PPE is necessary while providing care to patients and can reduce the misuse and over-consumption of PPE. Furthermore, proper use of PPE reduces the transmission of the virus especially when following the correct sequence of donning and doffing protective equipment.[591] However, HCWs reported that during the Covid-19 pandemic there was a training gap on the use of protective equipment and how to safely don and doff PPE.[592]

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[586] 'Using personal protective equipment (PPE) to control risks at work' (Health and Safety Executive) <https://www.hse.gov.uk/ppe/overview.htm> accessed 19 November 2023, 'Coronavirus staff guidance PPE key principles' (NHS, 2021) <https://www.uhb.nhs.uk/coronavirus-staff/ppe-key-principles.htm> accessed 11 August 2023.
[587] Shazia P Sharif and Elizabeth Blagrove, 'Covid-19, masks and communication in the operating theatre: the importance of face value' (Psychological medicine, 2022), T Hampton, R Crunkhorn, N Lowe, 'The negative impact of wearing personal protective equipment on communication during coronavirus disease 2019' (The Journal of Laryngology & Otology, 2020).
[588] Sue Hignett, Ruth Welsh and Jay Banerjee, 'Human factors issues of working in personal protective equipment during the Covid-19 pandemic' (Anaesthesia, 2021).
[589] 'Women Clinicians report significant difficulties with coronavirus PPE: "Apparently masks for smaller faces don't exist!"' (Loughborough University. 2020) <https://www.lboro.ac.uk/news-events/news/2020/july/women-report-more-issues-with-ppe-then-men/> accessed 11 August 2023.
[590] Michelle Roberts, 'Coronavirus: Has the NHS got enough of the right PPE?' (BBC, 2021) <https://www.bbc.co.uk/news/health-52254745> accessed 25 March 2023.
[591] Robert McCarthy, Bruno Gino, Philip d'Entremont, et al., 'The importance of personal protective equipment design and donning and doffing technique in mitigating infectious disease spread: a technical report' (Cureus, 2020).
[592] Katarina Hoernke, Nehla Djellouli, Lily Andrews, et al., 'Frontline healthcare workers' experiences with personal protective equipment during the Covid-19 pandemic in the UK: a rapid qualitative appraisal' (BMJ, 2021).

HCWs were unaccustomed to the use of specific PPE required to treat patients during a novel pandemic and were concerned about the lack of accessible training provided to them. NHS England urged all organisations to ensure that they provided PPE training to all HCWs. These include fit test training, hand wash training and refresher training on the use of PPE.[593] In instances where training was not easily available or promptly provided to workers, HCWs took the initiative into their own hands and taught themselves the safe use of PPE or in some instances, training organisations provided free online PPE training to NHS staff.[594]

When the NHS as an employer failed to fulfil its legal duty to provide PPE training, digital training experts Cineon training alongside University of Exeter responded by providing free online PPE training to NHS staff so as to fill this training gap. This virtual training was based on the guidelines provided by the Public Health England on the safe use of PPE.[595] The online training provided the flexibility to HCWs as they were able to participate when it was suitable to them given their irregular work shifts.[596] The training focused not only on the correct use of PPE but also on the equipment necessary for each scenario. During the Covid-19 pandemic, workers were transferred to different sectors and were moving around different parts within the hospital which required the use of different PPE. The training helped HCWs distinguish the different uses of PPE while also teaching the correct sequence of putting on and taking off protective equipment.[597]

PPE training is crucial as it enables HCWs to understand the situation and select the correct and most suitable protective equipment required.[598] During the Covid-19 pandemic, research indicated that nurses were more aware of the correct protective equipment that they were supposed to use when compared to midwives and nursing aides. The underlying reasoning behind the lack of awareness might be due to the fact that training opportunities are easily accessible to HCWs working in high-risk environments compared to workers in primary care, general wards and surgery.[599] Despite the lack of proper guidance provided by the government regarding the use of PPE, the health and safety legislation places employers

[593] 'NHS England and NHS Improvement' (NHS, 2020) <https://www.england.nhs.uk/wp-content/uploads/2020/03/20200302-COVID-19-letter-to-the-NHS-Final.pdf> accessed 25 March 2023.
[594] Katarina Hoernke, Nehla Djellouli, Lily Andrews, et al., 'Frontline healthcare workers' experiences with personal protective equipment during the Covid-19 pandemic in the UK: a rapid qualitative appraisal' (BMJ, 2021).
[595] 'Experts create free online PPE training for NHS staff' (University of Exeter, 2020) <https://news-archive.exeter.ac.uk/homepage/title_790393_en.html> accessed 25 March 2023.
[596] Ibid.
[597] 'Free online Covid-19 PPE training for health workers' (Cineon Training, 2020) <https://www.youtube.com/watch?v=97DHuoMwwCA> accessed 25 March 2023.
[598] C Houghton, P Meskell, H Delaney, et al., 'Barriers and facilitators to healthcare workers' adherence with infection prevention and control (IPC) guidelines for respiratory infectious diseases: A rapid qualitative evidence synthesis' (Cochrane Database of Systematic Review, 2020).
[599] Katarina Hoernke, Nehla Djellouli, Lily Andrews, et al., 'Frontline healthcare workers' experiences with personal protective equipment during the Covid-19 pandemic in the UK: a rapid qualitative appraisal' (BMJ, 2021).

under a legal duty to ensure that their employees are protected from health and safety risks by conducting suitable and sufficient risk assessments and appropriate measures are put in place to minimise the risk of harm to employees as far as it is reasonably practicable.[600] Furthermore, the PPER 2022 places duties on employers to ensure that PPE is used correctly by workers, maintained and stored properly, provided with instructions on how to use it safely and properly assessed before use to make sure it is fit for purpose.[601]

3.3 Summary

Employers bear a plethora of responsibilities towards their employees throughout the different stages of employment. UK law obliges employers to protect the health and safety of workers from any potential harm during their employment by taking all necessary measures within the workplace to mitigate risks. The Covid-19 pandemic threatened the health and safety of NHS HCWs due to the unprecedented nature of the outbreak and the lack of foreknowledge among workers of how to provide care and assistance to a rapidly growing number of covid infected patients. Shortly after the inception of the pandemic, workers were unaware of the risks associated with providing care to infected patients. However, HCWs should not have been subjected to such risks at the outset as the legislation requires employers to conduct risks assessments in order to identify such risks and to address them. Without a doubt the Covid-19 pandemic risked the safety of frontline HCWs and the NHS failed to alleviate risks and protect its employees. The lack of adequate supply of PPE during the pandemic adversely affected the workers' mental and physical health. The ill-fitting PPE that was available to female HCWs resulted in a higher risk of infection. The lack of suitable PPE caused anguish and anxiety amongst workers as they had to overcome hurdle after hurdle solely to do their job and provide care to patients.

Conclusion

Analysis of my data under the three themes identified above suggests that, although the global pandemic was unprecedented in many respects, the majority of the problems faced by NHS workers pre-existed the pandemic. BME NHS workers were already accustomed to unfair treatment and to the preferential treatment that white colleagues could receive at work.

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[600] 'Do employers have to provide personal protective equipment (PPE)? (Health and Safety Executive) <https://www.hse.gov.uk/contact/faqs/ppe.htm> accessed 21 May 2023.
[601] 'Using personal protective equipment (PPE) to control risks at work' (Health and Safety Executive) <https://www.hse.gov.uk/ppe/overview.htm> accessed 21 May 2023.

Migrant workers already faced the challenge of harsh visa and immigration rules. The standardised mass production of protective equipment that all workers required did not meet the needs of female HCWs. The pathway to getting suitable protective equipment was challenging for numerous reasons, from receiving conflicting guidance on the use of PPE, lack of risk assessments, the access to ill-fitting equipment, physical issues due to the prolonged use of protective equipment and to the shortage of sufficient PPE. My data analysis therefore highlights issues that the NHS were aware of prior to the pandemic yet the NHS failed to address adequately during the pandemic. The health and safety of HCWs should be a priority for the NHS. Instead, however, there is some evidence of trusts side-lining their legal responsibilities to provide a safe system of work and repeated failure to provide the necessary protective equipment. Following the analysis of mental health and safety issues affecting workers, the next chapter will focus on the physical health risks they encountered during the pandemic.

Chapter 6 Healthcare Workers' Physical Health

Introduction

The previous chapter focused on the mental health impact on NHS staff who were working during the Covid-19 pandemic. Data analysis suggested that employers sometimes failed to act in accordance with the law to protect the health and safety of these workers. This resulted in numerous direct and indirect impacts on workers' mental health.

In this chapter, I will explore whether employers were able to adhere to health and safety legislation to protect HCWs so as to mitigate the risks associated with physical health issues. With the aim of addressing this question, I will focus on three of the five overarching themes identified as the data were collected. The first two themes are – *Inconsistent advice across the NHS workforce* and *The intention to leave the healthcare profession*. These two themes are dealt with together, as they are interlinked and have similar elements including a lack of proper management and guidance provided to HCWs within their workplace and the subsequent effect on their physical wellbeing during and after the global pandemic. They also speak to the importance of job security, as there is a correlation between secure employment and physical wellbeing.[602] Similar to chapter five, the final theme *The Supply of Personal Protective Equipment* will reiterate the significance that this had for HCWs and, in particular, its effect on the physical health of those workers.

Similar to chapter five, before moving on to the main body of the chapter, I will explain how the three themes are linked to the physical health of workers.

Firstly, the first theme focuses on the constantly changing advice provided across the NHS which caused confusion amongst HCWs.[603] The advice was mainly in relation to the use of PPE and self-isolation guidelines. PPE provides a physical barrier that reduces infection transmission and in instances where this barrier is not present when providing care in a highly contagious environment, workers are prone to the direct exposure of droplet/airborne

[602] Inmaculada Silla, Nele De Cuyper, Francisco J. Gracia, et al., 'Job insecurity and well-being: Moderation by employability' (Journal of Happiness Studies, 2009), Francis Green, 'Health effects of job insecurity' (IZA World of Labour, 2020).
[603] Cecilia Vindrola-Padros, Lily Andrews, Anna Dowrick, et al., 'Perceptions and experiences of healthcare workers during Covid-19 pandemic in the UK' (BMJ, 2020).

transmission.[604] This will significantly increase the risk of infection, which can cause workers prolonged physical discomfort including a sore throat, headaches and fever.[605] The lack of PPE can cause further respiratory issues such as acute lung injury, difficulty in breathing, low oxygen saturation and abnormal chest x-rays.[606] These adverse physical health issues experienced by workers stemmed from the lack of PPE and the contradicting user guidelines available to workers. This increased the likelihood of workers contracting the Covid-19 virus and having to self-isolate, in accordance with government guidelines. However, self-isolation lead to the loss of earning, resulting in workers facing significant financial barriers and loss of income.[607] The financial struggles had an adverse effect on the mental and physical health of HCWs.[608] The mental health issues endured by these workers could have a direct or indirect effect on the physical health of workers.[609] This is due to the fact that stress and depression may weaken and alter the immune functioning and change cellular immunity leading to reduced immune response.[610] Studies have linked stress to adverse physical health outcomes specifically increased rates of cardiovascular disease, chronic health conditions and mortality risks.[611] As financial uncertainties aggravated the stress of workers, the associated mental health effect had an indirect impact on worker physical health.

Secondly, the next theme focuses on the extensive number of HCWs leaving the NHS during and in the immediate aftermath of the Covid-19 pandemic. The government mandated all NHS health care workers to receive the Covid-19 vaccine as the initial vaccine rollout indicated lower infection levels, which enabled workers to continue their role with minimum reservations when providing care for their patients.[612] While mandating the Covid-19 vaccine was controversial across the NHS workforce it was effective in mitigating the spread

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[604] Chen Zhang, Peter V Nielsen, Li Liu, et al,. 'The source control effect of personal protection equipment and physical barrier on short-range airborne transmission' (Building and Environment, 2022).
[605] Hyunju Kim, Sheila Hegde, Christine LaFiura, et al., 'Access to personal protective equipment in exposed healthcare workers and COVID-19 illness, severity, symptoms and duration: population – based case-control study in six countries' (BMJ global health, 2021).
[606] Ibid.
[607] Sarah Reed, William Palmer, Mike Brewer, et al,. 'Tackling Covid-19: A case for better financial support to self-isolate' (Nuffield Trust, 2021).
[608] Tom May, Henry Aughterson, Daisy Fancourt, et al,. 'Financial adversity and subsequent health and wellbeing during the COVID-19 pandemic in the UK: A qualitative interview study' (SSM-Qualitative Research in Health, 2023), Martin McBride, Christopher A Martin, Lucy Teece, et al., 'Investigating the impact of financial concerns on symptoms of depression in UK healthcare workers: data from the UK-REACH nationwide cohort study' (BJPsychopen, 2023).
[609] Gregory A Aarons, Amy R Monn, Laurel K Leslie, et al., ' Association between mental and physical health problems in high-risk adolescents: A longitudinal study' (Journal of Adolescent Health, 2008).
[610] Janice K Kiecolt-Glaser and Ronald Glaser, 'Psychoneuroimmunology: can psychological interventions modulate immunity?' (Journal of consulting and clinical psychology, 1992).
[611] Brenda R Whitehead and Cindy S Bergeman, 'The effect of the financial crisis on physical health: Perceived impact matters' (Journal of health psychology, 2017), 'Financial stress linked to worse biological health' (UCL, 2024) <https://www.ucl.ac.uk/news/2024/jan/financial-stress-linked-worse-biological-health> accessed 21 May 2025.
[612] Annelies Wilder-Smith, 'What is the vaccine effect on reducing transmission in the context of the SARS-CoV-2 delta variant' (The Lancet Infectious Diseases, 2022).

of the virus and the risk of severe clinical issues.[613] However, some workers were reluctant to get the vaccine due to the rapid vaccination rollout and the lack of research of its long-term effects,[614] which put further pressures on the already understaffed NHS. It is no surprise that the NHS was facing a chronic workforce shortage even prior to the perils of the Covid-19 pandemic. Yet, due to the unusual demand of patients that needed care during the pandemic many NHS workers were overworked. Having to work for long periods of time without adequate breaks affected workers' mental and physical health.[615] While mental health issues, in the form of stress and exhaustion, might be more direct, the indirect effect on workers' physical health may be more significant. Working for long periods of time can lead to chronic pain, type 2 diabetes and/or high levels of body mass index.[616] These effects created physical strain amongst workers as a result of being overworked. Workers also suffered from moral distress having cared for covid positive patients. While moral distress is commonly regarded as a mental health issue, workers who suffer from moral distress could have indirect physical health issues such as heart palpitations and headaches.[617] Although mental health issues are more commonly associated with this theme, the indirect effect it has on workers' physical health is significant and it will be discussed below.

The final theme draws attention to the supply of PPE and the physical health issues that workers endured as a consequence of wearing the cumbersome protective equipment for prolonged periods. It is apparent that the normal day-to-day working practises of HCWs changed rapidly during the Covid-19 pandemic. Due to the extraordinary nature of the pandemic, workers had to learn the intricacies of using the different types of protective equipment.[618] Preventing the spread of the virus came at the cost of workers wearing the uncomfortable protective equipment at all times.[619] HCWs were wearing these equipment

[613] Marios Politis, Sotiris Sotiriou, Chrysoula Doxani, et al,. 'Healthcare workers' attitudes towards mandatory COVID-10 vaccination: a systematic review and meta-analysis' (Vaccines, 2023).
[614] Marios Politis, Sotiris Sotiriou, Chrysoula Doxani, et al,. 'Healthcare workers' attitudes towards mandatory COVID-10 vaccination: a systematic review and meta-analysis' (Vaccines, 2023).
[615] Ro-Ting Lin, Yu-Ting Lin, Ying-Fang Hsia, et al., 'Long working hours and burnout in health care workers: non-linear dose-response relationship and the effect mediated by sleeping hours- a cross-sectional study' (Journal of Occupational health, 2021).
[616] Kapo Wong, Alan HS Chan and S C Ngan, 'The effect of long working hours and overtime on occupational health: a meta-analysis of evidence from 1998-2019' (International journal of environmental research and public health. 2019), Violeta Clement-Carbonell, Irene Portilla-Tamarit, Maria Rubio-Aparicio, et al., 'Sleep quality, mental and physical health: a differential relationship' (International journal of environmental research and public health, 2021).
[617] Steven MA Bow, Peter Schröder-Bäck, Dominic Norcliffe-Brown, et al,. 'Moral distress and injury in the public health professional workforce during the COVID-19 pandemic' (Journal of Public Health, 2023).
[618] Katarina Hoernke, Nehla Djellouli, Lily Andrews, et al., 'Frontline healthcare workers' experiences with personal protective equipment during the Covid-19 pandemic in the UK: a rapid qualitative appraisal' (BMJ, 2021).
[619] 'Covid-19: The impact of the pandemic on the medical profession' (British Medical Association, 2024) <https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-the-impact-of-the-pandemic-on-the-medical-profession> accessed 21 March 2025.

for more than six hours without any comfort breaks due to the hassle of doffing PPE.[620] Workers endured untoward physical health issues such as musculoskeletal conditions, urinary issues, respiratory and nervous disorders. However, the most prominent physical disorder reported was associated with health care workers skin.[621] Skin health was one of the main physical health issues that workers endured as a consequence of wearing the cumbersome protective equipment.[622] Dermatitis related issues were drastic and were in the form of dryness, itching, erosion and erythema.[623] In order to limit the spread of the virus, workers were washing their hands more than ten times a day which amplified dermatitis conditions.[624] These physical health issues were burdensome to workers as they not only had to navigate the uncertainties of working during the pandemic, but also cope with the supply shortage of protective equipment.

