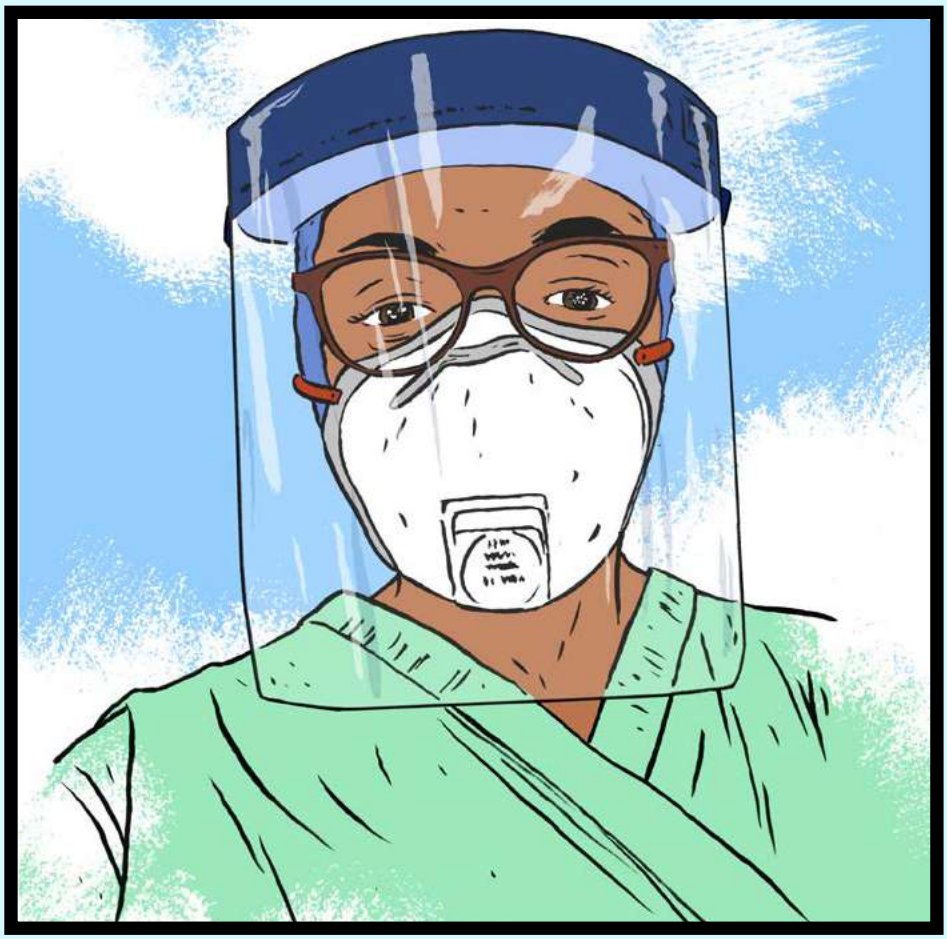
Interviews with Critical Workers (2020)



Harun Morrison

Interviews with Critical Workers (2020) is an e-zine comprising eleven interviews between artist Harun Morrison and a cross-section of individuals working within the UK public sector during the Covid-19 pandemic. They include surgeons, junior doctors, a social worker, a psychiatrist, a student nurse, a secondary school teacher, a biochemist, a speech therapist and a paramedic.

The publication has been co-edited with curator Lily Hall, designed by Rose Nordin and features illustrations by Sherwin Tija. It was made with the support of a Metal Remote Residency and in the context of Harun Morrison's 2020 Wheatley Fine Art Fellowship (Birmingham School of Art & Eastside Projects).

Tamsin
Danny
Tasnim
Charlie
Tani
Safiya
Belal
Khaldoon
Liam
Jordan
Natalie

'There are certain things that you'll never forget. There are things you can't un-see. Conversations you can't un-hear. So much...weight. Imagine seeing someone in the worst state ever. Someone's dying and there's no one with them. It's a lot to deal with.'

— Tamsin, speech therapist, May 2020

I had returned to the UK after several cancelled flights from Tunis via Amsterdam on the 17th of March. There was a palpable sense of stress in the departure queues. A worry that Tunis-Carthage International Airport would close, or a connecting flight might be missed. Instagram images of empty supermarket shelves in London distorted our impression of the city we would return to... After a week in London, on the 23rd of March, a national lockdown was announced.

At that time there was no sense of how long it would last and what it would mean for future plans. Diaries were updated, meetings were pushed back or postponed indefinitely. I was due to continue designing a community garden in Merseyside, Liverpool in the Summer. I had prepped for an extended canal boat journey from St Pancras Basin in Kings Cross via the Grand Union Canal to the West Midlands. The Canal & River Trust called for boats to stop moving, so this too was halted. I was constantly comparing diary entries of where I had expected to be at any given point with my new circumstances. I imagined a parallel version of myself enacting plans that this version of myself was no longer able to do.

Suddenly I had an expanse of unscripted time before me. This was in stark contrast to my sister Tamsin, who is a general surgeon. It rapidly became clear to me how differently people were experiencing the temporalities of lockdown.

The ways different governments worldwide have responded to Covid-19 has been revelatory in many ways, not least in the context of chronopolitics, a term 'descriptive of the relation of time-perspectives to political decision making'[1]. There were also micro-chronopolitics at play, all affected by the lockdown. Whether you were afforded the privilege of an open field of time was also dependent on whether you had dependents; your health; your financial situation (including savings); your capacity to work from home; access to the internet — and so on. A friend waiting for her asylum papers joked, 'welcome to my world'. Disabled artists questioned how mainstream news outlets talked of lockdown and confinement and why, when a non-disabled majority could no longer attend a place in person, remote options were so readily acceptable when they had not been before.

While images of homegrown veg and self-baked pastries proliferated on some people's feeds, I was conscious that for others their days were even more intense than usual, with even less free time. This became especially clear when thinking of who was working at a hospital in the East of England — and by extension other critical workers, parents, researchers, hygiene workers and carers across the country.

I was consuming multiple news outlets, the few interviews with key workers I read were heavily steered or cramped into formats that were over-determined by what constituted 'news'. Alongside Tamsin, a significant number of my relatives work in the public sector, and so I decided to interview them, to understand their perspectives and hear subjective positions from-inside-the infrastructure. Their proximity to me allowed a trust and openness that might have been harder to achieve

with people approached cold. However, as the interviews progressed, friends or friends-of-friends were also approached, on the same understanding. This project was initiated independently with no affiliation to the NHS or any other public body — and initially without funding.

There was never a plan to build an overview of experiences of Covid-19 in the public sector. A driving impulse was the curiousity of other's experiences; especially how individuals relate to the work structures they are part of and operate within. The interviews are not only with medical professionals but also those in teaching and social work, so that the impact of Covid-19 on these other sectors and their inter-relationships can also begin to be comprehended.

These interviews were primarily conducted by phone or video call, and simultaneously typed up by me. They were sent back to the interviewees to make clarifications or alterations; and to check the explanatory notes I'd added intermittently throughout the conversation for specific medical terms, acronyms or colloquialisms — an act of translation for the language so familiar to them, and which flowed whilst they spoke, but was unknown to me and to potential future readers. Sometimes these explanations have been put in brackets after the term; longer explanations or context are added through footnotes.

I asked each participant if they could share a photograph of themselves of their choice to accompany their text. These were the basis of the accompanying illustrations, to avoid a newspaper aesthetic and foreground the casualness of the discussions, the informality that comes with speaking to friends and other relations. That said, the conversations all honour codes of confidentiality and professionalism. The portraits were drawn by Sherwin Tija, who has also worked as a medical illustrator for many years.

The interviews have been edited with Lily Hall, who I've collaborated with on multiple publications in the past. As the interviews progressed and the intuitive, expansive, associative logics of the zine began to emerge, Lily suggested interviewing her cousin Charlie, a student nurse, who has now graduated and started a new nursing job, since her interview was conducted.

The date the interview first took place is listed beneath the first name, age and profession of each interviewee, although the editing and back-and-forths went on for months. The earliest interviews were conducted in May and the most recent in September. They haven't been presented here chronologically, and could easily be read in different orders or as stand-alone interviews. Together they function as a short-term time capsule with earlier interviews speculating on the possibility (in Autumn-Winter 2020).