Section one of this chapter will discuss the problems HCWs faced due to the inconsistent advice across the NHS. The data indicate that HCWs were given inconsistent advice under two different circumstances. Firstly, HCWs who were in the social care sector felt that they were considered as an afterthought when Covid-19 regulations were put in place. Workers were often given contradicting guidance on the effect of the virus as they were told that in a social care setting there was less risk of "covid breeding" that required minimum protection.[625] These guidelines confused workers, however, as elderly patients in social care homes were contracting the virus, putting HCWs' health and safety in danger. The physical health of these workers was compromised as they did not have the appropriate PPE or the accurate guidelines in order to be protected from the virus. Secondly, HCWs received varying forms of advice regarding the self-isolation policies implemented by the government. NHS trusts complicated these guidelines and confused workers. Self-isolation in itself was a novel concept for NHS workers however, when it had a direct consequence on their financial stability these workers were further pressured. The constantly evolving

[620] Giuseppe Candido, Constanza Tortù, Chiara Seghieri, et al., 'Physical and stressful psychological impacts of prolonged personal protective equipment use during the COVID-19 pandemic: a cross-sectional survey study' (Journal of Infection and Public Health, 2023).
[621] Giuseppe Candido, Constanza Tortù, Chiara Seghieri, et al., 'Physical and stressful psychological impacts of prolonged personal protective equipment use during the COVID-19 pandemic: a cross-sectional survey study' (Journal of Infection and Public Health, 2023).
[622] Arpi Manookian, Nahid Dehghan Nayeri and Mehraban Shahmari, 'Physical problems of prolonged use of personal protective equipment during the COVID-19 pandemic: A scoping review' (In Nursing Forum, 2022).
[623] Emily S Burns, Pirunthan Pathmarajah and Vijaytha Muralidharan, 'Physical and psychological impacts of handwashing and personal protective equipment usage in the Covid-19 pandemic: A UK based cross-sectional analysis of healthcare workers' (Dermatologic Therapy, 2021).
[624] Emily S Burns, Pirunthan Pathmarajah and Vijaytha Muralidharan, 'Physical and psychological impacts of handwashing and personal protective equipment usage in the Covid-19 pandemic: A UK based cross-sectional analysis of healthcare workers' (Dermatologic Therapy, 2021), 'Hand hygiene: top tips for skin health and glove use' (Royal College of Nursing, 2024) <https://www.rcn.org.uk/magazines/Advice/2024/May/Hand-hygiene-top-tips-for-skin-health-and-glove-use> Accessed 19 October 2024.
[625] Nihar Shembavnekar, Lucinda Allen and Omar Idriss, 'How is Covid-19 impacting people working in adult social care?' (The Health Foundation, 2021).

Covid-19 policies marginalised NHS workers impacting their physical health. This became clear when the government renounced the special paid leave policy that was in place for NHS staff who were sick and self-isolating in 2022 amidst an ongoing pandemic.[626] The RCN states that this decision by the government to end sick pay for time spent in isolation would be a burden for NHS staff with ongoing health issues.[627] Many HCWs feared self-isolating, due to anxiety about receiving reduced pay or losing their jobs. As a result, some HCWs who contracted coronavirus during the Covid-19 pandemic have had to suffer the physical consequences of having to live with chronic illnesses or long covid.

In the second section of this chapter, I will explore the underlying reasons why a significant number of NHS HCWs intended to leave the healthcare service having experienced working during the Covid-19 pandemic. Following the revolutionary introduction of the Covid-19 vaccine, the government initiated a policy that required NHS staff to be fully vaccinated by the 1st of April 2022. Although this decision was made with the intention of reducing the spread of the virus and its infection, most HCWs viewed this policy as unfair. HCWs who refused to get the vaccine were faced with the decision of having to leave the profession. Most of these workers believed that the vaccine could have negative effects on their physical health, however, they also feared losing their jobs which caused high levels of stress impacting their physical health.

Although HCWs' physical health might not have been protected due to the uncertainty of employment security, mandating the Covid-19 vaccine on all HCWs was regarded as an essential decision to help protect the health and safety of HCWs. It assisted in mitigating the risks associated with the physical health of HCWs. The long working hours that HCWs had to endure during the pandemic could be linked to the lack of sufficient NHS frontline workers. This resulted in overworking staff and physically impairing their health due to the lack of adequate sleep and rest.

Under section three of this chapter, I will explore the use of PPE by the HCWs during the Covid-19 pandemic. Employers have a legal duty to provide protective equipment to employees if a risk assessment indicates that it is required.[628] During the Covid-19 pandemic,

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[626] Ashleigh Webber, 'NHS to end full pay for Covid-19 sick leave in England' (Personnel Today, 2021) <https://www.personneltoday.com/hr/nhs-covid-sickness-absence-change-england/> accessed 21 May 2023.
[627] 'Royal College of Nursing responds to reports that NHS Covid-19 sick pay to be cut in England' (Royal College of Nursing, 2022) <https://www.rcn.org.uk/news-and-events/Press-Releases/covid-sick-pay-july-2022> accessed 21 May 2023.
[628] 'Using personal protective equipment (PPE) to control risks at work' (Health and Safety Executive) <https://www.hse.gov.uk/ppe/overview.htm> accessed 21 May 2023.

PPE was required to prevent the spread of the coronavirus.[629] Consequently, in order for workers to be protected from contracting the virus and to mitigate the transmission, the UK government along with the NHS encouraged the use of appropriate PPE.[630] While PPE is used to manage risk and to protect workers' health and safety, this section will highlight if the employers conducted the appropriate risk assessments associated with the prolonged use of protective equipment and whether these risks could have been mitigated.

The prolonged use of PPE was physically demanding for HCWs. PPE trapped all the heat that the body produced and prevented the body from naturally secreting heat by sweat and evaporation making it more difficult for a person to maintain their natural body temperature.[631] Some HCWs worked in environments that were warm, had poor ventilation and were without sufficient airflow or air-conditioning which resulted in some suffering from heat stress.[632] Air-conditioners also enabled the virus to linger in the air for longer, resulting in HCWs having to endure working in full PPE during hot spells without air conditioning, which was a hazard to workers' health and safety.[633]

This negatively impacted the workers' performance, as having to provide care to patients while physically struggling with heat stress was challenging for workers.[634] The discomfort that workers felt having to wear the cumbersome protective equipment did not cease after a shift as they had to be cautious of when and how they removed PPE in order to be fully protected from the virus.

When the UK government encountered a shortage of PPE, the healthcare sector faced significant challenges.[635] Workers had to resort to buying PPE with their own money or to

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[629] Sani Rachman Soleman, Zhaoging Lyu, Takuya Okada, et al., 'Efficacy of personal protective equipment to prevent environmental infection of Covid-19 among healthcare workers: a systematic review' (Environmental Health and Preventative Medicine, 2023).
[630] 'Accessing supplies of Personal Protective Equipment (PPE)' (NHS) <https://www.england.nhs.uk/coronavirus/primary-care/infection-control/ppe/> accessed 11 July 2023.
[631] Alexis Tabah, Mahesh Ramanan, Kevin B Laupland, et al., 'Personal protective equipment and intensive care unit healthcare workers safety in the Covid-19 era (PPE-SAFE): An international survey' (Journal of critical care, 2020), Yudong Mao, Yongcheng Zhu, Zhisheng Guo, et al., 'Experimental investigation of the effects of personal protective equipment on thermal comfort in hot environments' (Building and Environment, 2020).
[632] Natasha Smallwood, Warren Harrex, Megan Rees, et al., 'Covid-19 infection and the broader impacts of the pandemic on healthcare workers' (Respirology, 2022).
[633] Louise Walsh 'Coronavirus pandemic Making safer emergency hospitals' (University of Cambridge) <https://www.cam.ac.uk/stories/emergency-hospitals#> accessed 11 July 2023, Joe Pinkstone, 'Nightingale-style emergency hospitals with large open-plan air-conditioned halls may allow coronavirus to spread more widely,' Cambridge study warns' (Daily Mail, 2020) <https://www.dailymail.co.uk/sciencetech/article-8263037/Low-tech-changes-reduce-airborne-Covid-19-spread-emergency-hospitals.html> accessed 11 July 2023.
[634] Craig Brierley, 'It's been very humbling' (University of Cambridge) <https://www.cam.ac.uk/stories/backtoclinic> accessed 11 July 2023.
[635] 'Lack of protective equipment for health and social care staff is "a crisis within a crisis"' (UNISON, 2020) <https://www.unison.org.uk/news/article/2020/04/lack-protective-equipment-health-social-care-staff-crisis-within-crisis/> accessed 21 May 2023.

rely on donations which was unreasonable, as their employers are legally obliged to provide necessary PPE when at work. Regardless of who provided their PPE, workers still needed to wear the protective equipment in order to prevent the transmission of the virus. Section three of the chapter will also address one of the biggest concerns that HCWs had to face due to the increased use of PPE.[636] The prolonged use of PPE had an adverse effect on HCWs' skin.[637] In order to prevent such adverse effects and to minimise skin irritation, the NHS encouraged workers to follow the three-step preventative approach, *avoid-protect-check*. However, these measures were broad and not directed towards addressing the issues that HCWs faced during the Covid-19 pandemic.

On the basis of this analysis, the chapter concludes that the employers failed to protect the health and safety of NHS HCWs as it provided inconsistent advice across the different healthcare sectors and NHS trusts, indirectly affecting workers' physical health. Furthermore, employers failed to provide a safe environment of work, breaching the legal responsibilities they are entrusted with under the health and safety legislation.

1. Inconsistent advice across the NHS workforce

The Covid-19 pandemic caused challenges to all individuals in varying degrees,[638] however, HCWs were met with the difficulty of having to navigate work during this unprecedented time without having sufficient guidance and assistance from their employers.[639] According to my data, it seems that many workers were confused by the policies that were in place to safeguard their health and safety or they were unable to keep up with the constantly evolving policies.

[636]Mimi Launder, 'Healthcare workers 'taking time off' for dermatitis caused by PPE and hand washing' (Nursing in Practice, 2020) <https://www.nursinginpractice.com/clinical/dermatology/healthcare-workers-taking-time-off-dermatitis-caused-ppe-hand-washing/> accessed 21 May 2023.
[637] Ramanathan Swaminathan, Bimantha Perera Mukundadura and Sashi Prasad, 'Impact of enhanced personal protective equipment on the physical and mental well-being if healthcare workers during Covid-19' (Postgraduate medical journal, 2022).
[638] Helen Onyeaka, Christiana K Anumudud, Zainab T Al-Sharify, et al., 'Covid-19 pandemic: A review of the global lockdown and its far-reading effects' (Science progress, 2021).
[639] Cecilia Vindrola-Padros, Lily Andrews, Anna Dowrick, et al., 'Perceptions and experiences of healthcare workers during Covid-19 pandemic in the UK' (BMJ, 2020).

1.1 Safe environment of work

Within the NHS ecosystem care services can be categorised broadly into four different sectors, these include; primary care, secondary care, tertiary care and community health.[640] As shown below these four sectors are responsible for providing different forms of healthcare within their categories.

[640] 'The healthcare ecosystem' (NHS) <https://digital.nhs.uk/developer/guides-and-documentation/introduction-to-healthcare-technology/the-healthcare-ecosystem> accessed 21 May 2023.

Figure 6: The NHS ecosystem

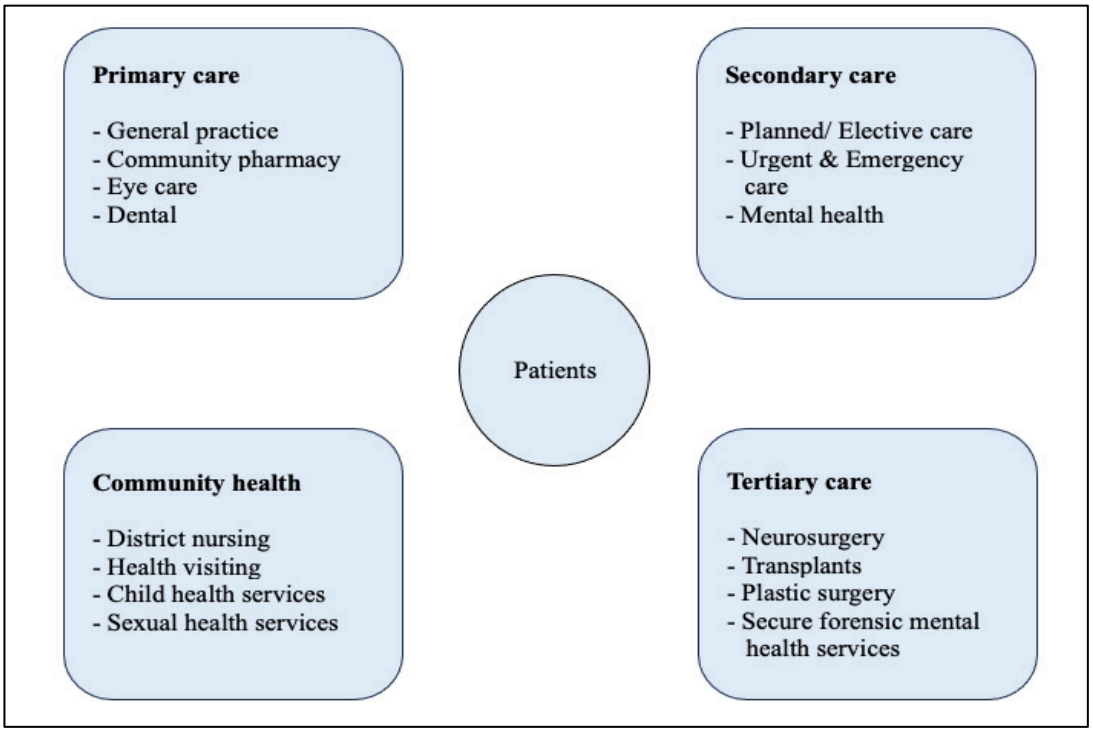

Figure 6[641]

[641] Ibid.

Providers are not expected to work in isolation from other sectors as they are often integrated with one another and are required to act as a unified integrated care system. In most instances primary care is the first point of contact with a healthcare professional for patients and if needed passed along to specialist secondary care within the NHS.[642] In this integrated NHS ecosystem, patients are allocated according to their clinical needs.

When the Covid-19 pandemic started, these healthcare sectors were overwhelmed by the nature of work they had to carry out and each sector was faced with new challenges.[643] The pandemic required all HCWs to work in new settings across primary, secondary and community care.[644] NHS staff redeployment entailed HCWs working in unfamiliar environments under new clinical roles and engaging in work beyond their normal scope.[645] Often workers either consider redeployment as a threat if they felt uncomfortable working in a new environment or an opportunity for a new experience and to enhance their working knowledge.[646] During the Covid-19 pandemic, on the one hand HCWs were relocated within the different sectors due to the chronic staff shortage across the NHS.[647] Although the workers had little to no choice when making these decisions, problems arose when workers were confused as to the rules that they were supposed to follow as different rules were put in place across the four sectors. On the other hand, patients were also transferred to different sectors due to the shortages of beds and healthcare. This overwhelmed HCWs as some were previously in positions that required little to no contact with patient care and unexpectedly these HCWs were required to treat patients who were dying of the virus.[648] Ultimately, the HCWs were in a position where they were burning the candle from both ends in order to meet the demands and provide healthcare to their patients.

During the Covid-19 pandemic this was prominently seen in the community care sector, in particular adult social care, where HCWs believed that policy decisions that were made for

[642] 'Health and social care rights' (Mind) <https://www.mind.org.uk/information-support/legal-rights/health-and-social-care-rights/about-healthcare/> accessed 21 May 2023.
[643] John Willan, Andrew John King, Katie Jeffery, et al., 'Challenges for NHS hospitals during covid-19 epidemic' (BMJ,2020).
[644] 'Covid-19: Deploying our people safely' (NHS England, 2020) <https://www.england.nhs.uk/coronavirus/documents/covid-19-deploying-our-people-safely/#:~:text=As%20the%20outbreak%2C%20and%20our,previous%20experience%2C%20health%20and%20wellbeing> accessed 21 July 2023.
[645] Ibid.
[646] Van der Colff, Jacob J and Sebastiaan Rothmann, 'Occupational stress, sense of coherence, coping, burnout and work engagement of registered nurses in South Africa' (SA Journal of Industrial Psychology, 2009).
[647] 'Redeployment and unsustainable pressures' (Royal College of Nursing, 2023) < https://www.rcn.org.uk/Get-Help/RCN-advice/redeployment-and-unsustainable-pressures> accessed 21 January 2024.
[648] Michael Dunn, Mark Sheehan, Joshua Hordern, et al., 'Your country needs you': the ethics of allocating staff to high-risk clinical roles in the management of patients with Covid-19' (Journal of Medical Ethics, 2020).

the sector were considered as an afterthought.[649] For instance, approximately 25,000 patients who were in hospitals were discharged into different care homes without making sure that they were first tested for the Covid-19 virus.[650] These care homes were employed by different entities that had varying guidelines on how to mitigate the risks of infection which further confused workers. The workers in care homes were informed that their working environments were 'less covid breeding' and that they only required minimum protection which resulted in lesser restrictions being placed in care homes.

The social care sector felt abandoned during this time period due to the lack of adequate PPE and the absence of testing that was provided.[651] Frontline residential care worker Chika Ruben emphasised the importance of providing suitable guidelines to HCWs as she believed that care home workers did not receive proper guidance on the proper use of PPE or its benefits.[652] This resulted in workers contracting the coronavirus. Furthermore, due to the overwhelming amount of work that workers had to provide, care home residents were being overlooked and adequate attention to their needs were not provided by the HCWs.[653] The repercussions of these actions collectively resulted in an upsurge of deaths in care homes across England.[654] The outcome of this had a domino effect which ultimately severely affected the health and safety of HCWs.

According to a survey conducted by UNISON on social care staff working through the pandemic, 40% of the respondents stated that they felt unsafe attending work due to concerns about the lack of adequate and appropriate PPE, timely access to testing and up to date safety procedures at work.[655] The Government's response to Covid-19 regulations, specifically

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[649] Joe Duffy, Colin Cameron, Helen Casey, et al, 'Service User Involvement and Covid-19- An Afterthought?' (The British Journal of Social work, 2022).
[650] 'Readying the NHS and adult social care in England for Covid-19' (National Audit Office, 2020) <https://www.nao.org.uk/wp-content/uploads/2020/06/Readying-the-NHS-and-adult-social-care-in-England-for-COVID-19.pdf > accessed 21 January 2024.
[651] 'Readying the NHS and adult social care in England for Covid-19' (UK Parliament, 2020) <https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/405/40507.htm#_idTextAnchor014> accessed 21 January 2024.
[652] 'Frontline workers' (All Party Parliamentary group on Coronavirus, 2020) <https://www.appgcoronavirus.uk/meetings/blog-post-title-three-chxrx-9txzt-tll2s-d3jna-g9n56-npy4l-xhfng> accessed 30 March 2023.
[653] 'Impact of Covid-19 on UK care homes for older people and workforce revealed' (UCL, 2023) <https://www.ucl.ac.uk/news/2023/apr/impact-covid-19-uk-care-homes-older-people-and-workforce-revealed> accessed 30 January 2024.
[654] 'Deaths involving Covid-10 in the care sector, England and Wales: deaths registered between week ending 20 March and week ending 21 January 2022' (Office for National Statistics, 2022) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsregisteredbetweenweekending20march2020andweekending21january2022> accessed 21 January 2024.
[655] 'Care after Covid: A UNISON vision for social care' (UNISON, 2020) <https://www.unison.org.uk/content/uploads/2020/06/A-UNISON-Vision-for-Social-Care-June-2020.pdf> accessed 21 May 2023.

PPE, initially excluded the social care workforce. Priority was given to frontline workers of other sectors.[656]

The inconsistent advice across the different healthcare sectors begs the question, whether the government was already under pressure to meet the demand of providing PPE across the different healthcare sectors due to the lack of PPE during the early months of the Covid-19 pandemic. This ultimately resulted in care workers treating patients who might have positive coronavirus symptoms without the appropriate PPE and in doing so, putting themselves and their families at risks. Trade unions such as the General, Municipal, Boilermakers and Allied Trade Union (GMB) deliberated over the government's lack of uniformity when providing guidance related to the coordination of PPE. This pressure created by the trade unions pushed the government into issuing guidance on the use of PPE in the social care workforce. These guidelines changed daily, however, and the workers struggled to keep up with the changes. Once the regulations were agreed, the next biggest issue faced by frontline social care workers was access to PPE, which was an issue for many weeks.[657] Frontline residential care worker, Zoe Smith, further asserts this issue and highlighted the consequence it had on pregnant workers within the workplace.[658] At first this group of workers were advised to attend work despite later being categorised as 'high risk' individuals who were subsequently advised to shield as they had a higher risk of severe illness from coronavirus.[659] However, the inconsistent advice, especially towards a 'high risk' group, poses significant physical health risks due to the decreased immunity and in most advanced cases, causing congenital anomalies in the foetus.[660]

The lack of consistent Covid-19 health and safety guidelines across healthcare sectors was problematic especially in the social care sectors as employers appeared to be implementing guidelines that suited their own needs. For instance, some employers required workers to attend work despite working with high-risk groups and urged workers to remain in the work

[656] 'BMA Covid Review 2, The impact of the pandemic on the medical profession' (British Medical Association, 2022) <https://www.bma.org.uk/media/5620/20220141-bma-covid-review-report-2-the-impact-of-the-pandemic-on-the-medical-profession-final.pdf> accessed 11 May 2023.
[657] 'GMB Union- APPG on coronavirus' (GMB Union) <https://static1.squarespace.com/static/61c09c985b6cc435c9948d88/t/61c3620f2b5182123f04ae04/1640194575472/GMB_Union_-_APPG_Coronvirus_Written_Evidence.pdf> accessed 21 May 2023.
[658] 'Frontline workers' (All Party Parliamentary group on Coronavirus, 2020) <https://www.appgcoronavirus.uk/meetings/blog-post-title-three-chxrx-9txzt-tll2s-d3jna-g9n56-npy4l-xhfng> accessed 30 March 2023.
[659] 'Pregnant workers and Covid-19' (UNISON) <https://www.unison.org.uk/about/what-we-do/fairness-equality/women/key-issues/pregnant-workers-covid-19/#:~:text=NHS%20advice%20is%20that%20pregnant,workplace%20to%20remove%20the%20risk> accessed 11 May 2023.
[660] R Sindhuri, Reenaa Mohan, Pravin Surendran, et al., 'Unheard voices of pregnant health care professionals during Covid-19 pandemic? – A Qualitative study' (Indian Journal of Occupational & Environmental Medicine, 2023).

premises as there were patients who were infected with the virus and needed care and assistance.[661] Furthermore, the male population among the social care workforce had seen a dramatic increase in deaths involving Covid-19. It is estimated that during February and October 2020 the rate of male social care workers who died during lockdown was 2.9 times higher than before the Covid-19 pandemic.

1.2 Save lives - stay home (without pay)

In order to mitigate the spread of the Covid-19 virus the government implemented a number of different restrictions, rules and guidelines in the form of wearing face masks, observing social distancing and imposing stay at home orders during the different stages of the Covid-19 pandemic.[662] In addition to the general rules, healthcare staff were also bound by restrictions set out by the UK Health Security Agency (UKHSA).[663] First published in April 2022, UKHSA advised staff and managers within the NHS *who did not provide direct inpatient care*, who had symptoms of the infection of the Covid-19 virus, including a high temperature, to avoid their workplace, self-isolate and avoid contact with people.[664] Staff were also informed to follow the general public guidance if they got a positive Covid-19 test and were encouraged to undertake a risk assessment with their line managers before continuing with the normal line of work.[665] Health Care Workers *who provided direct inpatient care*, were required to take a Polymerase Chain Reaction (PCR) test if they were feeling unwell and unable to attend work. PCR tests indicate the presence of Covid-19 virus.[666] If a test was negative, workers were advised to attend work and if the test was positive they were urged not to attend work for at least ten consecutive days after getting a positive test and if living with a coronavirus positive person they were advised to self-isolate for fourteen days. Similar to workers who did not provide direct in-patient care, these workers were advised to conduct a risk assessment and only attend work if they felt well enough. Despite the above guidance provided by the government on managing healthcare staff with the symptoms of respiratory infection, in practice when HCWs contracted the

[661] Patrick Sawer, 'Care staff told to 'remain on site' if coronavirus strikes vulnerable residents' (The Telegraph, 2020) <https://www.telegraph.co.uk/news/2020/03/25/care-staff-told-remain-site-coronavirus-strikes-vulnerable-residents/> accessed 21 March 2023.
[662] Liam Wright, Elise Paul, Andrew Steptoe, et al., 'Facilitators and barriers to compliance with Covid-19 guidelines: a structural topic modelling analysis of free-text data from 17,500 UK adults' (BMC Public Health, 2022).
[663] 'Covid-19: managing healthcare staff with symptoms of a respiratory infection' (GOV.UK, 2023) <https://www.gov.uk/government/publications/covid-19-managing-healthcare-staff-with-symptoms-of-a-respiratory-infection> accessed 11 March 2023.
[664] Ibid.
[665] Ibid.
[666] 'Covid-19 testing: What you need to know' (Centers for Disease Control and Prevention, 2023) <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html> accessed 11 January 2024.

Covid-19 virus or had symptoms of the virus, self-isolating and not attending work was by no means clear-cut and straightforward as portrayed by the government guidelines.[667]

These guidelines were further complicated by the existence of significant inconsistencies in the guidance given to HCWs by different NHS trusts. Certain NHS trusts advised its staff, mainly doctors and nurses, to attend work even in the instance where someone in their household had coronavirus symptoms, without having to self-isolate for fourteen days, which contradicted the official guidance given by the government.[668] This lack of consistent advice to their employees within the NHS trusts resulted in apprehension among staff members.[669] Different NHS trusts interpreted the government guidance differently as the following examples demonstrate. *West Midlands Trust* briefed their staff by saying that the guidance on self-isolation did not apply for HCWs as it was only curated towards the general public and encouraged staff to attend work even if they had symptoms of Coronavirus.[670] *Calderdale and Huddersfield Trust* staff were told that if they decided to self-isolate it would be considered as part of their annual leave rather than sick leave.[671] Although self-isolation was not a legally imposed requirement, if a worker contracted Covid-19 and had a positive test, the responsibility was in the hands of the employer to decide what they should do with the employee. Workers had two options, either to follow the government guidance on self-isolation or to follow the NHS self- isolation policy.[672] Asking HCWs to take annual leave when they were advised to self-isolate infringes upon their right to sick pay under to the 'coronavirus Statutory Stick Pay Rebate Scheme'.[673] According to Advisory Conciliation and Arbitration Services (ACAS) employees should be entitled to sick pay if they are unable to work due to ill health through contracting the Covid-19 virus.[674] The *Calderdale and*

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[667] J McVeigh, J Super and M. Jeilani, 'Eradicating inconsistencies in isolation guidance for NHS healthcare workers' (Public Health, 2021) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7895505/> accessed 11 March 2023.
[668] Shaun Lintern, 'Coronavirus: NHS trusts gave staff the wrong advice on self-isolation' (Independent, 2020) <https://www.independent.co.uk/news/health/coronavirus-nhs-hospitals-staff-isolation-symptoms-a9409726.html> accessed 11 February 2023.
[669] J McVeigh, J Super and M. Jeilani, 'Eradicating inconsistencies in isolation guidance for NHS healthcare workers' (Public Health, 2021) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7895505/> accessed 11 March 2023.
[670] Shaun Lintern, 'Coronavirus: NHS trusts gave staff the wrong advice on self-isolation' (Independent, 2020) <https://www.independent.co.uk/news/health/coronavirus-nhs-hospitals-staff-isolation-symptoms-a9409726.html> accessed 11 February 2023.
[671] Shaun Lintern, 'Coronavirus: NHS trusts gave staff the wrong advice on self-isolation' (Independent, 2020) <https://www.independent.co.uk/news/health/coronavirus-nhs-hospitals-staff-isolation-symptoms-a9409726.html> accessed 11 February 2023.
[672] 'Covid and work- Self-isolation' (ACAS) <https://www.acas.org.uk/working-safely-coronavirus/self-isolation#:~:text=Self%2Disolating%20(staying%20at%20home,policy%2C%20if%20they%20have%20one> accessed 11 March 2023.
[673] 'Claim back Statutory Sick Pay paid to your employees due to coronavirus (COVID-19)' (HM Revenue & Customs, 2020) < https://www.gov.uk/guidance/claim-back-statutory-sick-pay-paid-to-employees-due-to-coronavirus-covid-19#:~:text=The%20Coronavirus%20Statutory%20Sick%20Pay%20Rebate%20Scheme%20will%20repay%20employers,absences%20after%2017%20March%202022> accessed 11 March 2023.
[674] 'Covid and work- Self-isolation' (ACAS) <https://www.acas.org.uk/working-safely-coronavirus/self-isolation#:~:text=Self%2Disolating%20(staying%20at%20home,policy%2C%20if%20they%20have%20one> accessed 11 March 2023.

Huddersfield Trust further complicated this guidance by stating that if a family member of a HCW showed symptoms of the virus, the health care worker could request leave under medical suspension where they would be granted full pay and not have their sickness record affected. This advice is perplexing as evidently the member of staff who chose to self-isolate due to ill-health should be treated the same as a worker who was in close contact with a coronavirus positive patient. Nevertheless, the *South Tyneside and Sunderland Trust* also informed their staff that they would not advise members to self-isolate if a member of their household was unwell and encouraged staff to attend work unless they showed symptoms of coronavirus.[675] It is important to mention that during this period South Tyneside had the highest number of Covid-19 positive cases in England.[676] The surge resulted in South Tyneside and Sunderland NHS Trust staff having to self-isolate.[677] Having these contradicting self-isolation rules exposed HCWs to risks of contracting the virus putting their physical health in jeopardy. The trust went to great lengths by suspending all visits to adult inpatient care in order to minimise the spread of the Covid-19 virus.[678] Yet the trust also advised their staff to attend work despite a family member of a worker contracting the virus. This begs the question whether the trust as an employer breached its legal duties under Section 2 of the HSWA to provide a safe system of work and to provide adequate information, instruction, training and supervision for its employees.[679]

HCWs struggled to follow the NHS self-isolation policy as there were many discrepancies within each policy drafted by the different NHS trusts. On the one hand, although NHS workers were advised to self-isolate in the event of contracting the Covid-19 virus, workers were reluctant to take time off of work as they were worried about the overwhelming pressures it would put upon their colleagues.[680] Under the normal course of work, these workers would have taken the appropriate statutory sick leave. Yet, these workers continued to work as they felt that their colleagues could not cope with the pressures of providing care to an influx of patients. These workers were aware that the wards and surgeries within the NHS were understaffed and the camaraderie that they had within the workplace encouraged

[675] Shaun Lintern, 'Coronavirus: NHS trusts gave staff the wrong advice on self-isolation' (Independent, 2020) <https://www.independent.co.uk/news/health/coronavirus-nhs-hospitals-staff-isolation-symptoms-a9409726.html> accessed 11 February 2023.
[676] 'Covid: South Tyneside case rate now highest in England' (BBC, 2021) <https://www.bbc.co.uk/news/uk-england-tyne-57811923> accessed 11 February 2023.
[677] Ibid.
[678] 'Hospital visiting suspended after Covid' (Health watch South Tyneside) <https://www.healthwatchsouthtyneside.co.uk/hospital-visiting-suspended-after-covid-spike/> accessed 17 February 2023.
[679] Health and Safety at work etc Act 1974, S 2(2)(a) & S. 2(2)(c)
[680] Kristina L Newman, Yadava Jeve and Pallab Majumder, 'Experiences and emotional strain of NHS frontline workers during the Peak of the Covid-19 pandemic' (International Journal of Social Psychiatry, 2022).

a sense of obligation towards its co-workers.[681] On the other hand, HCWs were also concerned that they would receive reduced sick pay or were unlikely to receive full pay for time spent in self-isolation.[682]