> We watched.
> For every funeral we planned
> There were sixty we couldn't.[2]

Harun Morrison, 2020

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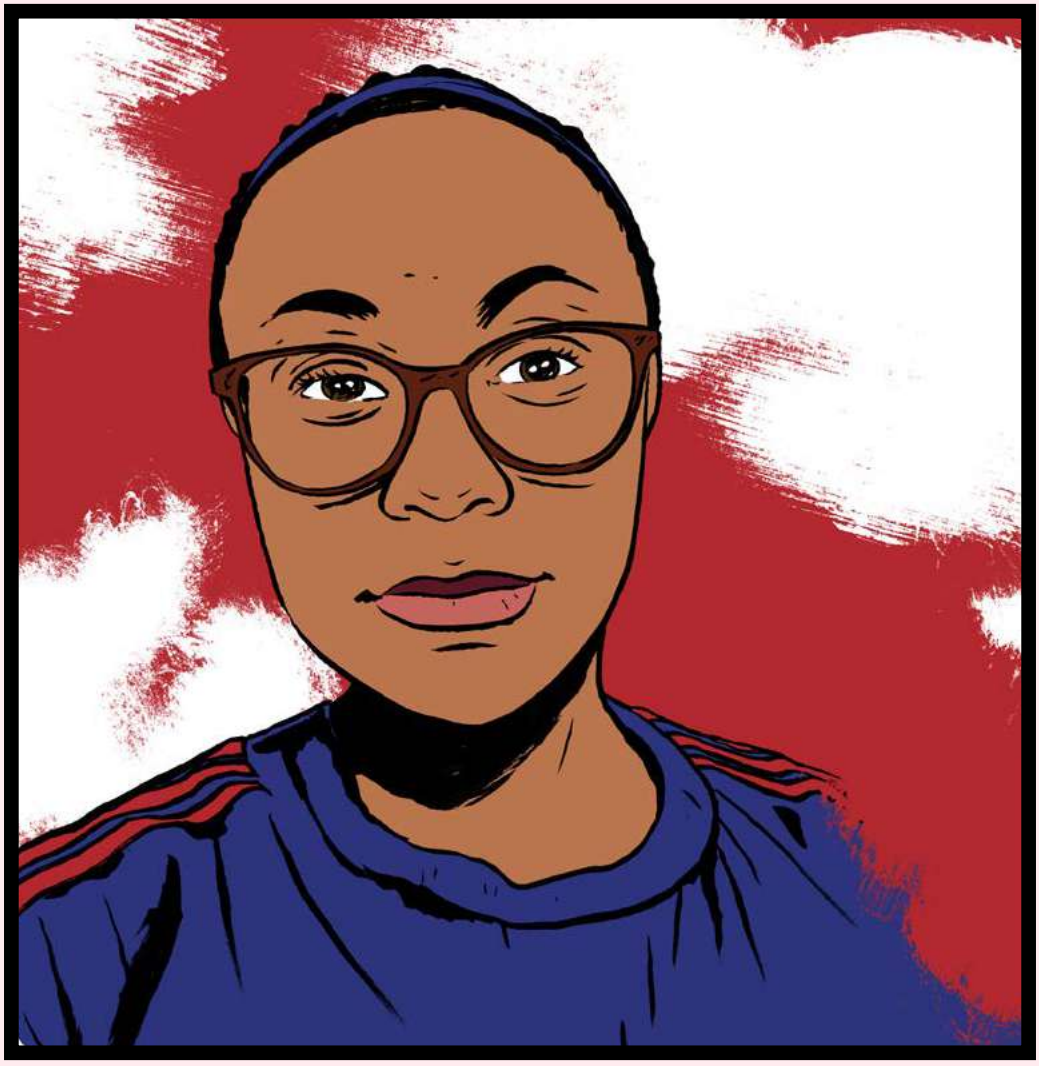
[1] Wallis, G.W., 'Chronopolitics: The Impact of Time Perspectives on the Dynamics of Change', in *Social Forces*, Volume 49, Issue 1, September 1970, pp. 102–108

[2] Mahmoud, E., *People Like Us, Sisters' Entrance*, Andrews McMeel Publishing, 2018 (a collection recommended by Tasnim)

Tamsin, 33
General Surgeon
20.05.2020



Harun: So where do you work and what's your role?

Tamsin: I work as a general surgeon in a hospital in East England. I am a 'registrar', a senior doctor on the ward, but I'm still undergoing specialist training.

General surgery includes surgical treatment of the gastrointestinal tract, from the oesophagus to the anus. It can also include breast conditions; kidney, pancreas and liver transplantation; trauma to the abdomen and thorax; and certain skin conditions.

My department is divided into two sub-specialities: Colorectal and Upper GI surgery. Colorectal surgery treats diseases of the colon, rectum and small bowel, whereas Upper GI surgery covers diseases of the gall bladder, liver and pancreas (the hepatobiliary system), as well as the oesophagus, stomach and small bowel.

Harun: Could you describe a typical day in your working life?

Tamsin: A typical day as a registrar varies depending on which part of the rolling rota you are on. The rota is divided into two parts: elective (i.e. planned) duties, and emergency services.

During elective weeks you will be allocated to a 'Registrar of the Week' (ROW) role, where you are responsible for and do the 'ward round' for all of the non-emergency inpatients, together with a junior doctor and a specialist nurse. Elective duties will usually include operating lists, outpatient clinics, departmental meetings and endoscopy training. If you're in the operating theatre you usually come in a little early, meet the patient, have a theatre briefing before the case where all team members introduce themselves, discuss the patient and any risks, and outline the operative / recovery plan.

In an emergency block, you are timetabled to cover either days or nights 'on call'; or emergency theatres, which is called a 'CEPOD' shift (8am–5pm). A week on call will be a set of twelve-hour shifts (8am–8pm) on a weekday, with rest days called zero days interspersed. A week on nights comprises twelve-hour night shifts from Monday to Thursday (20.00–08.00). Weekend shifts run from 08.00–20.00, or nights from 20.00–08.00, or weekend ward round-shifts from 8am to early afternoon, to see all the non-emergency inpatients with a junior doctor, Foundation Year 1 (FY1). We have a handover meeting every morning at 8am where we discuss all of the new and existing emergency patients. At this point the Consultants (specialist doctors who see patients at specific times) will decide which specialty department the patient needs to be allocated to.

So in short, it changes all the time, except for one thing — my day always starts with a cappuccino :)

Harun: How has the pandemic and the lockdown affected your hospital?

Tamsin: The pandemic has had huge and wide-ranging effects on patients and staff, as well as the standard operating procedures and structure of the hospital itself. I would say we were hit relatively hard geographically, as we are so close to central London with the largest concentration of cases.

Of course the first noticeable difference was in Accident & Emergency (A&E) wards, operating theatres and intensive care, as these are the 'front line' of our service.

I was actually on call in the early

stages of the pandemic and although we were well aware of what was happening, we hadn't yet had time to process its scale and impact in reality. Patients were coming into A&E resus (the area in A&E where people are taken to be resuscitated) very sick, and anaesthetists were intubating[1] people in A&E who were struggling from a respiratory point of view. Others were being wheeled to theatre for intubation where there are machines that can provide ventilator support. The Intensive Treatment/Care Unit (ITU) was at full capacity so the operating theatres were being used for intubated Covid patients.

Non-critical operating cases were put on hold. There was a distinct air of uncertainty and unease, the focus was getting the patients stabilised quickly but safely. As plans were put in place and things became more structured, along with the implementation of lockdown, things changed again.

> Harun: How did the organisation of your hospital change?

Tamsin: ITU and High Dependency Units (HDUs) were at capacity quite quickly, so operating theatres were used as temporary ITUs. Non-Covid patients who could be stepped down to ward-based care with close observation were moved. Medical wards were converted into Covid/Intensive Care wards. Surgical wards were converted into medical wards. These were very empty at one point, which is unusual. I heard of hospitals running out of oxygen, which is normally unheard of. Many services, like endoscopy, were carried out in exceptional or emergency conditions only.

Areas such as A&E and Children's A&E were changed into clean green zones, intermediate amber zones and red Covid zones with 'donning and doffing' (putting on and taking off) PPE (Personal Protective Equipment) sites before you could enter each zone. It felt like you were gearing up for battle sometimes. Previously you would simply walk into the ED (Emergency Department). On top of this, the usual routes for admissions changed, so that the only route was via the A&E triage[2] zones.

Departments you wouldn't expect became inundated with workloads very quickly, such as the bereavement centre, or the IT department, as many staff needed access to work-from-home equipment, or the accommodation department, as people needed places to stay to shield their vulnerable relatives.

> Harun: It seems not only schedules and use of space were changing — but staff roles too?