The discrepancies imposed on HCWs were highlighted by HCW Livia. Livia was a care-home worker who provided care for adults with learning disabilities. Having suspected that she had contracted the Covid-19 virus, she had to self-isolate which meant that she was unable to attend work. She was not paid for the two weeks that she had to isolate and was faced with the heavy burden of having to provide financially for her mother and son, who she was living with at the time, without getting paid. This financial burden could have had an indirect effect on her physical health. Scholarly research has indicated that financial instability can strain the physical health of an individual.[683] Where an individual believes that their employment is not secure and unstable, it often leads towards the workers being diagnosed with a chronic disease or poor self-related health.[684] In most extreme cases, high levels of financial stress are associated with long-term physical health outcomes such as increasing the possibility of a cardiovascular disease of a worker.[685] Livia was unable to financially provide for her family due to the self-isolation regulations. This financial impact on her physical health could increase the risk towards chronic health conditions. Livia further stated that due to the fear of losing out financially if she was required to self-isolate, she decided not to download the NHS track and trace app.[686] The app was developed by the government to trace the virus and notify users if they had come into contact with a person who tested positive to the virus.[687] However, people like Livia were concerned about downloading the app as they could not afford to self-isolate without pay. This only aided the outbreak of the Covid-19 virus, as staff who suspected that they were carrying the disease continued to provide care for vulnerable patients. This put the patient, other workers within the work environment and most importantly the worker themselves in danger of risking their

[681] Helen Salisbury, 'Discouraging self-isolation with covid' (BMJ, 2022) <https://www.bmj.com/content/378/bmj.o1637> accessed 11 February 2023.
[682] Sarah Reed, Dr Billy Palmer, Mike Brewer, et al., 'Tackling Covid-19: A case for better financial support to self-isolate' (Nuffield Trust, 2021) < https://www.nuffieldtrust.org.uk/research/tackling-covid-19-a-case-for-better-financial-support-to-self-isolate> accessed 11 February 2023.
[683] Maria E Davalos and Michael T. French, 'This recession is wearing me out! Health-related quality of life and economic downturns' (The journal of mental health policy and economics, 2011) <https://europepmc.org/article/med/21881162> accessed 11 February 2023.
[684] Pekka Virtanen, Jussi Vahtera, Mika Kivimäki, et al., 'Employment security and health' (Epidemiology & Community Health, 2022).
[685] Safiya Richardson, Jonathan A Shaffer, Louise Falzon, et al., 'Meta-analysis of perceived stress and its association with incident coronary heart disease' (American journal of Cardiology, 2012).
[686] 'Care employers still not giving sick pay to Covid-hit staff, says UNISON survey' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/06/care-employers-still-not-giving-sick-pay-to-covid-hit-staff-says-unison-survey/> accessed 11 February 2023.
[687] 'Introducing the NHS test and trace app' (NHS Test and Trace) <https://covid19.nhs.uk/pdf/features-pack.pdf> accessed 11 February 2023.

health and safety.[688] According to a survey conducted by UNISON, one in ten care staff stated that they attended work despite having Covid-19 symptoms when they should have been off work self-isolating.[689] These workers should not have been put in a position to risk their health and safety at work over financial security as the government advised employers to ensure that their staff were paid in full.[690]

Healthcare worker Maria was also faced with a similar situation where she was required to self-isolate for two weeks having found out that a relative tested positive for Coronavirus.[691] She was not paid for the two weeks that she had to isolate and was instructed by her employer to use her holiday leave in lieu of sick leave. Even prior to the Covid-19 pandemic Maria refrained from using her sick leave as she could not afford to live without attending work. It is unfair to intimidate HCWs into attending work by putting significant financial pressure and not paying sick pay only encourages workers to attend work if they feel unwell, risking the outbreak of the virus within an already vulnerable care setting.[692]

Lastly, support worker Clare was required to self-isolate upon a request by the test and trace app as one of the colleagues within her workplace tested positive for the coronavirus. She felt undervalued, unappreciated and angry when she was informed that she would not be paid as she was advised to apply for Statutory Sick Pay or use her holiday leave.[693] She felt that it was unfair of her employer to ask her to use her holiday leave as she believed that she deserved her normal holiday allowance having provided care for patients during the Covid-19 pandemic. She became depressed during this time period and this could have had an indirect effect on her physical health due to the financial burden and uncertainty of payment during the pandemic. Clare's employer had a legal duty of care under the health and safety law to ensure that the environment she worked in was safe and to take reasonable steps to

[688] Luke Haynes, 'Self-isolation exemption for NHS staff 'desperate and potentially unsafe', BMA warns' (GPonline, 2021) <https://www.gponline.com/self-isolation-exemption-nhs-staff-desperate-potentially-unsafe-bma-warns/article/1723039> accessed 11 February 2023.
[689] 'Care employers still not giving sick pay to Covid-hit staff, says UNISON survey' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/06/care-employers-still-not-giving-sick-pay-to-covid-hit-staff-says-unison-survey/> accessed 11 February 2023.
[690] 'Covid and work- Self-isolation' (ACAS) <https://www.acas.org.uk/working-safely-coronavirus/self-isolation#:~:text=Self%2Disolating%20(staying%20at%20home,policy%2C%20if%20they%20have%20one> accessed 11 March 2023.
[691] 'Care employers still not giving sick pay to Covid-hit staff, says UNISON survey' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/06/care-employers-still-not-giving-sick-pay-to-covid-hit-staff-says-unison-survey/> accessed 11 February 2023.
[692] 'Coronavirus advice for social care workers; (UNISON) <https://www.unison.org.uk/care-workers-your-rights/coronavirus-advice-social-care-workers/> accessed 21 May 2023.
[693] 'Care employers still not giving sick pay to Covid-hit staff, says UNISON survey' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/06/care-employers-still-not-giving-sick-pay-to-covid-hit-staff-says-unison-survey/> accessed 11 February 2023.

mitigate such risks by conducting risk assessments.[694] The employer is further bound by the guidance provided by the Department of Health and Social Care (DHSC), Infection Prevention and Control which advices workers to self-isolate if an infection was identified within the workplace and to help prevent the spread of the virus by recognising and reporting it promptly.[695] This would reduce the risk of harm to patients whilst also protecting workers as they were advised to not attend work if they were unwell.[696] However, Clare's employer failed to comply with the above-mentioned preventive measures putting her physical health and safety in harm's way.

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The overall suggestion from the data is that despite receiving inconsistent advice from their employers, HCWs still prioritised their work and even if they did not feel safe, they had to face the stark choice of going to a contaminated work environment risking infection or staying at home without pay. According to a study conducted by UNISON, approximately 37% of the respondents in the survey stated that they were not paid while they were self-isolating having contracted the virus working in highly infectious work settings.[698] Financial

[694] 'Keeping everyone safe at work' (ACAS) <https://www.acas.org.uk/keeping-everyone-safe-at-work#:~:text=Employers%20must%3A,health%20and%20safety%20risk%20assessment> accessed 11 February 2023. 'Coronavirus (Covid-19) Advice for workplaces' (Health and Safety Executive) <https://www.hse.gov.uk/coronavirus/index.htm> accessed 11 February 2023.
[695] 'Infection prevention and control: resource for adult social care' (Department of Health and Social Care, 2024) <https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care> accessed 21 March 2023.
[696] 'Coronavirus advice for social care workers; (UNISON) <https://www.unison.org.uk/care-workers-your-rights/coronavirus-advice-social-care-workers/> accessed 21 May 2023.
[697] Ben Clover, 'Be careful of celebrating staff as 'heroes', NHSE advises trusts' (HSJ, 2023) <https://www.hsj.co.uk/workforce/be-careful-of-celebrating-staff-as-heroes-nhse-advises-trusts/7035743.article> accessed 21 May 2023.
[698] 'Care after Covid: A UNISON vision for social care' (UNISON, 2020) <https://www.unison.org.uk/content/uploads/2020/06/A-UNISON-Vision-for-Social-Care-June-2020.pdf> accessed 21 May 2023.

security is a necessary component that all workers seek to achieve and having worked tirelessly throughout the pandemic, these workers deserve adequate pay notwithstanding periods of self-isolation. Showing support for NHS staff through clapping, although a nice gesture, does not help pay the bills.[699]

1.3 Summary

It is unclear why different trusts construed the government self-isolation guidelines in different ways. Whether it was due to underlying economic and political motives or simply following the trust's own agenda, it resulted in complicating the guidelines which subsequently affected the health and safety of HCWs. The social care sector felt this lack of assistance the most, as they received inconsistent guidelines on the use of PPE and self-isolation. Although workers were entitled to statutory sick pay even if they were required to self-isolate, in practise most HCWs did not receive their salary while they were self-isolating. This infringes upon the advice given by the ACAS on workers' entitlement to statutory sick pay. Consequently, as these workers were receiving reduced pay or no payment at all, workers continued to work despite contracting the Coronavirus. This instigated major concerns as these workers are often providing care for vulnerable patients, which creates an environment that is unsuitable for these patients to recover from the virus. It further exposed fellow colleagues within the workplace and more importantly placed a physical health risk towards oneself.

2. The intention to leave the healthcare profession

One of the biggest challenges currently encountered across the NHS is a chronic workforce shortage.[700] The mounting pressures that the NHS frontline workers had to face as a result of the Covid-19 pandemic has led towards declining staff health and well-being and low morale, which has influenced the poor retention of NHS staff. Many HCWs have either left the profession after the pandemic or have a strong intention to leave having worked during the pandemic. There are several reasons that lead HCWs into making this significant decision including the risk and detriment towards their health and safety. In this section I

[699] 'Unmasked- Real stories of Nursing in Covid-19' (Royal College of Nursing, 2021) <https://www.rcn.org.uk/library-exhibitions/Unmasked> accessed 21 May 2023.
[700] Jim Reed, 'NHS in England facing worst staffing crisis in history, MPs warn' (BBC, 2022) <https://www.bbc.co.uk/news/health-62267282> accessed 07 February 2023.

will be focusing on the physical health and safety concerns that lead NHS HCWs to consider leaving the profession.

2.1 Get-your-vaccine!

Introducing the vaccine roll out quickly was a significant turning point during the Covid-19 pandemic.[701] The United Kingdom was the first country to launch a vaccination programme which was curated with the intention of controlling the spread of the Covid-19 virus.[702] At the inception of the roll out, the aim of the overall programme was to alleviate the pressure on both the NHS and the wider social care system and to reduce mortality.[703] Although the initial roll out created discrepancies as to who should be vaccinated first, it was reasonable to assume that frontline HCWs who provided care to patients should be one of the first to receive the jab.[704] However, in order to reduce mortality, priority was given to vulnerable elders.[705] Nevertheless, over time, the programme evolved in order to reduce morbidity and the vaccination was made available to low risk individuals.[706] According to the Centre for Disease Control and Prevention (CDCP), the vaccine enabled individuals to avoid potentially serious illness and built a more reliable and safe means to be protected from contracting the Covid-19 virus.[707] Consequently, the vaccine roll out had great potential with the possibility of reducing the long-term effects and transmission of the virus.[708]

Public Health England conducted a study which investigated the reinfection rates and the immune response to contracting the coronavirus over a 12-month period following 40,000

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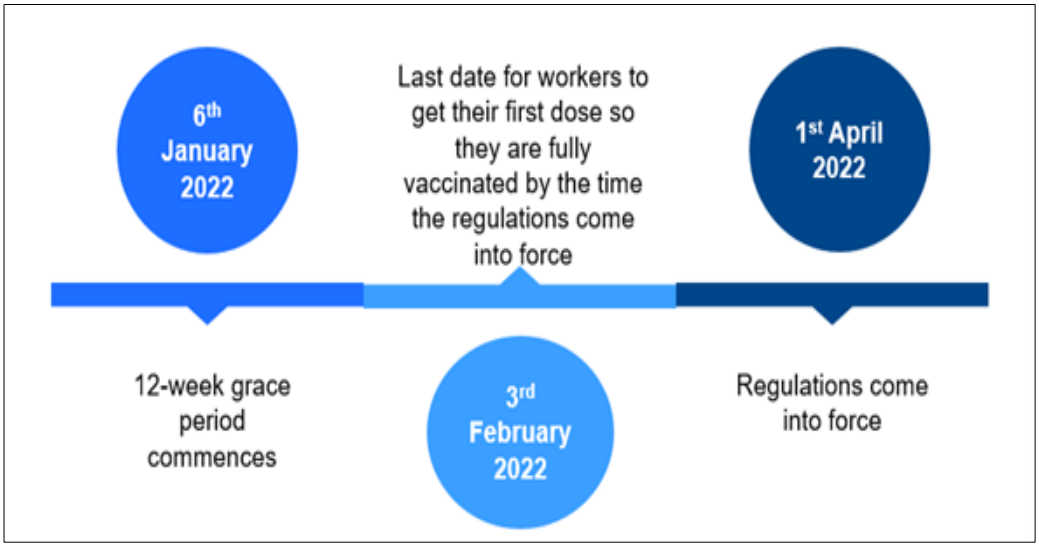
[701] 'NHS vaccine programme 'turning point' in battle against the pandemic' (NHS England, 2020) <https://www.england.nhs.uk/2020/12/nhs-vaccine-programme-turning-point-in-battle-against-the-pandemic/> accessed 07 February 2023.
[702] Sandra Mounier-Jack, Pauline Paterson, Sadie Bell, et al., 'Covid-19 vaccine roll-out in England: A qualitative evaluation' (PLoS One, 2023).
[703] 'Covid-19 vaccine: First person receives Pfizer jab in UK' (BBC, 2020) <https://www.bbc.co.uk/news/uk-55227325> accessed 10 March 2023.
[704] Tim Cook and Simon Lennane, 'Nurses, ambulance crews and support workers should get the covid vaccine first' (HSJ, 2020) <https://www.hsj.co.uk/comment/nurses-ambulance-crews-and-support-workers-should-get-the-covid-vaccine-first/7029239.article> accessed 10 March 2023.
[705] 'Frontline workers should be first in vaccine queue' (The Guardian, 2020) <https://www.theguardian.com/world/2020/dec/08/frontline-workers-must-be-first-in-covid-vaccine-queue> accessed 10 March 2023.
[706] 'Joint Committee on Vaccination and Immunisation' (GOV.UK) <https://www.gov.uk/government/groups/joint-committee-on-vaccination-and-immunisation> accessed 10 March 2023.
[707] 'Benefits of getting a Covid-19 vaccine' (Centers for Disease Control and Prevention, 2023) <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/vaccine-benefits.html#:~:text=to%20Build%20Protection-,Getting%20a%20COVID%2D19%20vaccine%20is%20a%20safer%2C%20more%20reliable,associated%20with%20COVID%2D19%20infection> accessed 10 March 2023.
[708] 'Covid-19 vaccine found to be effective in reducing long Covid symptoms' (University of Oxford, 2024) <https://www.ox.ac.uk/news/2024-01-12-covid-19-vaccines-found-be-effective-reducing-long-covid-symptoms> accessed 10 March 2024, Annelies Wilder-Smith, 'What is the vaccine effect on reducing transmission in the context of the SARS-CoV-2 delta variant' (The Lancet Infectious Diseases, 2022).

HCWs who had been vaccinated.[709] The results indicated that after one dose of the vaccine, 72% of HCWs were less likely to develop an infection. After two vaccine doses the percentage increased by 14%, with 86% of the workers within the study unlikely to be infected by the virus, regardless of whether any symptoms were present.[710] The introduction of the vaccine to combat the Covid-19 virus was a major step towards protecting the health and safety of NHS workers within the workplace.[711] It indicates that the employer identified a risk within the workplace and took reasonably practicable steps to mitigate such risks.

The success rate of the vaccination programme on HCWs persuaded the government to enforce a new regulation on the 6th of January 2022. The government mandated that NHS workers needed to be fully vaccinated with an authorised Covid-19 vaccine no later than the 1st of April 2022.[712] This meant that the government provided a 12-week grace period starting from the beginning of the 6th of January which enabled HCWs who did not have their first dose to receive the vaccine. As a minimum of eight weeks was needed between the first and the second dose, a HCW would need to receive their first dose by the 3rd of February 2022 in order to be fully vaccinated by the 1st of April.[713]

[709] Mary Ramsay, 'Covid-19: analysing first vaccine effectiveness in the UK' (GOV.UK, 2021) <https://ukhsa.blog.gov.uk/2021/02/23/covid-19-analysing-first-vaccine-effectiveness-in-the-uk/> accessed 10 March 2023.
[710] Mary Ramsay, 'Covid-19: analysing first vaccine effectiveness in the UK' (GOV.UK, 2021) <https://ukhsa.blog.gov.uk/2021/02/23/covid-19-analysing-first-vaccine-effectiveness-in-the-uk/> accessed 10 March 2023.
[711] 'Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers: Phase 1- Planning and Preparation' (NHS, 2021) <https://www.england.nhs.uk/coronavirus/documents/vaccination-as-a-condition-of-deployment-vcod-for-healthcare-workers-phase-1-planning-and-preparation/> accessed 10 March 2023.
[712] 'Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers: Phase 1- Planning and Preparation' (NHS, 2021) <https://www.england.nhs.uk/coronavirus/documents/vaccination-as-a-condition-of-deployment-vcod-for-healthcare-workers-phase-1-planning-and-preparation/> accessed 10 March 2023.
[713] 'Covid-19: mandatory vaccine guidance' (British Medical Association) <https://www.bma.org.uk/advice-and-support/covid-19/vaccines/covid-19-mandatory-vaccine-guidance> accessed 10 March 2023.