Tamsin: The re-organisation of the hospital's use of space was mirrored by shifts in staffing. This was physically and emotionally demanding on everyone, but had a huge impact on the Intensive Care staff in particular. Junior doctors were re-deployed from other specialties such as surgery to help in medicine. For first year doctors, their jobs suddenly required a greater element of responsibility and adaptability than would typically be demanded. This is an experience that will stay with them for life. It will have been traumatic for some, especially the ones who worked in Covid ITU. More death in a few weeks than they have ever seen before; physical strain; the discomfort of wearing PPE for long hours; the uncertainty of their daily roles; the requirement to 'step up'; and all of this in an environment so alien to anything they have ever previously experienced. Meanwhile, senior nurses in management roles went back to the 'shop floor' to do clinical work on the wards and in theatres so that their junior nurses and ODPs (Operating Department

Practitioners) could go and help in ITU and Covid wards.
Medical and surgical consultants who were no longer on the 'Consultant Medical on Call' rota returned to help out, and all of the current surgical consultants stepped 'down' to cover emergency operations. As a work-force, we also dwindled in numbers as so many staff were sent home sick or self-isolating, adding even more pressure. We were also dealing with colleagues and other frontline staff dying of Covid-19.

What initially felt novel — being kitted out in full PPE for surgery and to see patients — soon became normalised. Communication is defi-nitely harder in the operating theatre when everyone is wearing an FFP3 mask. On the upside there is definitely more mixing of different specialties now. I now regularly see and talk to colleagues I had never met before this.

Harun: How did this affect patients?

Tamsin: In terms of patient management, we discharged anyone who didn't have a strict need to still be in hospital. Other than exceptional circumstances, face-to-face clinics were cancelled and became telephone consultations. There was a lot more telephone communication with relatives, which was difficult at times. We were also having to take people into operations that they might not survive, without their family being allowed to come in and say goodbye in person, like they normally would before a high-risk surgery. You really noticed the absence of visitors.

In a way, we relied more than ever on patients to cooperate with us in their own recovery. We also relied heavily on our ERAS (Enhanced Recovery After Surgery) nurses to help get patients back on their feet. So many patients had a great attitude, which helped.

I think some of the longer-staying patients got a rare insight into the reality of the pandemic, watching from inside the hospital walls, which was very different to what I called the 'socially distanced world'. Inpatients were desperate to get home as quickly as safely possible.

Thankfully people largely heeded advice to stay at home and emergency admissions significantly reduced. Those who did come in were truly sick or critically unwell.

Harun: How did things change in your particular department?

Tamsin: In the surgery department we moved to a special Covid Pandemic rota. It kept changing to account for existing or potential sickness and the absence of junior staff. Usually you would have several weeks' notice to sort childcare and so on, but there was a sense of having to do whatever could be done. There was no longer a need for the ward registrar, as we only had emergency patients. Some formal elements of 'training' as we knew it were put on hold, but we were learning equally important things from this entire situation.

I felt lucky to remain in surgery at all, as friends and colleagues had been moved to other departments such as ITU, which some of us have not done for nearly a decade. The rota system changed daily, swapping between day and night consultantcy or registrar duties. Consultants covered the emergency theatre, as the registrars stepped down to cover the duties of their junior colleagues. Every day we had one person on standby, so that if one person became sick there was cover for them.

Emergency operating did not slow down, patients were coming in more sick than ever. Previously simple procedures like appendicitis were

arriving gangrenous and perforated, abscesses were presenting with flesh-eating bugs as people had prolonged staying at home. Only cancer cases continued with strict precautions. Patients were recovered in a 'Clean Surgical HDU' area to minimise Covid exposure.

We were governed by national guidelines from the Royal College of Emergency Medicine, which kept evolving as we learned more about the virus and its behaviour. For example laparoscopic (keyhole) surgery was advised against, as we did not know the risks of particulate / gas transmission. Considering the situation and the stresses, I think we coped well overall and we are now in the process of trying to normalise some services again.

Harun: How would you re-design the healthcare system?

Tamsin: The strains are multifactorial. The pre-existing debt of the NHS to the Government and an already fragile infrastructure put us on the back foot from the outset. Funding was provided when it was required but we still relied on public and industry donations.

It was also novel for us, compared to countries that have had viral epidemics before, who were much better equipped and had prior experience. Here, things were evolving and adapting in real time. This included adequate reserves of PPE. We were acquiring kit at a time when the whole world was trying to do the same. Pharmaceutical labs and countries who had dealt with epidemics already had these in stock.

So it was strain on an already strained system. Hospitals here are already always at capacity, particularly ITU beds. The public's collective effort helped immensely.

Although we now know that our healthcare system can adapt and deal with unfamiliar terrain with little warning, it came at great cost. We need to re-think our modelling of 'what if' scenarios. How to deal with patient overflow and more ITU beds in particular. ITU nursing requires a high level of skill and training, yet people were being asked to move to ITU with minimal refreshers. Perhaps we should all be keeping up such emergency skills more regularly. Some practices with regards to infection control we might well continue, like using face shields in surgery.

I feel there is a greater feeling of mutual appreciation and respect between all hospital staff; among nurses, porters, matrons, doctors and cleaners. We're more likely to say hi and nod to each other. That's definitely a positive change I hope will last.

Harun: How do you stay motivated?

Tamsin: You just get on with the job at hand. The patients are the priority. I think people who work in healthcare are generally quite motivated anyway. I did enjoy a fun photo or two with colleagues. I'm grateful to the public for their efforts, I'm grateful I have a job and an active role in all this. That keeps me motivated.

Harun: How do you keep your spirits up?

Tamsin: The NHS is my family. It feels like we are all in this together. For most of us, we know this is far reaching and will have an impact for a long time, but we've known 'normal' before this and will know 'normal' after, albeit a new normal. I do wonder about first year doctors and nurses and how this experience might shape their working attitude in the future. I can imagine they must feel

daunted. I particularly felt looked after by the senior nurses in my department, in every aspect. It made such a difference.

My friends, family, previous colleagues — they keep you going. Particularly people checking in on you to see how you're doing and to thank you. Social media, WhatsApp, Zoom and virtual quizzes have all become a more prevalent part of my life.

The tougher moments have been conversations with patients' relatives on the telephone. I recall one relative in tears, begging me to do all I can to keep his critically unwell brother alive following an emergency operation. The uncertainty, the promise that you can't give, only that you are doing your best. That can be tough.

Early on, there seemed to be a disconnect between what was happening in hospitals and people who were 'locked down'. I recall people defiantly claiming they were going on holiday regardless, that it's all media hysteria, that there is no real risk here, or 'I'm young, fit and healthy'. I don't think people really got it at first. The reality for us soon hit home.

I found documentaries like the BBC Hospital Covid Special on the reality of the pandemic in the UK insightful for this. It showed the reality of my own pandemic experience — it was raw. But it also showed how relatives at home were feeling, how the socially distanced world was managing.

In the quiet moments when not at work, I would digest my experiences and ponder more on my feelings about the situation. Probably because I have been isolated on my own when not at work to protect my vulnerable family.

I found news updates about staff who died upsetting, or family members recording a goodbye message from their children to play to their mother on a ventilator. I also remember reading a comment on social media about staff who had died saying, 'Why are we thanking and protecting the NHS? IT should be protecting us, it's their job.' To describe the NHS as 'it' in that context I found disturbing. Because to me, the NHS is 'we' — it is not an object, we are a workforce, we are people too. No one is paid to die for their job. It's hurtful because a lot of us have made significant personal sacrifices to be where we are in general and also during this pandemic. We found ourselves updating our own wills, talking to family about the reality that we might not survive this pandemic ourselves. Colleagues were sending their children away; people didn't hesitate to return to ITU having changed careers years before. We take our duties seriously despite the emotional and physical burden — and most of us would go through it ten times over again if it were required of us. But regardless of our profession, someone has lost a life, a child has lost their mother and the lack of respect for that alone I found shocking. This pandemic has affected everyone in very different ways.

> Harun: Are there counsellors on-site?

There is a wellbeing hub. A relaxation room with food, drink, volunteers and many links to counselling support.

> Harun: What's your take on the disproportionately high number of deaths of BAME NHS staff?

The death rate of BAME patients is higher, we know that from the data, even when adjusted for age, gender and geographical variation. Thirty of the first thirty-two deaths amongst the NHS were BAME staff. The reasons are not clear and probably multifactorial.

It may be a combination of pre-existing health issues and diseases that we know are more common in BAME people, which also increase the risk of Covid complications. It might also relate to cultural or behavioural and social differences. The contribution of differing roles, societal treatment and ingrained attitudes towards BAME staff was raised by a UK news reporter. How illness is interpreted amongst different ethnicities has also been raised previously. Some elements may relate to the BAME workforce feeling less empowered to speak up about health or workplace inequalities, like a lack of PPE.