© NHS[714]

Mandating Covid-19 vaccination for HCWs sparked differing opinions about the issue within the community as the workers who failed to meet these requirements by the end of the deadline were at risk of dismissal.[715] This policy created anxiety within the health care sector, as the fear of dismissal weighed on the mind of the HCWs who worked face-to face with patients. Midwife Erika Thompson feared the risk of dismissal as she made a personal decision not to get the vaccine.[716] Although she faced the possibility of contracting the virus due to the vulnerability of not having the vaccine, she believed that natural immunity should be considered as mandatory inoculation infringed on her human right to make decisions about her own healthcare.[717] Yet, the DHSC believed that the best defence against coronavirus remained getting vaccinated as it not only protected the workers from contracting the virus, but it also protected the patients from infection.[718]

The government intended for this mandatory Covid-19 vaccine on NHS HCWs to be a win-win situation. They believed that if HCWs were protected from contracting the virus by getting the vaccination, the health and safety of staff would be protected and there would be

[714] 'Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers: Phase 2 – VCOD implementation' (NHS, 2022) <https://www.england.nhs.uk/coronavirus/documents/vaccination-as-a-condition-of-deployment-vcod-for-healthcare-workers-phase-2-vcod-implementation/#:~:text=3rd%20February%202022%20–%20the%20last,and%20countries%20and%20territories%20with> accessed 10 March 2023.
[715] 'Covid-19: mandatory vaccine guidance' (British Medical Association, 2022) <https://www.bma.org.uk/advice-and-support/covid-19/vaccines/covid-19-mandatory-vaccine-guidance> accessed 10 March 2023.
[716] Olivia Devereux-Evans, 'Unjabbed midwife fears losing her job over compulsory vaccines for NHS staff after she chose not to have Covid jab because she has heart condition' (Daily Mail, 2022) <https://www.dailymail.co.uk/news/article-10405625/Unjabbed-midwife-fears-losing-job-compulsory-vaccines-NHS-staff.html> accessed 10 March 2023.
[717] 'Covid: Hampshire midwife fears for job over vaccine refusal' (BBC, 2022) <https://www.bbc.co.uk/news/uk-england-hampshire-59986794> accessed 10 February 2023.
[718] 'Covid: Hampshire midwife fears for job over vaccine refusal' (BBC, 2022) <https://www.bbc.co.uk/news/uk-england-hampshire-59986794> accessed 10 February 2023.

more workers available to look after patients by not having to shield or call off sick.[719] In fact, it resulted in a win-lose situation as an alarming number of HCWs, approximately 40,000, left the NHS due to being pressured into getting the Covid-19 vaccine.[720] *Allette v Scarsdale Granger Nursing Home Ltd* (Case No: 1803699/2021) is a recent employment tribunal case that ruled on the contractual vaccination requirement and unfair dismissal.[721] The tribunal deliberated that the dismissal of the worker on the grounds of compulsory immunisation was within range of reasonable response and it was proportionate in the circumstances as it was implemented in order to protect the vulnerable patients within the care facility.[722] Such tribunal decisions provided the confidence for employers to require their staff to be fully vaccinated in order to protect the health and safety of both staff and patients within the workplace.

2.2 You've reached maximum capacity

The lack of sufficient investment towards training new NHS staff driven by years of insufficient funding and inadequate workforce staffing, has highlighted the lack of government accountability that continues to be the outcome of a vicious cycle. Although the Covid-19 pandemic exacerbated and increased the number of workers intending to leave the healthcare profession, the NHS embarked the pandemic with approximately 50,000 nursing vacancies and over 100,000 vacancies in nursing posts in social care.

Although it is essential to recruit more nurses and doctors to the NHS, it is also essential to understand why a significant number of workers are intending to leave or have already left the profession. It is not only a concern of just losing numbers. HCWs who choose to leave the profession after a number of years are taking their experiences and intellectual resources with them. The NHS is losing significant skills and expertise that these workers have, having been in the profession for a number of years. They leave due to the increasing workload and the severe understaffing issues, which ultimately results in the workforce being left with increasingly complex and vulnerable patients in the hands of junior doctors who have significantly less knowledge. The lack of adequate staff in the NHS raises alarm bells as it

[719] 'Government to introduce Covid-19 vaccination as a condition of deployment for all frontline health and social care workers' (GOV.UK, 2021) <https://www.gov.uk/government/news/government-to-introduce-covid-19-vaccination-as-a-condition-of-deployment-for-all-frontline-health-and-social-care-workers> accessed 10 February 2024.
[720] 'I witnessed colleagues' careers ending after they got Covid-19' (Trades Union Congress) <https://www.tuc.org.uk/workplace-guidance/case-studies/i-witnessed-colleagues-careers-ending-after-they-got-covid-19> accessed 10 February 2023.
[721] Allette v Scarsdale Granger Nursing Home Ltd (Case No: 1803699/2021).
[722] Allette v Scarsdale Granger Nursing Home Ltd (Case No: 1803699/2021).

implies that NHS workers are struggling to cope with the additional pressures of providing care to patients.[723]

Nicki Creadland, the chair of the British Association of Clinical Care Nurses, who has worked alongside other frontline HCWs, stated that the staffing ratios in the critical care nursing units were shocking. Although workers were redeployed to intensive care units, due to the increase in bed capacity alongside the increase in patients, the ratio of patients to staff dramatically increased up to six-to-one in some instances.[724] These unrealistic ratios created disparity between the expectation of the standard of patient care and the level of care that was actually received in practice. For a healthcare worker it was a physically unachievable task to provide adequate care to all patients, which ultimately resulted in workers being over-worked. Consequently, workers had to compensate for the lack of staff by working long shifts without satisfactory breaks adversely affecting their health and well-being.[725]

The data pool highlighted student ambulance technician David was working eight consecutive nightshifts from 10pm to 10am.[726] Amidst the tiring work shifts, covid-related treatment backlogs made ambulances queue outside hospitals for extended periods of time. David was struggling with his mental health having been confined to the ambulance with minimum ventilation and wearing a disposable mask for protection. David further states that: "I've had mental health issues and the pressures made me up my medication. But the private ambulance firm I worked for just ignored my situation".[727] This experience made David leave the healthcare service. The overwhelming pressure of having to work for long periods of time during the Covid-19 pandemic and having minimum support from his employer regarding his health and safety within the employment indicates that workers' health and safety was neglected during the pandemic. HCWs who work for long periods of time often experience burnout due to their lack of decent sleep.[728] The main aim of sleep is to restore energy which enables individuals to recover from illnesses and allows the body to rest and

[723] Rachel Gemine, Gareth R Davies, Suzaane Tarrant, et al., 'Factors associated with work-related burnout in NHS staff during Covid-19: a cross-sectional mixed methods study' (BMJ, 2021).
[724] 'Workers: Wellbeing, Burnout and NHS Capacity' (APPG Coronavirus, 2021) <https://www.appgcoronavirus.uk/meetings/blog-post-title-three-chxrx-9txzt-tll2s-d3jna-g9n56-npy4l-xhfng-9wjle-kanp2-6h9cz-slp8w-zcekr-my4hr-7t6g6-tj3dc-hn525-35dsd-th664-5nzep-9hk6g-cds9e> accessed 10 March 2023.
[725] Ro-Ting Lin, Yu-Ting Lin, Ying-Fang Hsia, et al., 'Long working hours and burnout in health care workers: non-linear dose-response relationship and the effect mediated by sleeping hours- a cross-sectional study' (Journal of Occupational health, 2021).
[726] 'Covid pressures triggering mental health issues among health staff' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/> accessed 10 March 2023.
[727] Ibid.
[728] Ro-Ting Lin, Yu-Ting Lin, Ying-Fang Hsia, et al., 'Long working hours and burnout in health care workers: non-linear dose-response relationship and the effect mediated by sleeping hours- a cross-sectional study' (Journal of Occupational health, 2021).

recover.[729] However, workers who work for long periods of time without adequate sleep have a risk of afflictions related to their physical health in the form of chronic pain, type 2 diabetes and a higher level of body mass index.[730] NHS workers having to work for long periods of time during the Covid-19 pandemic and having minimum support from their employer indicates that workers' health and safety was neglected, which would subsequently impact workers' physical wellbeing.

According to a survey conducted by the British Medical Association, 53% of the participants who suffer from moral distress mentioned that insufficient staffing to provide satisfactory treatment to their patients as the main reason.[731] Moral distress in this instance can be defined as, a healthcare worker being unable to provide appropriate care towards a patient due to institutional or resource constraints. They may feel apprehensive that they were unable to fulfil their duty and responsibility towards the patient and failed to take the ethically correct action.[732]

An interesting correlation is seen amongst workers who intend to leave the healthcare sector and their moral distress, as many feel that they have been put on an unreasonably high pedestal and that they are struggling to stay in that position.[733] This duty and responsibility was further emphasised by the "clap for heroes" which was initially seen as a wonderful gesture towards the NHS workers.[734] It was an opportunity for the public to show their support and appreciation towards the frontline HCWs. However, this heart-warming act quickly turned into a poisoned chalice as many workers felt that they were not able to give-up or fail in their duty.[735] HCWs were forced to make decisions that they would have not made prior to the pandemic, often at times making HCWs question their moral compass.

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[729] Monique Van der Hulst, 'Long workhours and health' (Scandinavian journal of work, environment & health, 2003).
[730] Violeta Clement-Carbonell, Irene Portilla-Tamarit, Maria Rubio-Aparicio, et al., 'Sleep quality, mental and physical health: a differential relationship' (International journal of environmental research and public health, 2021).
[731] 'The impact of the pandemic on the medical profession' (British Medical Association, 2022) <https://www.bma.org.uk/media/5645/bma-covid-review-2nd-report-19-may-2022.pdf> accessed 10 March 2023.
[732] 'Covid pressures triggering mental health issues among health staff' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/> accessed 10 March 2023.
[733] 'The impact of the pandemic on the medical profession' (British Medical Association, 2022) <https://www.bma.org.uk/media/5645/bma-covid-review-2nd-report-19-may-2022.pdf> accessed 10 March 2023.
[734] Ibid.
[735] 'Workers: Wellbeing, Burnout and NHS Capacity' (APPG Coronavirus, 2021) <https://www.appgcoronavirus.uk/meetings/blog-post-title-three-chxrx-9txzt-tll2s-d3jna-g9n56-npy4l-xhfng-9wjle-kanp2-6h9cz-slp8w-zcekr-my4hr-7t6g6-tj3dc-hn525-35dsd-th664-5nzep-9hk6g-cds9e> accessed 10 March 2023.

Michelle who was a NHS nurse who struggled to cope with the unusual nature of the work that she had to carry out during the pandemic.[736] She describes her experience as a "nightmare" having to provide care for covid positive patients who were dying under her supervision.[737] She felt guilty and helpless unable to do anything to prevent patients from dying. Although she was mentally struggling, she stated that: "no support was offered because everyone was so busy dealing with patients".[738] Michelle might have experienced moral distress due to the overwhelming pressure of having to provide care to vulnerable patients and due to the lack of support from her workplace, no longer works as a healthcare professional. It is often difficult to address moral distress as individuals experienced symptoms in the form of headaches, heart palpitations, guilt or frustration.[739]

In a survey conducted by the British Medical Association which included 1,797 respondents in spring 2021, 78% of the respondents stated that their experience of work in the healthcare sector was one of the key reasons that resonated with moral distress.[740] A GP worker quoted that "moral distress – being forced to practice in ways I would never believe I would have accepted – contributed to me leaving clinical medicine".[741]

While some workers were actively involved in working in the frontline with covid patients, others were continuing to do their duty and work in more routine ways. Duty in this instance looked different for different groups as NHS professionals who were working in cancer care, maternity, paediatric and mental health services were continuing to treat patients and keep them as safe as possible even though it was not frontline or centre stage. One such healthcare worker is Jocelyn Blumberg, who is a clinical psychologist working in the *Camden and Islington Foundation Trust*.[742] Jocelyn stated that "it is important to remember that they are all cogs in the bigger NHS and social care machine".[743] Workers like Jocelyn, who was a

[736] 'Covid pressures triggering mental health issues among health staff' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/> accessed 30 March 2023.
[737] Ibid.
[738] 'Covid pressures triggering mental health issues among health staff' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/> accessed 30 March 2023.
[739] Pam Stephenson and Andrea Warner-Stidham, 'Nurse Reports of Moral Distress During the Covid-19 Pandemic' (SAGE Open Nursing, 2024).
[740] 'Covid pressures triggering mental health issues among health staff' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/> accessed 30 March 2023.
[741] 'Covid pressures triggering mental health issues among health staff' (UNISON, 2021) <https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/> accessed 30 March 2023.
[742] Jocelyn Blumberg, 'Off the frontline? Experiences of NHS staff not working on the Covid wards' (KeepingWell NCL, 2021) <https://keepingwellncl.nhs.uk/podcast/off-the-frontline-experiences-of-nhs-staff-not-working-on-the-covid-wards/> accessed 18 March 2023.
[743] Ibid.

clinical psychologist, worked with both staff on the covid ward and staff who continued to provide treatment as usual to non-covid patients observed that using the term 'NHS heroes' only polarised the NHS.[744]

2.3 Summary

The Covid-19 vaccine was a revolutionary invention, designed specifically to limit the spread of the coronavirus. This technology significantly reduced severe illness and death by enabling the body's immune system to produce specific antibodies which could target the virus.[745] However, although the vaccination rollout program was generally considered a success, like most technological advancements, the Covid-19 vaccine sparked controversies. These controversies were quite prominent when the government initiated the mandatory vaccination policy. The major disagreement within the NHS workforce was that although most workers believed that they needed to do everything possible to protect themselves and their patients by getting the vaccine,[746] others believed that getting a vaccination was a personal decision and that legally mandating the vaccine across the NHS deprived their liberty of bodily autonomy.[747] Although these workers faced direct psychological impact and indirect physical health issues as a result of facing dismissal, however, it remains the case that the overall vaccination rollout assisted in protecting both the health and safety of workers and their patients. Additionally, the NHS has struggled to fill the many vacancy positions, which was further exacerbated by many staff leaving either due to refusing to receive a vaccine or undergoing moral distress due to the extreme pressures that were placed on staff during the pandemic. Although most employers attempted to comply with the health and safety legislation by providing a safe work environment, they ultimately failed to protect the workers' physical health as workers were often overworked, compromising their health and safety.

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[744] Jocelyn Blumberg, 'Off the frontline? Experiences of NHS staff not working on the Covid wards' (KeepingWell NCL, 2021) <https://keepingwellncl.nhs.uk/podcast/off-the-frontline-experiences-of-nhs-staff-not-working-on-the-covid-wards/> accessed 18 March 2023.

[745] 'About Covid-19 vaccination' (NHS, 2023) <https://www.nhs.uk/conditions/covid-19/covid-19-vaccination/about-covid-19-vaccination/#:~:text=If%20you're%20at%20increased,catching%20and%20spreading%20COVID%2D19> accessed 18 March 2023.

[746] Louise C Savic, Sinisa Savic and Rupert M Pearse, 'Mandatory vaccination of National Health Service staff against Covid-19: more harm than good?' (British Journal of Anaesthesia, 2022).

[747] 'Coronavirus vaccinations: can I be forced to get the Vaccine?' (Liberty) <https://www.libertyhumanrights.org.uk/advice_information/coronavirus-vaccinations-can-i-be-forced-to-get-the-vaccine/#:~:text=Apart%20from%20these%20situations%2C%20any,international%20treaties%20on%20medical%20treatment> accessed 18 March 2023.

3. Supply of Personal Protective Equipment

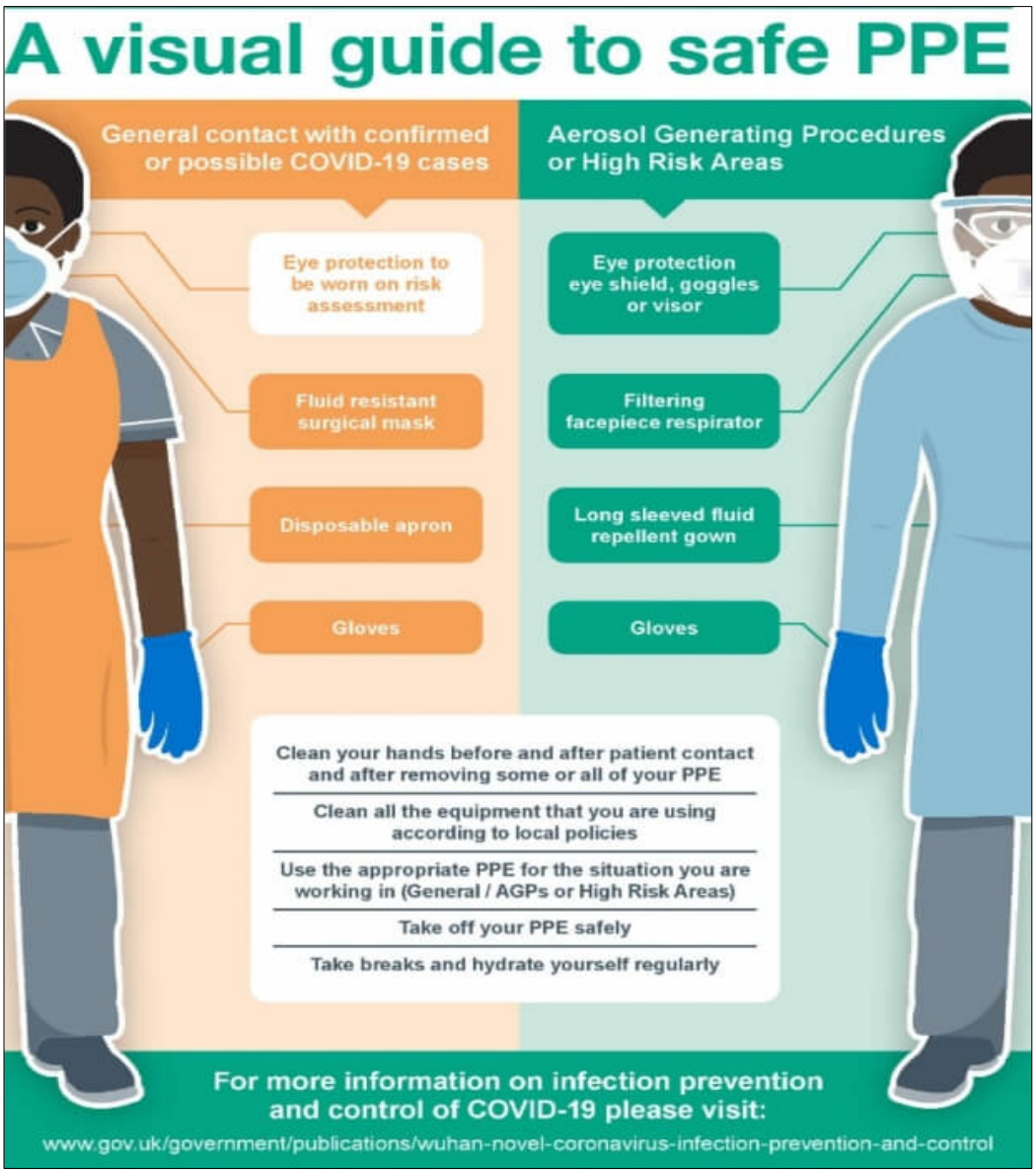
As mentioned in the previous chapter, the use of PPE was a focal point during the Covid-19 pandemic for various reasons. In this section I will focus on the most significant reason, that PPE enabled HCWs to effectively respond to the crisis by providing care to patients.[748] Frontline HCWs were deemed as the most at-risk group of professionals within the UK.[749] Prolonged contact with patients who either had the Covid-19 virus or who were symptomatic required these HCWs to use PPE. Protective equipment not only protects the HCWs from virulent pathogens but it is also an effective way of protecting both the patient and the healthcare provider from exposure to respiratory droplets and bodily fluids.[750]

3.1 PPE still processing!

Employers have a statutory duty under the health and safety legislation to ensure that workers are protected from risks.[751] These risks are mitigated by conducting suitable and sufficient risk assessments and deciding when, where and what type of PPE is required in order to protect their employees.[752] During the Covid-19 pandemic, HCWs who provided care to patients were required to wear PPE to reduce risks in order to stay safe at work.[753] The UK government and the NHS advised workers who were working within two metres of a suspected or confirmed Covid-19 patient whether in primary care or community care, to strictly observe wearing appropriate PPE.[754] These included eye protection, which was to be worn upon a risk assessment, a Fluid Resistant Surgical Mask (FRSM), a disposable apron

[748] Katarina Hoernke, Nehla Djellouli, Lily Andrews, et al., 'Frontline healthcare workers' experiences with personal protective equipment during the Covid-19 pandemic in the UK: a rapid qualitative appraisal' (BMJ open, 2021), Ignazio Roberto Terranova, Tatiana Bolgeo, Roberta Di Matteo, et al., 'Covid-19 and personal protective equipment: The experience of nurses engaged in care of Sars-Cov-2 patients: A phenomenological study' (Journal of Nursing Management, 2022).
[749] Long H Nguyen, David A Drew, Mark S Graham, et al., 'Risk of Covid-19 among front-line health-care workers and the general community: a prospective cohort study' (The Lancet Public Health, 2020), 'Covid-19:personal protective equipment (PPE) plan' (Department of Health and Social Care, 2020) <https://www.gov.uk/government/publications/coronavirus-covid-19-personal-protective-equipment-ppe-plan/covid-19-personal-protective-equipment-ppe-plan> accessed 19 October 2023.
[750] Hitoshi Honda and Kentaro Iwata, 'Personal protective equipment and improving compliance among healthcare workers in high-risk settings' (Current opinion in infectious diseases, 2016), Robert McCarthy, Bruno Gino, Philip d'Entremont, et al., 'The importance of personal protective equipment design and donning and doffing technique in mitigating infectious disease spread: a technical report' (Cureus, 2020).
[751] 'Using personal protective equipment (PPE) to control risks at work' (Health and Safety Executive) <https://www.hse.gov.uk/ppe/overview.htm> accessed 21 March 2024.
[752] 'Personal protective equipment (PPE) and Covid-19' (Royal College of Nursing, 2023) <https://www.rcn.org.uk/Get-Help/RCN-advice/personal-protective-equipment-ppe-and-covid-19> accessed 21 March 2024.
[753] Katarina Hoernke, Nehla Djellouli, Lily Andrews, et al., 'Frontline healthcare workers' experiences with personal protective equipment during the Covid-19 pandemic in the UK: a rapid qualitative appraisal' (BMJ, 2021).
[754] 'New personal protective equipment (PPE) guidance for NHS teams' (GOV.UK, 2020) <https://www.gov.uk/government/news/new-personal-protective-equipment-ppe-guidance-for-nhs-teams> accessed 19 October 2023.

and gloves.[755] In the instance where a worker was working in a high risk area or conducting Aerosol Generating Procedures (AGPs), they were advised to wear a higher level of protective equipment which included eye protection, in the form of an eye shield, goggles or a visor, a filtering facepiece respirator, a long sleeved fluid repellent gown and gloves.[756]



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[755] 'Covid-19: infection prevention and control guidance Appendix 2' (Public Health England, 2020) <https://madeinheene.hee.nhs.uk/Portals/0/COVID-19%20Infection%20prevention%20and%20control%20guidance%20Appendix%202%20%2820_05_2020%29.pdf> accessed 19 October 2023.
[756] Ibid.
[757] 'Covid-19: infection prevention and control guidance Appendix 2' (Public Health England, 2020) <https://madeinheene.hee.nhs.uk/Portals/0/COVID-19%20Infection%20prevention%20and%20control%20guidance%20Appendix%202%20%2820_05_2020%29.pdf> accessed 19 October 2023.

It was evident that when protective equipment was comprehensively and appropriately used there was a decline in the risk of coronavirus transmission.[758] The use of face masks was particularly effective, as the virus was distributed mainly by droplet transmission and/or contact.[759] The mechanical filtration in certain face masks enabled the small particles to be retained by the diffusion characteristics as the weaves of the fibres and the electrostatic properties assisted in blocking the transmission of droplets, which aided in reducing the viral transmission.[760]

This was apparent amongst the HCWs at the Addenbrooke's Hospitals in Cambridge which forms part of the Cambridge University Hospitals NHS Foundation Trust (CUH). Following the upgrade to Filtering Face Piece 3 (FFP3) masks and respirators, the infection rate of the Covid-19 virus among staff dramatically reduced.[761] The UK government guidance advised HCWs to use type IIR Fluid Resistant Surgical Face Masks (FRSM), yet the CUH believed that workers who provided care to Covid-19 infected patients were at greater risks and implemented a change from FRSM to FFP3 masks and respirators.[762] This change in respiratory protective equipment was a ground-breaking change within the healthcare community as it helped to mitigate the direct infection of the virus and effectively protect workers.[763] Similarly, the use of protective gowns and gloves assisted HCWs in preventing and limiting the spread of the virus particles to their exposed skin and specifically to and from objects.[764] In addition to using PPE, the World Health Organization and the UK government encouraged HCWs to observe behavioural infection control measures by maintaining good hand hygiene and practising physical distancing.[765]

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[758] 'The effectiveness of PPE in protection against Covid-19 transmission' (GOV.UK, 2021) <https://www.gov.uk/government/publications/nihr-the-effectiveness-of-ppe-in-reducing-the-transmission-of-covid-19-in-health-and-social-care-settings-december-2021-update-12-december-2021/nihr-the-effectiveness-of-ppe-in-reducing-the-transmission-of-covid-19-in-health-and-social-care-settings-december-2021-update-12-december-2021> accessed 19 October 2023.

[759] 'Coronavirus disease (Covid-19): How is it transmitted? (World Health Organisation, 2021) <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/coronavirus-disease-covid-19-how-is-it-transmitted> accessed 19 October 2023.

[760] L De Gabory, A Alharbi, M Kerimian, et al., 'The influenza virus, SARS-CoV-2, and the airways: Clarification for the otorhinolaryngologist' (European annals of otorhinolaryngologist, head and neck diseases, 2020).

[761] 'Upgrading PPE for staff working on Covid-19 wards cut hospital- acquired infections dramatically' (University of Cambridge, 2021) <https://www.cam.ac.uk/research/news/upgrading-ppe-for-staff-working-on-covid-19-wards-cut-hospital-acquired-infections-dramatically> accessed 09 May 2023.

[762] Ibid.

[763] Mark Ferris, Rebecca Ferris, Chris Workman, et al., 'Efficacy of FFP3 respirators for prevention of SARS-CoV-2 infection in healthcare workers' (Elife, 2021).

[764] Tom Jefferson, Liz Dooley, Eliana Ferroni, et al., 'Physical interventions to interrupt or reduce the spread of respiratory viruses' (Cochrane database of systematic review, 2023).

[765] 'Infection prevention and control health-care facility response for Covid-19' (World Health Organisation,2022) <https://www.who.int/publications/i/item/WHO-2019-nCoV-HCF_assessment-IPC-2020.1> accessed 19 October 2023, 'The effectiveness of PPE in protection against Covid-19 transmission' (GOV.UK, 2021) <https://www.gov.uk/government/publications/nihr-the-effectiveness-of-ppe-in-reducing-the-transmission-of-covid-19-in-health-and-social-care-settings-december-2021-update-12-december-2021/nihr-the-effectiveness-of-ppe-in-reducing-the-transmission-of-covid-19-in-health-and-social-care-settings-december-2021-update-12-december-2021> accessed 19 October 2023.

While in principle it may be acceptable to expect workers to adhere to the above measures and exercise the correct and rational use of PPE, in practise observing intricate PPE guidelines appeared to be challenging. This was highlighted by Samantha Margerison, who worked as a critical care nurse in the intensive care unit of the NHS in the south coast of England.[766] She states that prior to the Covid-19 pandemic, the nurses in the intensive care unit bore immense responsibility when providing care to patients and the Covid-19 crisis further challenged these workers. There was an added level of precaution that they had to adhere to when providing care to patients as workers had to wear gloves, a long-sleeved gown and a tight-fitting face mask even before they entered the outer doors of the unit.[767] Samantha was required to wear the PPE for the entire duration of her twelve hour shift in the unit and she expressed that "wearing all this gear is hot; its physically draining".[768] HCWs who use PPE for extended time periods are susceptible to heat exhaustion, as the moisture and excess heat is retained inside the equipment and the added layers of protection prevents the body from naturally cooling down by getting rid of the sweat.[769] It is no surprise that workers such as Samantha are exhausted by the end of their work shift as the extended use of PPE increases the likelihood of heat-related disorders. Prior to the pandemic, workers were able to take quick toilet breaks or rest breaks during their work shifts, however, Samantha states that she would hesitate to undertake even these simple self-care activities as she would need to strip off all PPE in the safe zone and then later re-dress herself. This would not only require a significant amount of time but would result in disposing of equipment that was in good condition.

Having to prioritise patient care and virus transmission over physical needs and physical comfort took a heavy toll on HCWs. According to the Working Time Regulations 1998, workers are entitled to have the right to rest for 20-minutes if they are required to work for more than 6 hours.[770] These rest periods are critical for HCWs as it allows them to remove

[766] Helen Coffey, 'I am an NHS nurse treating coronavirus patients in the ICU. We're fighting a war and soon we won't have any bullets' (Independent, 2020) <https://www.independent.co.uk/life-style/health-and-families/icu-nurse-critical-care-nhs-hospital-coronavirus-covid-19-ppe-a9477486.html> accessed 12 May 2023.
[767] Ibid.
[768] Helen Coffey, 'I am an NHS nurse treating coronavirus patients in the ICU. We're fighting a war and soon we won't have any bullets' (Independent, 2020) <https://www.independent.co.uk/life-style/health-and-families/icu-nurse-critical-care-nhs-hospital-coronavirus-covid-19-ppe-a9477486.html> accessed 12 May 2023.
[769] 'Limiting heat burden while wearing Personal Protective Equipment (PPE)' (Centers for Disease Control and Prevention, 2020) <https://www.cdc.gov/niosh/topics/heatstress/heat_burden.html#:~:text=Holds%20excess%20heat%20and%20moisture,muscle%20increases%20body%20heat%20production> accessed 12 May 2023, 'Personal protective equipment and heat: risk of heat stress' (Public Health England, 2021).
[770] 'Rest and breaks at work' (ACAS) <https://www.acas.org.uk/rest-breaks> accessed 12 May 2023.

PPE, rehydrate by using wet towels and reduce the core body temperature.[771] The importance of rest periods are also highlighted by ACAS as the lack of adequate rest could negatively impact workers' mental and physical health.[772] Samantha's employer had a duty to proactively ensure that suitable working arrangements were in place to take rests whilst at work in order to ensure that her physical health was protected.

The protective equipment provided a sense of security for HCWs: they were able to treat patients selflessly and with courage knowing that they are protected from infection as much as possible.[773] Following the shortage of PPE, however, both doctors and nurses started to voice their frustration and exasperation at the lack of adequate PPE supplies in the healthcare sectors.[774] For instance, in a survey conducted by the BMA on UK doctors during the first wave of the pandemic, it unveiled the disappointment that these doctors felt as they did not receive adequate support from the government and felt badly let down.[775] The survey indicated that 55%, which is more than half the participants, were pressured into conducting AGPs without proper protection. These procedures were considered 'high risk' and required additional protection, yet the government was not transparent with the healthcare community and did not declare that they had insufficient supplies and so misled the workers.[776] The suboptimal protection that workers received resulted in causing apprehension at work. Dr Roberts, who worked in the ITU during the height of the pandemic in a Midlands hospital, expressed the physical and mental distress the medical professionals felt.[777] The intensive care beds reached full capacity and the death toll continued to escalate all while having to cope with the shortage of proper PPE. Dr Roberts had to resort to fashioning PPE out of clinical waste bags, wearing skiing goggles as eye protection and using plastic aprons.[778]

[771] 'Temperature in the workplace' (Health and Safety Executive) <https://www.hse.gov.uk/temperature/employer/heat-stress.htm> accessed 12 May 2023.
[772] 'Rest and breaks at work' (ACAS) <https://www.acas.org.uk/rest-breaks> accessed 12 May 2023.
[773] Tim Tonkin, 'Let down' (British Medical Association, 2022) <https://www.bma.org.uk/news-and-opinion/let-down> accessed 12 May 2023.
[774] Denis Campbell and Heather Stewart, 'Doctors threaten to quit NHS over shortage of protective kit' (The Guardian, 2020) <https://www.theguardian.com/world/2020/mar/24/doctors-threaten-to-quit-over-protective-equipment-shortage> accessed 12 May 2023.
[775] Keith Cooper, 'Most doctors still lack protective equipment, finds survey' (British Medical Association, 2020) <https://www.bma.org.uk/news-and-opinion/most-doctors-still-lack-protective-equipment-finds-survey> accessed 12 May 2023.
[776] Ibid.
[777] Claire Press, 'Coronavirus: The NHS workers wearing bin bags as protection' (BBC, 2020) <https://www.bbc.co.uk/news/health-52145140> accessed 12 May 2023.
[778] Ibid.