It has been questioned whether it relates to the nature of their jobs within the NHS, which leave them more exposed to the virus, but BAME deaths have been across all roles within the NHS, from surgeons to domestic staff. There is also a theory about a protein found in higher levels in the BAME population, which might affect the immune response. A high proportion of the NHS workforce are BAME. There are lots of unknowns. It's sad that any staff member of any ethnicity has lost their life to this pandemic.

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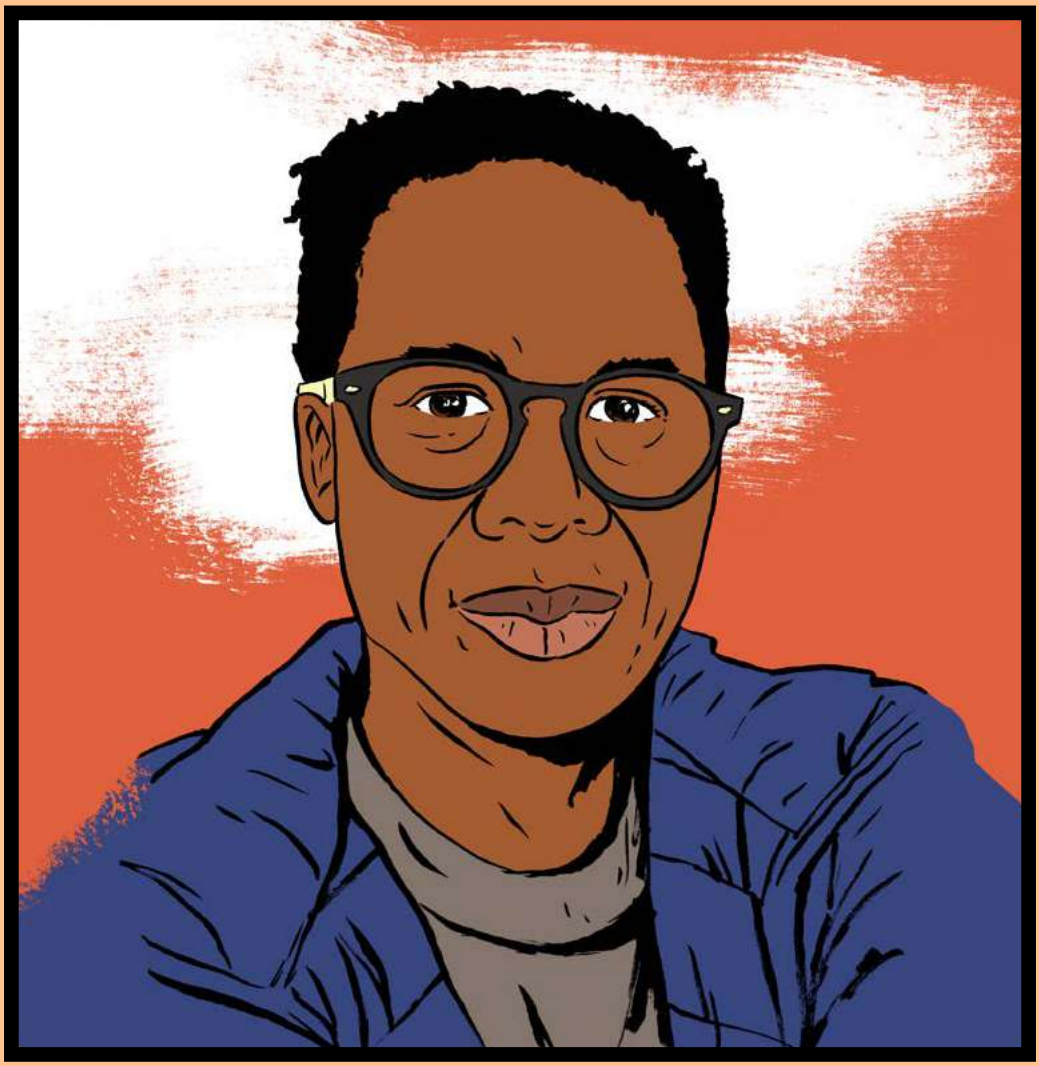
[1] Intubation is the process of inserting a tube, called an endotracheal tube (ET), through the mouth and then into the airway. This is done so that a patient can be placed on a ventilator to assist with breathing during anaesthesia, sedation or severe illness. The tube is then connected to a ventilator, which pushes air into the lungs to deliver a breath to the patient.

[2] Triage refers to the sorting of injured or sick people according to their need for emergency medical attention.

Danny, 56
Eye Surgeon
20.05.2020



Danny: This will be the first time anyone's even asking me about this. At home there's still things that I can't talk about in depth. I've got a fourteen year-old and a sixteen year-old. Not everything I see or hear is appropriate to share. Even when I speak to Sarah, as I start to tell her what's really going on, I see her eyes widen, I see this look. This conversation with you would have been very different two months ago.

Harun: So where do you work and what's your role?

Danny: I'm a consultant ophthalmologist[1] at Guy's & St Thomas' NHS in Westminster, a massive NHS teaching hospital, one of the biggest in the UK. In addition to that I work in two private hospitals, Portland and Cromwell; both of which have also been affected. The private hospitals instantly gave up space for Covid-afflicted and non-Covid patients.

I specialize in paediatric ophthalmology, children's eye care. This could include children with eye development problems, structural problems, facial abnormalities — which are usually benign, but can affect their vision. I also work with children with genetic syndromes such as Down's... and of course, in dealing with children, you're also dealing with their parents. Eighty percent of my work is with children, twenty percent with adults.

Harun: What did you do day-to-day prior to the pandemic?

Danny: Although my specialty, ophthalmology, is identified as a surgical specialty, whereas a cardiac surgeon might be in the operating theatre every day of the week, I'll be in theatre three times a week but in surgery for half-a-day at a time. So the main part of my job is working with outpatients (patients who attend a hospital for treatment without staying there overnight), and clinics (this can include diagnosis and non-surgical treatment of new and returning patients, counseling, initiating investigations and tests, and liaising with other specialties). These may have medical, i.e. non-surgical solutions. Clinics will vary in content, and certain clinics will be only once a month or for particular problems. For example, I have a genetic clinic for inherited eye problems.

On top of this, because it's a teaching hospital, I have a role as a clinical supervisor, responsible for two doctors in training at any given point. I was training one doctor who had only started working with me on the first of February. The situation with Covid has dominated our entire time together. You get to know each other really, really well. I was getting to know another doctor this same way. It turned out he looks after his mum, who's disabled and she has underlying health conditions. He's from a South Asian background. There are often unexpected dimensions to colleagues' lives you will not immediately know. These attachments can range from six months to a year. Then there are other groups of junior doctors I attend to... I wish there was another name for 'junior doctor', it's very misleading. They can have ten years of experience and still be called 'junior'. Half a day a week is devoted to teaching, you give mini lectures and go through case reports. Other parts of the week you run tutorials, and then on top of that you have 'on-calls'. I'm on-call three or four days a month. Fortunately I'm not frontline on call. But there's someone at the coalface 24/7. That means at any time, night or day, you can walk into the hospital and there's a specialist to attend to you if necessary.

Harun: How has the pandemic affected your work?

Danny: Initially it was treated like a 'pause' in our scheduling. Back at the beginning of March, we were pushing March appointments into May. It quickly became clear that things were not going to simply return to the way they had been before.

It was a month before lockdown that things became really bad for us, from mid-February. We had been treating some of the earliest recognised cases in London. The media were turning their attention to us as a hospital in the heart of Westminster. We knew that people were coming into contact to Covid. If you went into ITU at this stage people were wearing space suits. That set in early.

We were quickly gathering knowledge, trying to watch what was happening as reports of Covid spread. It was like a tidal wave coming towards you. At the same time we were watching the inactivity and lack of concern from the government.

Being aware that one of the first doctors to die of Covid, Dr Li Wenliang in Wuhan (on the 7th of February 2020, aged 33), was also an ophthalmologist was unnerving. Remember, he was pushed to one side; he was made to retract his warning. The later stages of Covid can present with eye problems. If you're aware one of the first to die from this was someone doing what you do, you can't ignore that.

By February, I was personally starting to alter my behavior in the hospital in terms of moving around people. I started to confine myself at work, take journeys on quieter corridors. That month I stopped using public transport. I began driving in or I'd take a cab.

By March — by the time we reached lockdown — conversations with colleagues were about rapid adjustments. Every single trained doctor was told that regardless of your age or seniority, you might be redeployed to the emergency wards. We were questioned about what ITU training we'd done, what our skill sets were. It was like being drafted. Upper management took two of our consultants. They took all the junior doctors.

In parallel, we were having conversations about how many beds we had in ITU, or, 'could these corridors become bed space?' Meanwhile they were building the Nightingale in the Docklands.[2]

My colleagues and I were doing our own research, trying to get up to speed, following data that other medics were sharing nationally and internationally. I started packing an emergency bag at home in case I fell ill.

We knew we were going to have a problem with capacity: lack of space, beds and ventilators. In March, my biggest fear was not solely getting ill, but being ill at the peak of the crisis. I feared I wouldn't get treatment.

Depending on where you were, word got round that people were dying from a simple numbers game. Fortunately we didn't exceed our capacity at Guy's and St Thomas'. London struggled overall having such a high concentration of people, but the NHS manages a database across its hospitals nationally, so they're aware that if London beds are full, there's a hospital in Hertfordshire, for example, that might have x number of beds. So we didn't exceed our capacity nationally.

The threat of Covid had also been underestimated. In January, the talk was that it was affecting the over 70s and those with underlying health conditions. Now we know there's absolutely no cut-off, and on top

of that there's the data around the higher impact on Black and minority communities. These risks were very real to me. People think I'm younger than I am, but I'm 56 and I have mild asthma. So my risk is relatively high. In March we were at the breakfast table and Ruby asked, 'It couldn't kill you dad could it?' and I said 'No'. It was a flat out lie. They were in lockdown; they had no idea how intense it was. This is the situation I was in. Sarah was very aware of that. You can look at the numbers, people in their late 30s and 40s dying of this.

> Harun: So what did you think of the initial announcement of the herd immunity strategy from the UK Government in March?

Danny: My initial response was NO... because of the severity of the illness and the numbers that were dying. I also started to look up the numbers on flu and old flu data, and the number people of people who had died of that by comparison. Remember the 1,500 people who typically die every day from all other causes: accidents, other illnesses...they're still dying.

I also wish politicians would drop the war analogies. They've used the wrong wording and phrases to deal with the whole situation from the outset... 'the virus, the enemy', and so on. At the same time it echoes a lot of the administrative language of the NHS itself.

> Harun: Do you think that's connected to it being founded only three years after the end of the Second World War?

Danny: Yes, that, being founded in the late 1940s... but also being shaped in the image of boys' public school and a military culture... especially with the emphasis on ranking and seniority. There was a lot of planning to prepare for the lockdown, especially in terms of communicating with patients. I remember walking out of the operating theatre on the 11th of March. I'd been going there on Wednesdays and Fridays for fifteen years — like clockwork. Jobs that were left to administrative staff are now done by the doctors. It's me ringing the patients, dealing with their anxieties; some feel it's too scary to come to the hospital, which brings another risk by staying away. We have people who really need attention but are too scared to come to the hospital.

So over this period we only dealt with emergencies. These are done with PPE. You get hot, you're slower and heavier; but still doing something like microsurgery is as hard as it ever was. Right now we're fighting for space and for priority. Not every emergency needs seeing face-to-face, you can do a lot through phone and video. Of course this is harder with small children. Nowadays you have more patients sending videos. I've got countless videos of eyes on my phone.

> Harun: How did the working culture change?

Danny: Colleagues feel closer together. We have a very active WhatsApp group, always sharing jokes. In the early weeks of March we were ordering medical equipment: thermometers, facemasks — talking through together what we might additionally need. We did our most to look after each other; we've had four consultants who had Covid. There's a collective pride in how we've handled things. There were a lot of eyes on us when we took in the Prime Minister. Part of the mental stress was handling the information overload. To the hospital's credit there are also many kinds of support: counsellors, there's a chapel and multi-faith prayer room. The different professional bodies, some of which I'm a member, like the

Royal College of Ophthalmologists, are also there for you.

> Harun: How do you think it will affect your line of work in the long term?

Danny: You know I started to read Tamsin's interview and then I stopped because I didn't want it to affect my responses, but it got me thinking how we're at vastly different moments in our careers. She's in her first third and I'm in the last quarter. I'm old enough to retire.

For the last five years I've been toying with retiring. Then you think, 'will the mortgage be paid off yet?' In March I would have wanted that retirement brought forward. Now I have reasons for pushing it back. Instead of a sixty hour week, I'm thinking of doing half that. Then focus more on the problems where I might be the only one who can genuinely help. In the hospital we are trying to get restarted and bring people back to a safe environment. You might have been able to see twelve or thirteen people in a morning, now it's going to be five or six and they'll need to be ranked in order of priority. The consequence of pushing back treatments that weren't urgent is that through the delay they become urgent. When we come round to dealing with this surgical backlog from the 18th of June we'll be doing so in PPE.

More broadly there's goodwill towards the NHS and more respect towards the wider health sector. I think this is something that won't be forgotten for a generation. It could shift voting patterns too.

Personally I'm frustrated by not having enough of a voice in what's going on. It's just the position I'm in as a surgeon. I've not been that politically active in the sector, mainly because of the way the British Medical Association has failed to support the medical professions. The response to the junior doctors' strike in 2016 was so flaccid and weak. They capitulated to Jeremy Hunt (UK Government Health Minister, 2012-2018) And we're now seeing the consequences of that. Politics always interferes with medicine. They interfered with how we managed waiting lists, the way assignments are done.

I'd end up being the person walking out of BMA meetings rather than kowtowing to what's happening in Westminster. If you engage with the emotional labour of the BMA politics, it compromises your work as a consultant, which is my personal priority. On top of that there is the racial dimension. Make no mistake, as a black man you're being watched. So an entry into politics brings in more opportunities for others to target or undermine you. I'm not allowed to make the same mistakes that others do.

What isn't even on the public's radar yet is the impending crisis in dealing with everything coming down the way logistically, dealing with everything that has been postponed.

> Harun: So this present crisis is also creating another crisis?

Danny: Yes. We're kicking the can down the road.

> Harun: If you were advising the government what would you tell them?

Danny: There's never been a better time to assert the value of public science. One of the reasons that the government has fallen down is they've tried to sell the idea of scientific certainty. Hence they put out incoherent messages. They propagate an idea that runs through many curricula: that science is black and white. Yes

and no. The people who really engage with ethical scientific thinking, the really good medics, understand what it means to deal with uncertainty. We're seeing many in the science communities and advisory committees break away from the government position because theory is saying it's too soon to ease the lockdown. Putting a business agenda over scientific advice is costing life.

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[1] A senior doctor who specializes in the diagnosis and treatment of eye disorders, including surgery.

[2] NHS Nightingale Hospitals were seven critical care temporary hospitals set up by NHS England as part of the response to the pandemic.

Tasnim, 30
Speech and Language Therapist
29.05.20

Harun: So where do you work and what's your role?

Tasnim: I work in a hospital in South London and I'm a speech and language therapist.

Harun: What do you do day-to-day?

Tasnim: I work across the hospital wards, specifically with adults. My job is to assess patients for the presence of swallowing and communication impairments and determine how best to manage them. That said, although as speech therapists we deal with both communication and swallowing, in the hospital we mostly work with people who have swallowing disorders, known as dysphagia[1], which typically occurs as the result of neurological or respiratory conditions.

We usually get referrals directly from the wards. For a swallow assessment we need to see the patient eat and drink so we can check how safely and effectively they're able to swallow. From there we can recommend the safest consistencies for them to continue eating and drinking and formulate a plan for ongoing management.

Harun: Do you also work with stroke-survivors?

Tasnim: I have previously, but I rarely do in my current role. There's a separate stroke ward which I don't cover.

Harun: What's swallowing got to do with speech and language?

Tasnim: The public perception of a speech therapist might be the guy in *The King's Speech*, or someone magically making a stutter disappear, but it's a much broader discipline than that.

Initially the management of dysphagia didn't really sit in any one field, even as it became more of a specialty. However, because a lot of the same anatomy is involved in both speech and swallowing, it was gradually incorporated into the speech and language therapy profession. For those of us who work with adults especially, at this point has become the bulk of the work.

Harun: How has the pandemic affected your work?

Tasnim: So my role is the same but what's changed is the kind of patients we are seeing and how they're presenting. Whereas pre-pandemic my patients tended to present with conditions I'm really familiar with, such as Parkinson's disease or dementia, Covid is completely new so we didn't actually know 100% how it might affect swallowing, or communication for that matter. As a team we're also seeing more patients with tracheostomies[2] and we're needing to spend more time in the Intensive Care Unit (ICU). So in many ways there's been quite a steep learning curve.