© BBC[779]

It is disconcerting to see that medical professionals had to resort to such extreme measures in order to protect themselves from the virus. Dr Roberts expressed concerns of having to work a thirteen-hour shift in full PPE every day to care for critically ill patients which was starting to strain hospital staff. The duty to protect the health and safety of Dr Roberts was breached by her employer as they failed to comply with the law according to the PPER 2022. Regulation 4 of the PPER 2022 places a duty on employers to ensure that *suitable protective equipment* should be provided to the employees.[780] It is evident that Dr Roberts was not provided with suitable PPE, as resorting to use of clinical waste bags and skiing goggles hardly constitute as appropriate protective equipment to prevent the transmission of droplets. Not to mention, the above image shows how uncomfortable and unsustainable the use of these quick fix solutions are over a long period of time. Furthermore, Dr Roberts stated that the respiratory face masks that the medical staff were using in the hospital had been relabelled to cover the best-before end dates. In one instance she found that there had been three stickers pasted on top of each other to cover the expiry dates ranging from 2009-2013-2021.[781] This is a breach of her right to suitable PPE as according to Regulation 4(1) of the PPER 2022 a duty is placed on the employer to ensure that protective equipment provided to workers is suitable and Regulation 4(3)(d) further states that an equipment is deemed suitable if it can *prevent or adequately control the risks*.[782] However, it is uncertain if face

[779] Claire Press, 'Coronavirus: The NHS workers wearing bin bags as protection' (BBC, 2020) <https://www.bbc.co.uk/news/health-52145140> accessed 12 May 2023.
[780] Personal Protective Equipment at Work (Amendment) Regulations 2022, Regulation 4(1).
[781] Claire Press, 'Coronavirus: The NHS workers wearing bin bags as protection' (BBC, 2020) <https://www.bbc.co.uk/news/health-52145140> accessed 12 May 2023.
[782] Personal Protective Equipment at Work (Amendment) Regulations 2022, Regulation 4(3)(d), 'Personal protective equipment at work The Personal Protective Equipment at Work Regulations1992 (as amended) Guidance on Regulations' (Health and Safety Executive, 2022) <https://books.hse.gov.uk/gempdf/L25.pdf> accessed 04 May 2023, 'Do employers

masks that are expired beyond their best before date, were fit for the purpose of adequately preventing droplet transmission. If its effectiveness was reduced at all, it would increase the overall risk of infection amongst workers, putting further pressure on their health and safety.

The shortage of PPE was at the centre of causing physical distress to HCWs as it forced them to source PPE themselves.[783] Dr Helen Kirby-Blount highlighted the distress that staff within her workplace felt having to provide critical care to patients with a shortage of PPE.[784] Dr Helen worked as a GP in the Riverside Health Partnership in Retford, Nottinghamshire. She stated that the partnership did not receive any protective equipment for three months, starting from the month of early March.[785] The staff in the partnership bought PPE online or made use of equipment that was donated. The costs of buying PPE individually was expensive for workers and many resorted to re-using equipment.[786] This, to an extent, defeated the purpose of using PPE to prevent transmission. Workers who provided care to critically ill patients without adequate PPE risked the transmission of the virus, putting their physical health in danger. In this instance, the employer failed to provide reasonably practicable duty of care to the employees by providing suitable PPE for workers and consequently failed to protect their health and safety at work according to section 2 of the HSWA.[787] Furthermore, section 9 of the HSWA specifically states that employers have a duty not to charge employees for anything done or provided.[788] However, charging workers for protective equipment has breached this duty and incidentally affected the physical health of workers.

3.2 Are you protected?

During the early stages of the pandemic, HCWs' main concerns regarding PPE focused on the adequate supply of equipment and the proper use of PPE.[789] Nevertheless, as time went by, HCWs soon came to realise that the constant and prolonged use of PPE affected them in

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have to provide personal protective equipment (PPE)?' (Health and Safety Executive) <https://www.hse.gov.uk/contact/faqs/ppe.htm> accessed 04 May 2023.

[783] 'Nearly half of England's doctors forced to find their own PPE, data shows' (The Guardian, 2020) <https://www.theguardian.com/uk-news/2020/may/03/nearly-half-of-british-doctors-forced-to-find-their-own-ppe-new-data-shows> accessed 04 May 2023.

[784] 'Coronavirus: Doctors 'buy their own PPE or rely on donations 2020''(BBC, 2020) <https://www.bbc.co.uk/news/uk-52519339#:~:text=%27Our%20biggest%20fear%22&text=She%20said%20staff%20have%20resorted,equipment%20they%20have%20bought%20themselves> accessed 04 May 2023.

[785] Ibid.

[786] 'Coronavirus: GPs use donated PPE after 'nothing received since March'' (BBC, 2020) <https://www.bbc.co.uk/news/uk-england-nottinghamshire-52529200> accessed 04 May 2023.

[787] The Health and Safety at Work etc. Act 1974. S.2

[788] The Health and Safety at Work etc. Act 1974. S.9

[789] David Oliver, 'Lack of PPE betrays NHS clinical staff' (BMJ, 2021) <https://www.bmj.com/content/372/bmj.n438> accessed 27 November 2023.

a much deeper way.[790] Workers experienced physical distress and anxiety when they became aware of skin irritation due to the extended use of PPE.[791] This health condition, commonly known as work-related contact dermatitis, is commonly seen in the healthcare sector. The constant hand washing and extended use of PPE lead workers into experiencing skin irritation, discomfort, burning sensation, skin tears, blisters, acne, atopic/eczema dermatitis and allergic responses.[792]

Employers have a legal obligation under the Control of Substances Hazardous to Health Regulations 2022 (COSHH) to ensure that their employees are protected from exposure to hazardous materials and protected from workplace injuries and ill health.[793] In order to comply with the above, employers must conduct the appropriate risk assessments on how to prevent or reduce risks. In order to do so, workers must be provided with information and training of the risks associated with potentially hazardous substances that workers might use during the course of the work.

According to the HSE, more reportedly nurses experience work-related contact dermatitis when compared to all other professionals.[794] The Royal College of Nursing further confirmed this account: according to a survey conducted on skin health, 93% of nursing staff experienced at least some form of skin condition.[795] The Covid-19 pandemic only aggravated this issue, as from the onset of the Covid-19 pandemic everyone was instructed to wash their hands thoroughly and regularly in order to prevent transmission of the virus.[796] Although nurses were accustomed to hand hygiene prior to the pandemic, the frequent handwashing, hand sanitization (with alcohol rub) and the use of rubber gloves all contributed to stripping the natural hydration and moisture from the skin, exposing it to abrasion.[797] Occupational dermatitis can be prevented and the NHS encourages workers to follow a three step preventative approach, *avoid-protect-check,* starting with *avoiding* direct contact with

[790] Arpi Manookian, Nahid Dehghan Nayeri and Mehraban Shahmari, 'Physical problems of prolonged use of personal protective equipment during the Covid-19 pandemic: A scoping review' (In Nursing Forum, 2022).
[791] Yu Sawada, 'Occupational skin dermatitis among healthcare workers associated with the Covid-19 pandemic: a review of the literature' (International Journal of Molecular Sciences, 2023).
[792] Ghassan M Barnawi, Azhar M Barnawi and Sahal Samarkandy, 'The association of prolonged use of personal protective equipment and face mask during Covid-19 pandemic with various dermatologic disease manifestations: a systematic review' (Cureus, 2021).
[793] Control of Substances Hazardous to Health Regulations 2022, Regulation 7(3).
[794] 'Work-related contact dermatitis in the health services' (Health and Safety Executive) <https://www.hse.gov.uk/skin/employ/highrisk/healthcare.htm> accessed 15 July 2023.
[795] 'Save your skin' (Royal College of Nursing, 2020) <https://www.rcn.org.uk/magazines/Bulletin/2020/June/Save-your-skin-COVID-19> accessed 15 July 2023.
[796] 'New campaign to prevent spread of coronavirus indoors this winter' (Department of Health and Social Care, 2020) <https://www.gov.uk/government/news/new-campaign-to-prevent-spread-of-coronavirus-indoors-this-winter> accessed 15 July 2023.
[797] 'Hand hygiene: top tips for skin health and glove use' (Royal College of Nursing) <https://www.rcn.org.uk/magazines/Advice/2024/May/Hand-hygiene-top-tips-for-skin-health-and-glove-use> accessed 19 October 2023.

hazardous substances and or wet work especially with unprotected hands.[798] This was difficult to practise during the pandemic as on average workers washed their hands with soap 22.8 times a day to observe good hand hygiene and they also used alcohol hand gel 22.7 times a day in order to prevent the transmission of the virus.[799]

This data presented by the British Association of Dermatologists (BAD) states that frequent hand cleansing with the exposure to water, soap and the use of alcohol hand gel by HCWs lead to a spike in skin irritation.[800] HCWs resort to excessive handwashing when their employers failed to provide suitable PPE to workers. The data highlighted the case of midwife and nurse Anita, who was assigned to provide care to patients who were suspected of having the coronavirus. In order to test the presence of the virus, however, a swab sample took two to three days to obtain a result and during the meantime she was not provided with any protective equipment when treating the suspected patient. Consequently, the only plausible preventive measure she was able to carry out was compulsively washing her hands.[801] Evidently, avoiding direct contact is not always realistic.

In instances where contact cannot be avoided, the NHS encourages workers to practice the second preventative measure:[802] contaminated skin should be *protected* by promptly washing it and completely pat drying the skin with disposable towels.[803] If workers wear gloves shortly after washing hands without drying them, the moisture in the hands could cause dermatitis.[804] Workers are also advised to replenish the natural oils of the skin at the end of the workday as a protective measure. It should be noted that the employers did not provide any form of after care to their employees to maintain the skin's protective barrier. It was in fact the public and cosmetic companies that provided workers with 'care packages' that helped replenish their skin. One individual provided 'pick-me-up' skin care packages to

[798] 'National standards of healthcare cleanliness 2021: health and safety' (NHS, 2021) <https://www.england.nhs.uk/wp-content/uploads/2021/05/B0271-national-standards-of-healthcare-cleanliness-2021-health-and-safety.pdf> accessed 19 October 2023.
[799] 'Audit highlights the impact of PPE and hand disinfection on the skin health of healthcare professionals during the Covid-19 pandemic' (British Association of Dermatologists, 2024) <https://bad.org.uk/audit-highlights-the-impact-of-ppe-and-hand-disinfection-on-the-skin-health-of-healthcare-professionals-during-the-covid-19-pandemic/> accessed 29 March 2024.
[800] Ibid.
[801] 'Stories from behind the mask' (BBC) <https://www.bbc.co.uk/programmes/articles/2cm0PfTtkPqjMymJQl38YJC/stories-from-behind-the-mask> accessed 19 March 2022.
[802] 'National standards of healthcare cleanliness 2021: health and safety' (NHS, 2021) <https://www.england.nhs.uk/wp-content/uploads/2021/05/B0271-national-standards-of-healthcare-cleanliness-2021-health-and-safety.pdf> accessed 19 October 2023.
[803] Purva Mathur, 'Hand hygiene: back to the basics of infection control' (Indian journal of medical research, 2022).
[804] Daniel Preece, Roger Lewis and Matt Carre, 'Efficiency of donning and doffing medical examination gloves' (International Journal of Ergonomics, 2020).

frontline staff who suffered skin damage due to the use of PPE.[805] These packages included creams, moisturisers and lip balms to hydrate and replenish dry and tired skin. Similarly, luxury beauty brand L'Occitane provided 10,000 hand creams to the NHS to alleviate skin irritation of frontline workers.[806] Yet, the NHS as the employer failed to provide this care to its workers.[807] Although this is not a legal requirement, providing these skin care products to workers could ensure that their skin was protected from irritation. While occupational hand dermatitis is not a major illness, if it is not prevented it could develop into a chronic condition resulting in workers becoming unable to work and having to take leave.[808]

In order to avoid this the NHS urges workers to follow the last and final preventive measure of *checking* their hands frequently to reduce the risks of dermatitis by spotting early signs of itchy, dry or red skin.[809] Treating dermatitis at an early stage is more effective and reduces the likelihood of infection. Checking for early signs of dermatitis was difficult for workers of black and brown skin, however, as redness was obscure amongst this group and many other workers were often preoccupied with having to provide care to their patients.[810] These preventative measures introduced by the NHS are broad and all-encompassing and does not specifically address issues that HCWs experienced during the Covid-19 pandemic.

3.3 Summary

Risk assessments are essential in order to protect the health and safety of workers when at work. Risk assessments identify if PPE is required and what type of equipment is needed to mitigate risks at work. PPE played an important role during the inception of the pandemic and continued to do so for its entirety. HCWs relied on PPE as it enabled them to provide care to patients who were infected with the virus or who were symptomatic.

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[805] 'NHS staff's PPE skin damage inspires 'pick-me-up' packs' (BBC, 2021) <https://www.bbc.co.uk/news/uk-england-humber-55650054> accessed 19 October 2023.
[806] Becki Murray, 'L'Ocitan donates over 10,000 hand creams to the NHS in light of coronavirus' (Harper's Bazaar,2020) <https://www.harpersbazaar.com/uk/beauty/skincare/a31467238/loccitane-hand-cream-donation-nhs/> accessed 19 October 2023.
[807] Emily S Burns, Pirunthan Pathmarajah and Vijaytha Muralidharan, 'Physical and psychological impacts of handwashing and personal protective equipment usage in the Covid-19 pandemic: A UK based cross-sectional analysis of healthcare workers' (Dermatologic Therapy, 2021).
[808] H O'Neill, I Natang, D A Buckley, et al., 'Occupational dermatoses during the Covid-19 pandemic: a multicentre audit in the UK and Ireland' (British Journal of Dermatology, 2021).
[809] 'National standards of healthcare cleanliness 2021: health and safety' (NHS, 2021) <https://www.england.nhs.uk/wp-content/uploads/2021/05/B0271-national-standards-of-healthcare-cleanliness-2021-health-and-safety.pdf> accessed 19 October 2023.
[810] Bridget Kaufman and Andrew Alexis, 'Eczema in Skin of Color: What You Need to Know' (National Eczema Association, 2023) <https://nationaleczema.org/blog/eczema-in-skin-of-color/#:~:text=Redness%20may%20be%20obscured%20in,this%20condition%20between%20ethnic%20groups> accessed 19 October 2023.

It is important to highlight that while PPE enables workers to mitigate the risk associated with working in covid infested environment, the ripple effect of the use of PPE resulted in causing physical distress. HCWs were working in full PPE which caused them heat stress as there were no means for the heat to escape the body and the rise in body temperature resulted in extreme physical discomfort. Workers were reluctant to take breaks when wearing PPE as it would require the worker to remove all PPE and re-dress themselves with new PPE. These breaks would have helped workers reduce the body temperature whilst also giving them a quick break from having to put on their cumbersome 'body armour'. However, workers did not want to run out of PPE and refrained from taking breaks when at work. If the government was successful in providing enough PPE to HCWs taking breaks would have been easier rather than being an afterthought.

The shortage of PPE supply caused physical and mental distress to workers. PPE reduced the risk of Covid-19 infection as it curbed the transmission of the virus. When the supply of PPE ceased, workers resorted to buying their own PPE and using random objects in lieu of proper and suitable PPE. This was a breach of the workers right to free and suitable PPE by their employers. Finally, workers experienced skin irritation due to the prolonged use of PPE. Although some guidelines to reduce the risk of dermatitis are available, they are not specifically tailored towards healthcare professionals who were regularly washing hands alongside wearing PPE for long periods.

Conclusion

When conducting the data analysis, it became evident that the three themes above were tightly interlinked. For instance, the first theme explored the physical health impact on HCWs due to receiving inconsistent advice across the NHS workforce. The confusion and complexity generated by the different policies and work arrangements across the health sectors could have prompted workers to leave the NHS. The lack of common standards and procedures within the different NHS trusts was a major factor in the risks to HCWs' morale. Workers' intention to leave the profession increased due to the shortage of HCWs in the healthcare sector. This resulted in overworking workers and due to the lack of adequate staff, workers who were infected with the virus or even if they had recently been in contact with a family member who had contracted the virus were encouraged to attend work. The employers failed to adhere to health and safety legislation on a number of different occasions. HCWs who contracted the Covid-19 virus were instructed to attend work by their

employers, creating a dangerous environment for both patients and themselves. Health and safety legislation requires employers to ensure that they provide a safe system of work and adequate information when at work. Workers often encountered financial loss having to self-isolate during the pandemic which negatively affected their mental and physical health. The shortage of PPE caused a fear among workers which resulted in many staff deciding to leave the NHS as they felt that their health and safety was not protected at work. Despite the above, employers were successful in mandating the Covid-19 vaccination program which mitigated the risk associated with contracting the virus and helped protect the health and safety of workers though it also contributed to significant numbers of HCWs leaving the NHS. Having completed the analysis, the next chapter will include a summary of the key findings of chapters and the overall conclusion of the thesis.