Also, because we work across the hospital, we're passing through any number of wards each day. This means you have to be super aware of whether the patient you're seeing is Covid + or Covid - , and the PPE (personal protective equipment) you'll need to wear for each patient. It adds a serious mental load to something that was much more routine before.

We were also seeing much younger patients, in ICU especially. Taking various risk factors into account, we predicted early on that we would have a higher number of admissions compared to other areas of the country. South London has a very diverse demographic and, of course, we now know that Covid is disproportionately impacting Black and Asian communities. Inevitably, we've

seen the reality of this first hand.

Harun: And how did Covid affect how the hospital ran?

Tasnim: The logistics of cross-infection engulfed the entire hospital. You have to think about where you're putting certain patients, trying to ensure that non-infected patients aren't crossing paths with infected patients. Then there's dealing with the need for expanded ICU space and organising the necessary beds, making sure there's adequate PPE and so, so much more.

Although I'm cautious about the war analogies, the language you hear, especially in the media, evokes this sense of being sent to war and, in a way, putting on PPE feels like you're putting on armour and heading into battle. The wards are hot. You're attending to someone who's delirious and you're just really conscious of the fact that all they can see is your eyes through your protective suit. It's all very surreal.

There are certain things that you'll never forget. There are things you can't un-see. Conversations you can't un-hear. So much...weight. Imagine seeing someone in the worst state ever. Someone's dying and there's no one with them. It's a lot to deal with.

Harun: How did you cope with this?

Tasnim: Honestly, I think I'm still processing my experiences. I don't think I'm far enough removed from it yet to be able to process it all fully.

When I wasn't at work I did what I could to remove myself from it. I started baking, which is very unlike me. There are also certain areas of social media I avoid and I stopped watching the news. There was too much speculation and unclear messaging. I also didn't like a lot of the language I was hearing. When you hear talk of 'sacrifice', when NHS workers are referred to as 'angels', I found it infuriating at times. We're healthcare professionals just trying to do the jobs we're trained to do, not lambs to the slaughter. We all made a choice to care for people, but the conversation has focused so much on clapping for the NHS and not enough on all the ways in which our jobs have only been made harder. For years the NHS has been crying out that we're understaffed and underfunded, and the government has done so little to address that. Me, Kara, Illyin none of us paid for our training.[3]

Harun: Did healthcare students previously study for free?

Tasnim: These costs were initially covered by the NHS. A few years ago they reintroduced fees for training. So if there's a 9K fee to study nursing what's the appeal when it's so under-paid? Then on top of that — part of your training involves 'hours in placement'; which impacts your ability to earn a living while you train.[4]

Harun: And nurses are the heart of the NHS...

Tasnim: Exactly. It's highly skilled work, and Covid patients need significant support, but where is that expertise going to suddenly come from? You can provide all the ventilators you want, but if you don't have staff trained to use them they're redundant.

Harun: How did the lockdown affect Ramadan for you?

Tasnim: I'd experienced being away from family and Muslim friends during Ramadan only once before and I was conscious that, this year in particular, it would likely be quite difficult. Not only was I working in quite a stressful environment, I was fasting alone,

breaking my fast on my own. It's usually quite a communal experience, so that was difficult at times. It was also tough having to spend so much of the day wearing full PPE.

That said, in the end it actually wasn't as hard as I thought it was going to be. I had a lot of time to reflect and I was really conscious about where I was channeling my energy outside of work, making sure I was eating well when I could and being really mindful of the importance of taking care of myself.

That's the thing I've learned over the last few months: you have to consciously think about how to keep yourself up and I was really aware of how important that would be.

> **Harun: You also run @Reads.and. Reveies, your instagram book review platform, how has reading helped you?**

Tasnim: For those of us working in hospitals things started getting more intense before lockdown hit the rest of the country — and initially I found it really hard to concentrate on reading anything, especially from around mid-March to the start of April.

But then in April I read more intensely than any other month. I've also turned to poetry even more than usual. One collection in particular was *Sisters' Entrance* by Emtithal 'Emi' Mahmoud, but also works by Mary Oliver, Lorna Goodison and Lucille Clifton, amongst others. As always, I found solace, inspiration and escape in the books I was reading.

> **Harun: How has the pandemic affected your dreams?**

Tasnim: At the start, I'd have the exact same dream almost every day, that the pandemic itself was a dream and then I'd suddenly wake up. It'd feel real for a few seconds and then I'd remember... I haven't had that dream for a while now though.

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[1] Dysphagia is the medical term for swallowing difficulties. Some people with dysphagia have problems swallowing certain foods or liquids, while others may not be able to swallow at all. Signs of dysphagia include coughing or choking when eating or drinking, difficulty controlling food in the mouth: and unexplained weight loss.

[2] A tracheostomy is a medical procedure — either temporary or permanent — that involves creating an opening in the neck in order to place a tube into a person's windpipe. The tube is inserted through a cut in the neck below the vocal cords. This allows air to enter the lungs.

[3] My sister Kara and cousin Illyin (Tasnim's sister) are employed by the NHS as a speech-therapist and midwife respectively.

[4] In the UK, Higher education tuition fees of £1,000 per year were first introduced by the Labour Government in 1998. These fees were paid upfront by students at the start of the academic year. In 2006 fees were raised to £3,000 and a new system of variable deferred fees and tuition fees loans was introduced. From 2006 fees rose gradually by inflation until 2012 when, under the Coalition Government, tuition fees were raised to £9,000 per year following an independent review of the student finance system.

Charlie, 22
Student Nurse
25.06.2020

Harun: So where do you work and what's your role?

Charlie: I'm a third year student nurse. 80% of my time is on the medical ward, the remainder is at university in North-Central England. I am currently having to self-isolate, because I came into contact with a patient with a false-negative test result. This is happening more and more since lockdown has been easing. It's not just a case of looking at how many people are dying. I'm dreading that the easing of restrictions will cause a second wave of infection. I hope I'm wrong. I have another ten days of isolation and an essay to write.

Harun: What do you do day-to-day?

Charlie: On a typical day I would be on a clinical placement (a period working in a specific hospital department to gain experience). Similar to a registered nurse, I'd be allocated to a senior nurse working with ten patients in a ward. This would include drug management, liaising with doctors, machine management and observing. Placements usually consist of about 400 hours of practice. Before the pandemic we could do 'spokes'[1] and spend a week within another area to gain additional experience.

We need to complete 2,300 hours of hospital experience to qualify. The training follows directives set by the Nursing and Midwifery Council (NMC) and, for now, the European Union.

It used to be the case that our tuition fees were paid outright by the government with an additional bursary. This recognised the fact that we were working clinical hours, which didn't allow for part-time work. That's all been cancelled now. We have to be part of a union, UNISON, which provides indemnity insurance. We also have university student unions, but I feel more attached to the nursing side of things than the university side of things.

I never originally intended to be a nurse. I initially went to uni to study French and History. Over that time I got a part-time job in a care home. The care home wasn't great. But I found the care work fascinating and really rewarding. I did it for a year. After three terms of French and History I re-enrolled to study nursing.

Harun: When did your hospital start to feel the impact of Covid-19?

Charlie: When it first appeared on the news it was just starting to get talked about. The hospital didn't respond very quickly. In the early days there were quite a few emails going round to say there's nothing to worry about — and that we've dealt with the flu. It wasn't 'til mid-March that the severity became apparent.

Harun: Once the hospital recognised the severity how did things change?

Charlie: There was a complete redesign of the entire layout of the hospital: we had a Covid side, and one for general medicine. Staff were redeployed and day surgery was stopped. Wards were moved around to accommodate this. So the hospital signage no longer made sense, but this didn't matter because we didn't have visitors, as long as staff knew where they were going it all kept functioning. We did our best to entertain our patients too,in the absence of visitors, and talk to their relatives over the phone.

As students we were asked to opt-in to help during the pandemic. Our typical clinic was cancelled, so we could either work during the pandemic or take a theory option. If you did the latter you wouldn't get the required

clinical hours, but you would be paid for this work — which you're not when you're on placement.

I was on theory between Christmas and March. Then I had some leave. I went to Guatemala for a holiday and ended up getting stuck there due to the complete lockdown because of Covid. It was tempting to stay out there. We were eventually repatriated via Germany. When I got back I was right in the thick of it. I got placed on a medical ward. A medical ward is anything non-surgical and non-high-dependency. Friends of mine were on HDU (High Dependency Ward); others were on the surgical ward, working with patients who have had surgery and are in recovery. The ward that had been cardiology was converted to general surgery.

Harun: So were you paid the same rate as qualified nurses?

Charlie: Student nurses were paid differently across different NHS Trusts. Band 5 would have been the typical pay. We were paid at Band 4, and students in some areas were paid at Band 3. Initially we signed up to be paid 'til September, but the government has scrapped this. They've just cancelled our contracts. The contracts were negotiated between the student nurses' university and the hospital they were on placement in. Initially the guidance came through Public Health England, a UK governmental organisation. My contract has been cut by three weeks so I'll now finish on the 24 August. Then I graduate as a registered nurse by the end of September.

Harun: So you'll be applying for jobs soon?

Charlie: I got my job yesterday! Because I've been working at the Trust for a while. It's very similar to what I've been doing over the last few months, but I'll have my PIN (a legal registration number from the midwifery council).

Harun: Congratulations! How have the last months affected you personally?

Charlie: On one hand, considering it's my final year, I've been called on to put all my experience into practice. I valued that extra level of responsibility. But it has been a challenge. Within the profession there's a lot of confusion and resentment. There's been very little clarity about our new roles — what we can do legally. There was definitely a delay in getting us out to practice. The biggest stress is the huge lack of certainty. As far as I'm aware there are plenty of pandemic plans; but they never materialised. On the plus side the Trust I work at has done quite well, we never ran out of PPE. Generally speaking it's been a good experience, especially when I compare it to what's been reported on other hospitals.

Harun: How did you cope with this?

Charlie: I was really lucky to have the people I live with over the lockdown. It must be so difficult for someone who lives alone.

Harun: How did you support your other colleagues?

Charlie: There's been a lovely sense of coming together. Trying to support each other as best as possible. We've been like a big household. I've made so many new friends.

Harun: How did you feel about the Clap for the NHS?

Charlie: I liked it the first time, as a recognition that we work really hard. It was nice to see a change of representation in the media. But it quickly felt disingenuous on the media's

part. The idea of labelling us angels or heroes was really unhelpful. It began to feel like whatever happened to us could be justified because we are 'heroes'. Which is not how we feel going into work. Nobody should be sacrificed.

From a student nurse point of view, I've been disheartened by MPs' responses to a letter sent on behalf of student nurses, which claims we don't provide a service. The debate centres around whether our placements are recognised as 'work'. Every single time I go on placement I make up a part of the team. We're obliged to demonstrate we can operate on our own. So it can't be reduced to shadowing. There's so little understanding — or wilful misunderstanding — about what we do in hospital among the government. In any other context they wouldn't get away with how they treat us. An apprentice has to be paid legally. Getting around not giving us remuneration by arguing 'we don't provide a service'— 'we just observe, we just shadow' is demonstrably untrue.

Harun: What permanent shifts might be made in your hospital?

Charlie: It's been demonstrated that it is possible to be adequately staffed — it's clearly possible. There may also be some retention of the way we've shifted the layout of the ward in the interest of infection control. For example, we now have four patients in a ward instead of five — that's better. There are mixed gender wards, alternating male bay, female bay, too.

Harun: How do you feel about mixed gender wards?

Charlie: Wards are mixed based on medical speciality rather than gender. Within each ward there are 'bays', a bit like dormitories, where five patients (currently four for social distancing) have their beds. Most wards where I work have five bays — twenty patients in total — and five single rooms for patients needing extra privacy or for infection control. I think this is preferable to gendered wards, because we can focus on the medical condition and gain experience caring for all genders. It also allows for slightly more flexibility in terms of patients identifying as trans or non-binary.

In terms of other changes that might become permanent, we've also used technology in more dynamic ways. If there is a consultant on call we could have them on a smart screen and the patient would interact with them this way. There are limits — the elderly population are generally less comfortable with this. But the advantages are great for infection prevention and minimising time in hospital.

Harun: Have you had any Covid-related dreams?

Charlie: I used to be able to switch off from work. Now I dream about my patients and work all the time. I woke up the other day panicking that I had miscategorised somebody's faeces.

[1] 'Hub and Spoke' is a practice-based learning model that uses the metaphor of a bike wheel in which you have a hub at the centre attached to spokes. In this case it facilitates a nurse to have a placement in one department, while also being able to expand their experience through 'mini-placements' alongside the primary one.

Tani, 26
Foundation Year 2 Doctor
30.07.2020

Harun: So where do you work and what's your role?

Tani: I am currently a Junior Doctor, so my training involves a series of rotations. Across the Spring and Summer I was in Cumbria in North West England, initially working in a general practice (GP).

I had my own clinic in that practice, so people would make appointments and I would see common complaints. If I had doubts or wasn't sure, I would ask senior GPs. On average I'd see about 30 people a day (this figure includes phone appointments). My placement was originally due to end at the beginning of April, but due to Covid our rotations were frozen. So I was there for three weeks longer. Then I was redeployed to General Medicine at the hospital.

Harun: What do you do day-to-day?

Tani: I'd be curious as to whether my experience in the North West was atypical; we were redeployed so late due to the strained services that we had already peaked in Cumbria by the time extra cover was brought into our hospital. We also have an older population. What this also meant — what was scary — was that the GP surgery became a mini-hospital. During the peak, the GP practice was encouraged to prevent patients going to hospital due to the fear and risk of overwhelming the NHS. Illnesses and cases that would usually be managed at hospital were being managed in the community, and we had a lower threshold for end-of-life care decisions. There was a lot of pressure and this was a very scary and sad period. So by the time I came to the hospital things had actually calmed down, and on top of that, the GPs were preventing people coming in unless absolutely necessary, in aid of lessening transmission. Weirdly, the hospital was very quiet. We had lots of staff and hardly any patients to begin with. We didn't know the peak had happened. We didn't know if it was the calm before the storm. So the stress was in this state of not knowing. I also felt guilty. It felt like the community had already taken the big hit.

Harun: How did you look after your own mental health?

Tani: Although I know a lot of people connected with their friends more, my natural reaction was to shut down. It was so overwhelming, especially the media stuff. I tried to stay away from excessively checking the media. I listened to music. I was dancing a lot in my bedroom. I really recommend that. I journaled a lot too and wrote my dreams. I was doing yoga everyday, running, and I was eating quite healthily. In many ways I had less of a workload once I was in the hospital. I put so much pressure on myself to not feel emotionally affected. But by the end I was really burnt out from just processing so many changes and thoughts. There are a lot of healthcare professionals who tend to feel guilty about being stressed and burnt out. There might be conversations between peers, but speaking about it with senior colleagues is seen as taboo. It's considered weak. But it needs to be spoken about to change the culture.

Harun: How has the pandemic affected your work?

Tani: I have renewed pride in working in the NHS. I feel a lot more passionate about it; even more than I did before. It's a real privilege to have this system, and it's a privilege to work in a job I find so meaningful — not everyone has that. I also relate to my colleagues differently. I used to have a more distanced, professional relationship. But that changed, they

were really the only people in my environment. I didn't have family or friends in the countryside. So there was a much stronger comradery.

Harun: How did you feel about the 'Clap for the NHS'?

Tani: I personally wasn't a big fan. Over time I felt like it became a little empty. It wasn't how the NHS needs to be shown appreciation. At the same time, while I didn't get anything from being clapped, I've read posts from friends who described returning home after a heavy night shift and being moved to tears. I just don't want people to think that clapping is any kind of substitute for caring for the NHS. We were being bombarded with free lunch boxes and smoothies by a billionaire. Towards the end, food was going to waste. There were piles of plastic and all these smoothies.

Harun: And meanwhile people were dependent on foodbanks?

Tani: Exactly. The queues are shocking right now. We would try and redistribute what we could. But the whole thing is symptomatic at many levels of how resources are mishandled.

Harun: So what are you up to now?

Tani: I now work in a North East London NHS Trust, in a dementia clinic, towards specialising as a psychiatrist. Within psychiatry you do a series of sub-specialty rotations. The sub-specialties I'm interested in include perinatal psychiatry[1], psychotherapy, and I'm interested to explore the therapeutic approaches that could be used with dementia patients, such as music therapy, while I am with the clinic.