Chapter 7 Conclusion

This thesis addressed the question, whether the health and safety legislation in place during the Covid-19 pandemic was adequate to protect the health and safety of HCWs in the United Kingdom. In order to analyse the degree to which the health and safety of workers was protected, it was essential to understand the various contributing factors. Accordingly, chapter one explained the structure of the NHS and the differences across the four nations. The analysis focused on the NHS healthcare system in England and the establishment of NHS trusts and foundation trusts. It thereby explained the internal administration of the health and safety standards within the different NHS trusts. This chapter also drew attention to the fact that HCWs were subjected to workplace risks and experienced mental and physical health issues prior to the pandemic, which were aggravated very significantly following its outbreak.

Chapter two described the methodology and the theoretical framework that was used to understand and address the main aim of the research. Using a 'research diary', it explained my thinking and decision-making on how I approached the research. It explains that I chose to use a socio-legal research method to analyse the effectiveness of the health and safety legislation during the Covid-19 pandemic. This method enabled me to understand how the law is applied and interpreted by employers, which provided insight into the application of the law and how society is shaped by its impact. Having established the research method, the data was collected from the testimonies published online. While consideration was given to other data collection methods such as conducting interviews, it was ultimately found that the secondary data was readily accessible for analysis. This was due to the growing body of HCWs voicing their experience of working during the pandemic. The workers had time to process their experience and did not feel the need to sugar-coat their experience to share it publicly. Themes began to emerge when conducting the initial data analysis. I was able to categorise this data into five distinctive themes, namely: the prejudicial treatment of Black Minority Ethnic workers, the lack of support for migrant workers, the supply of PPE, inconsistent advice across the NHS workforce and the intention to leave the healthcare profession. Using a qualitative thematic analysis enabled me to gain deeper insight into the effectiveness of the occupational health and safety legislation in the UK.

Chapter three analysed in detail the health and safety legislation surrounding workplace health and safety. The chapter focused on one of the most prominent aspects of the 1974 Act, recommended by the Robens Committee, which was the introduction of a self-

regulating system of enforcing workplace health and safety. While this enabled workplaces to move away from a fragmented system, the implementation resulted in inconsistencies across different NHS trusts. Such inconsistencies constituted an important point of discussion in chapters five and six.

Chapter four highlighted the important role played by trade unions and their constant efforts to improve the working conditions of workers. Collective bargaining was used during the Covid-19 pandemic in order to negotiate for better working conditions for frontline workers. When compared to the statutory protection that a worker should get, trade unions were able to navigate more nimbly, addressing the unique challenges of the pandemic and advocate for the health and safety of workers.

To assess the extent to which the health and safety of workers was protected, it was crucial to analyse how the pandemic affected the mental and physical health of these HCWs. Chapter five focused on the mental health of workers and questioned whether the legislation pertaining to mental health was deliberated and utilised by the employers within the NHS to support and safeguard the mental health of HCWs during the Covid-19 pandemic. Chapter six focused on the physical health impact the workers faced during the pandemic and the role played by their employers when adhering to the health and safety legislation in this respect. The fundamental piece of legislation that regulates and enforces the health, safety and welfare of the workplace is the Health and Safety at Work etc Act 1974. Although from the outset it may seem that the 1974 Act was capable of managing the safety of workers across all employment sectors, the research brought to light that the 1974 Act was unable to wholly protect the health and safety of HCWs during the pandemic.

It is important to emphasise that the research specifically focuses on HCWs' experience within the NHS. Consequently, the research findings are not directly transferable and their generalisability is limited to that scope. While the research provides valuable insight into the challenges and successes faced by workers during the Covid-19 pandemic, they are not directly transferable to other worker populations such as private healthcare or healthcare in other countries. Similarly, chapter four above clarifies that the observations about trade unions are fundamentally of the operations only within the NHS. Accordingly, any conclusions mentioned about trade unions may not apply to trade unions of other sectors of work. Finally, it is essential to clarify that this research does not provide a legal review nor offer legal interpretations, as the analysis is based on qualitative data on how HCWs lived and their experiences of working during the pandemic. The research does make reference to

certain aspects of policy and regulation in order to understand how they are navigated and implemented by HCWs in practice.

While undertaking research to address the main thesis question, a number of secondary questions arose, which helped to structure the data analysis and assisted in evaluating the overall aim. The first of these was *what were the conditions that led towards HCWs' health and safety being put in jeopardy?* Since the beginning of the Covid-19 pandemic, one of the main challenges involved the accessibility of PPE. The shortage and the lack of appropriate protective equipment left HCWs in a precarious position as covid infected patients still required care. Workers felt pressured to tend to patients and continue working in these unsafe environments. This was a direct breach of the workers' right to PPE. According to the PPER 2022, employers are under a duty to provide suitable PPE for their workers. In instances where protective equipment was provided, it was not suitable for all HCWs. As the data highlighted, it was often not fit for purpose and ill-fitting for many female HCWs which defeated the purpose of wearing protective equipment and put workers' health and safety in jeopardy. The guidance provided in the PPER 2022 further states that PPE is considered suitable only if it can adequately prevent and control risks.[811] However, the data indicated that most workers were not aware of the proper use of some equipment, since such equipment is not usually used on a daily basis, but rather only in special circumstances such as the Covid-19 pandemic. These conditions within the work environment certainly put the health and safety of workers at risk, despite the law setting out specific regulations to avoid or minimise the threat posed towards workers. As well as having to cope with the shortage of PPE, workers were also put at risk by the constantly changing and complicated government guidelines. The government guidelines on self-isolation and the use of the protective equipment for HCWs was inconsistent and it was different from one trust to the next. This resulted in discrepancies in compliance with the workers' right to statutory sick pay. As a result of the contradictory guidelines, this entitlement was infringed, as workers received reduced pay or no pay at all. During this period, many HCWs were reluctant to use their sick leave due to the fear of not getting paid, which resulted in workers continuing to work and risking their health and safety.

Were health care workers treated equally during the Covid-19 pandemic when it came to their health and safety? The analysis highlighted that many Black Minority Ethnic workers were treated unfairly and subjected to discrimination during the Covid-19 pandemic.

[811] Personal Protective Equipment at Work (Amendment) Regulations 2022, Regulation 4(3)(d),

Unfortunately, unfair treatment was not new to these workers; in fact, they were already familiar with prejudicial treatment while at work prior to the pandemic. Nevertheless, the discriminatory treatment of BME workers was exacerbated during the pandemic. This included cases where black HCWs were preferentially assigned to patients who were infected with the virus. A disproportionately high number of BME workers were also sent on home visits in comparison to their ethnic majority counterparts. The analysis revealed that this discrimination significantly affected workers' mental health as they felt helpless having to work in environments that risk their safety, with their employers failing to take reasonably practicable steps to reduce such risks. When considering the mental health of workers, it is important to consider the Equality Act 2010 which requires the employer to protect workers from being discriminated. In line with the above, BME workers were treated less favourably during the pandemic due to their race, especially when compared to their white colleagues. Similar to BME workers, migrant workers also endured difficulties working in the NHS. Prior to the pandemic, migrant workers were already bearing the burden of having to deal with the demanding and financially straining immigration rules and requirements. These requirements only got worse during the Covid-19 pandemic. Immigration requirements and rules were constantly changing and the fees were increasing at a rate such that workers were unable to keep up with the inflated expenses. Migrant HCWs often felt isolated, living in a different country to their family and friends and unable to visit for long periods due to pandemic border restrictions. Having to navigate working under a new set of guidelines and dealing with the constantly changing immigration requirements was a heavy mental toll on these workers.

What health and safety measures did the government introduce to meet the novel challenges and risks occasioned by the nationwide pandemic? The most important and noticeable measure introduced by the government was the mandatory vaccine rollout programme. Albeit controversial in its enforcement, the vaccine programme ensured the health and safety of workers. While not all HCWs were in agreement with the mandatory vaccination requirement, the statistics on the vaccination rollout programme indicated that it both reduced the number of workers contracting the virus and in the instance that workers still contracted the disease, ensured that the symptoms were less severe. While most NHS HCWs complied with the prerequisite, a minority group of workers who did not want to be vaccinated were put under extreme pressure and many chose to leave their profession. However, the mandatory requirement imposed by the NHS on its workers to get the vaccine was in line with the 1974 Act, specifically section 2 where employers are required to take

reasonably practicable steps to protect the health and safety of their workers. This is precisely what the NHS, as an employer, tried to achieve.

The section above provides an insight into the different themes of the analysis and how the health and safety legislation affected the mental and physical health of HCWs. It was intriguing to understand how the health and safety legislation applied in practice with the use of the socio-legal methodology. Having explored the evolution of health and safety legislation in Chapter three, I concluded that the impact of the laws on the HCWs was potentially remarkable. For instance, according to section 2 of the 1974 Act, employers have a duty to ensure that the health and safety of workers so far as is reasonably practicable, the health and safety of their workers. The NHS was able to comply with this duty when it implemented the mandatory vaccine rollout programme. This implementation had a clear difference on how the virus affected the HCWs. However, when the employers were unable to adhere to the law and implement their duties there was a negative effect on the health and safety of workers. For instance, the supply of PPE was not adequately met by the NHS which had a snowball effect on the health of workers. this often began with physical imprints leading towards indirect mental health issues amongst workers.

Although it was of course necessary to analyse the legislation, it was also important to consider the collective bargaining role played by the trade unions. This was highlighted in Chapter four which emphasised the importance of trade unions during the Covid-19 pandemic. Trade unions strive to achieve protection for workers. While the pandemic presented unique challenges, the unions continued to advocate for better protection at work, especially for frontline workers. Not only did trade unions advocate for the physical safety of workers they also strived to achieve workplace justice; to protect workers from discrimination within workplaces and encourage and assist workers to take claims to the employment tribunals in instances where they have been treated unfairly at work. This was an interesting discovery as it showed that the trade unions could be more effective at protecting the health and safety of HCWs than the legal framework. This could be due to the fact that trade unions have the means to conduct collective bargaining with employers. Trade unions are able to tailor their agreements in order to respond to specific needs in a flexible manner. The Covid-19 pandemic was an interesting episode in this respect, because it caused workers to need rapid solutions for health and safety issues within the workplace. While legal frameworks often require long time periods to produce outcomes, trade unions were able to innovate solutions without having to wait for law reform and consistency in labour legislation across different industries.

It is important to highlight the significant findings of my research. The data indicated that HCWs' health and safety was not adequately protected by NHS employers in line with the health and safety legislation during the pandemic. The lack of adequate protection and ill-fitting equipment posed significant risk to workers which caused anxiety and distress. Even in instances where there was a shortage of PPE, workers did not receive consistent advice which caused significant challenges within the workforces. While the self-regulating system provides the enforcement flexibility, the need for clear and consistent guidelines across the NHS workforce was apparent. Additionally, the research highlighted the deep-rooted issues within the healthcare system. The discrimination and unfair treatment towards Black Minority Ethnic workers was significant due to the disparities in health and safety protection when compared to their white colleagues. Employers failed to fulfil their duty to protect workers' health and safety not only under the 1974 Act but also the EqA 2010. BME workers were often preferentially required to work in covid infected environments putting them at a greater risk of being exposed to the virus and were required to work without adequately conducting risk assessments. The NHS also failed to advocate for change and support migrant health workers. A significant number of NHS HCWs that provided care during the pandemic were migrant workers and yet they were faced with particular issues due to the lack of employer support. The systematic discrimination and unfair treatment that BME and migrant workers faced had a significant impact on those workers' mental health.

Certainly, the Covid-19 pandemic will not be the last viral outbreak that we will experience in the coming years. Accordingly, the lessons learned from the Covid-19 pandemic carry particular importance on improving the healthcare system. The Covid-19 pandemic exposed the flaws in the healthcare system and practising the lessons learned from the pandemic could reduce the unnecessary stress put on HCWs. First and foremost, the government should invest in strengthening the public health surveillance system. Early intervention after a disease is detected allows for timely implementation of containment measures. Public health can be strengthened by having robust surveillance systems as the foundation, which can significantly minimise the impact and prevent the spread of infection. This highlights the importance of adequately allocating funding and resources into public health infrastructure, which also includes investing and rebuilding hospitals to increase patient capacity that could facilitate the administration of a surge of patients. Investing in suitable PPE is crucial as it could have a direct and/or indirect effect on their mental health. Prioritising HCWs' well-being is fundamental to the delivery of the quality of care.

This thesis considered the existing legislation protecting the health and safety of UK HCWs during the Covid-19 pandemic and whether it was adequate. The research revealed that the self-regulating system created by the legislation offered insufficient protection for workers within the NHS. Taking actions, such as investing in public health surveillance systems for early disease detection and providing adequate and suitable PPE are likely to increase the resilience of the healthcare system in the future. Further work should also be done on enforcing existing laws, such as the EqA 2010 to ensure that BME and migrant workers do not face discrimination. Overall, this research serves as an appeal to those within and in charge of health care that more is needed to protect health care workers both now and for any future public health emergency.

Abbreviations

Aerosol Generating Procedures (AGPs)

Advisory Conciliation and Arbitration Services (ACAS)

Accident and Emergency (A&E)

Agenda for Change (AfC)

All-Party Parliamentary Groups (APPG)

Approved Codes of Practice (ACoP)

British Association of Dermatologists (BAD)

Black Minority Ethnic (BME)

British Broadcasting Corporation (BBC)

British Medical Association (BMA)

Cable News Network (CNN)

Canadian Broadcasting Corporation (CBC)

Cambridge University Hospitals NHS Foundation Trust (CUH)

Central Manchester University Hospitals NHS Foundation Trust (CMFT)

Central Arbitration Committee (CAC)

Centre for Disease Control and Prevention (CDCP)

Control of Substances Hazardous to Health Regulations 2002 (COSHH)

Coronavirus (Covid-19)

Department of Health and Social Care (DHSC)

Ebola Virus Disease (Ebola)

Employment Relations Act 1999 (ERA 1999)

Emergency Departments (ED)

European Union (EU)

Equality Act 2010 (EqA 2010)

Factory Act 1833 (1833 Act)

Filtering Face Piece 3 (FFP3)

Fluid Resistant Surgical Mask (FRSM)

General, Municipal, Boilermakers and Allied Trade Union (GMB)

General Practitioner (GP)

Harrogate and District NHS Foundation Trust (Harrogate Trust)

Health and Safety at Work etc. Act 1974 (1974 Act) or (HSWA)

Health and Safety Executive (HSE)

Health & Social Care (HSC)

Healthcare Workers (HCWs)

Hepatitis B (HBV)

Hepatitis C (HCV)

Human Immunodeficient Virus (HIV)

Immigration Health Surcharge (IHS)

Independent Television (ITV)

Intensive Treatment Unit (ITU)

Learning Management System (LMS)

Management of Health and Safety at Work Regulations 1999 (MHAW)

Management Standards (MS)

Manchester University NHS Foundation Trust (MFT)

Migration Advisory Committee (MAC)

National Health Service Act 2006 (2006 Act)

National Health Service (NHS)

NHS Workforce Race Equality Standard (WRES)

North Central London (NCL)

Northern Ireland (NI)

Personal Protective Equipment at Work (Amendment) Regulations 2022 (PPER 2022)

Personal Protective Equipment (PPE)

Points-Based System (PBS)

Polymerase Chain Reaction (PCR)

Post-Traumatic Stress Disorder (PTSD)

Provision and Use of Work Equipment Regulations 1998 (PUWER)

Royal College of Nursing (RCN)

Severe Acute Respiratory Syndrome (SARS)

Severe Acute Respiratory Syndrome Coronavirus 2 (SAR-CoV-2)

South London & Maudsley NHS Foundation Trust (South London Trust)

South West Yorkshire Partnership NHS Foundation Trust (SWYP NHS Foundation Trust)

Terms and Conditions of Service (TCS)

Trades Union Congress (TUC)

Trade Union and Labour Relations (Consolidation) Act 1922 (TULRCA)

UK Health Security Agency (UKHSA)

United Kingdom (UK)

United States (US)

University Hospital of South Manchester NHS Foundation Trust (UHSM)

World Health Organisation (WHO)

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