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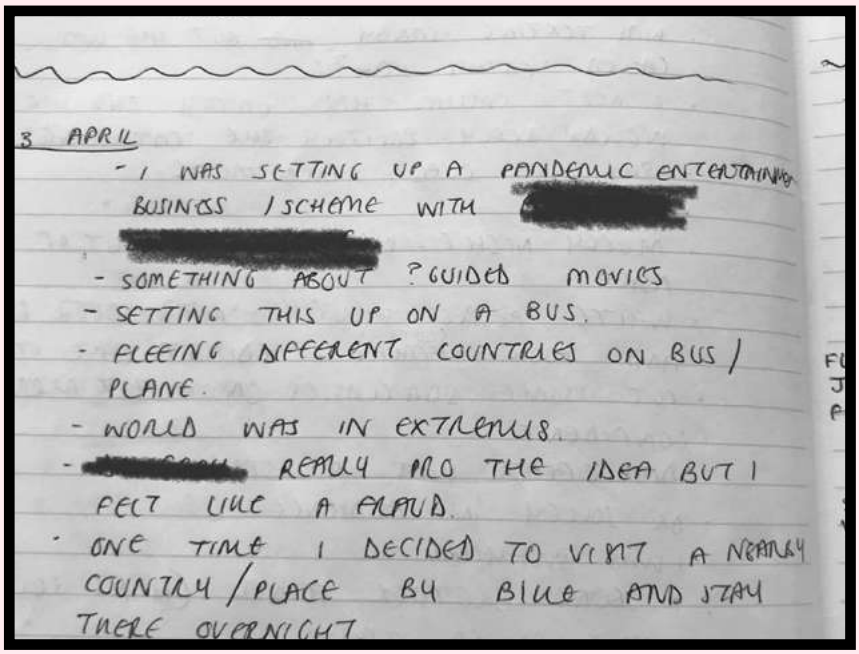
[1] Perinatal psychiatry is the branch of psychiatry dealing with the management of mental health disorders during and after pregnancy, in antenatal and postnatal periods.

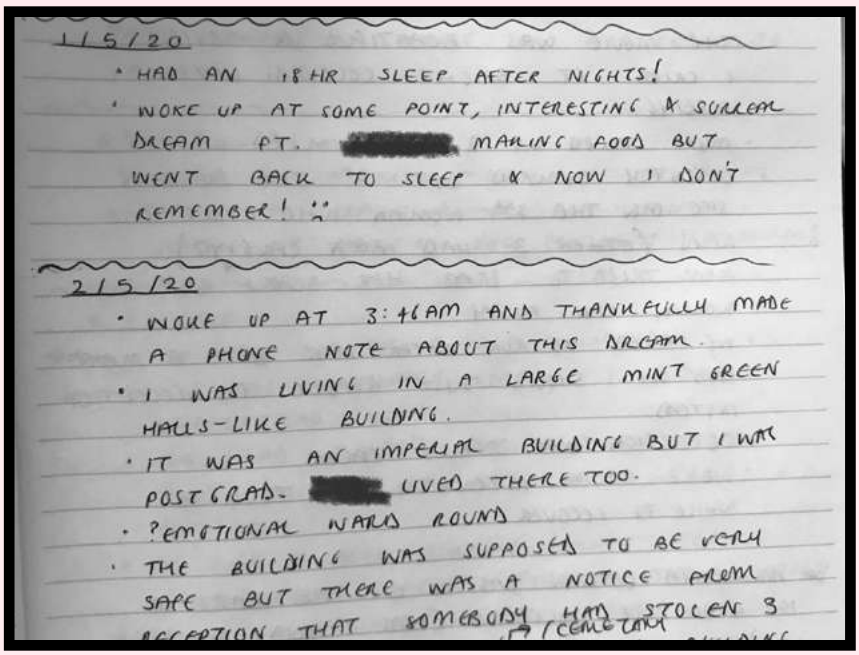
Harun: Has Covid affected your dreams?

Tani: I kept a dream journal…



3 APRIL

- I WAS SETTING UP A PANDEMIC ENTERTAINING BUSINESS / SCHEME WITH [redacted]
- SOMETHING ABOUT ? GUIDED MOVIES
- SETTING THIS UP ON A BUS.
- FLEEING DIFFERENT COUNTRIES ON BUS / PLANE.
- WORLD WAS IN EXTREMES.
- [redacted] REALLY PRO THE IDEA BUT I FELT LIKE A FRAUD.
- ONE TIME I DECIDED TO VISIT A NEARBY COUNTRY / PLACE BY BIKE AND STAY THERE OVERNIGHT

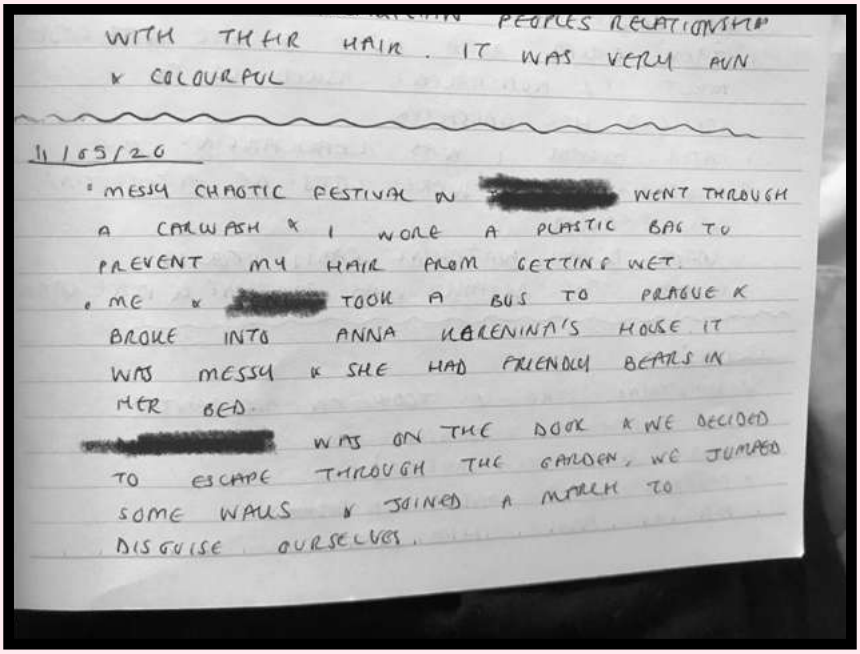


1/5/20

- HAD AN 18 HR SLEEP AFTER NIGHTS!
- WOKE UP AT SOME POINT, INTERESTING & SURREAL DREAM PT. [redacted] MAKING FOOD BUT WENT BACK TO SLEEP & NOW I DON'T REMEMBER! :'

2/5/20

- WOKE UP AT 3:46AM AND THANKFULLY MADE A PHONE NOTE ABOUT THIS DREAM.
- I WAS LIVING IN A LARGE MINT GREEN HALLS-LIKE BUILDING.
- IT WAS AN IMPERIAL BUILDING BUT I WAS POST GRAD. [redacted] LIVED THERE TOO.
- ?EMOTIONAL WARD ROUND
- THE BUILDING WAS SUPPOSED TO BE VERY SAFE BUT THERE WAS A NOTICE FROM RECEPTION THAT SOMEBODY HAD STOLEN 3 [illegible]

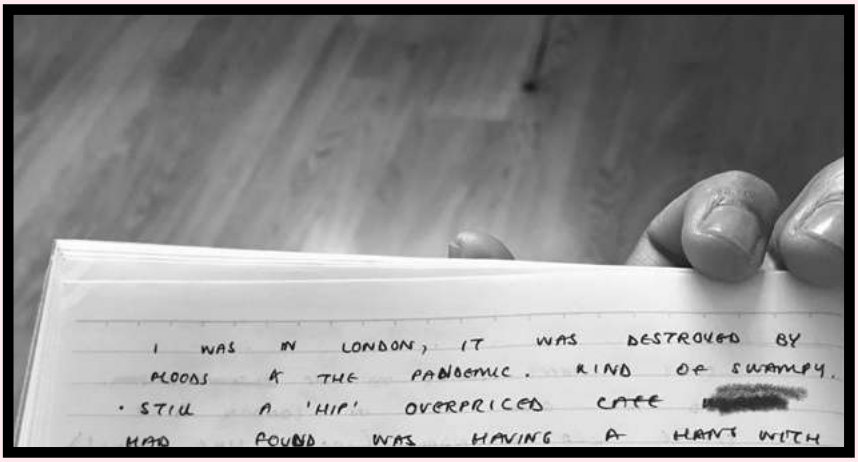


WITH THEIR HAIR. IT WAS VERY FUN
& COLOURFUL

11/05/20

- MESSY CHAOTIC FESTIVAL IN [redacted] WENT THROUGH A CARWASH & I WORE A PLASTIC BAG TO PREVENT MY HAIR FROM GETTING WET.
- ME & [redacted] TOOK A BUS TO PRAGUE & BROKE INTO ANNA KARENINA'S HOUSE IT WAS MESSY & SHE HAD FRIENDLY BEARS IN HER BED.

[redacted] WAS ON THE DOOR & WE DECIDED TO ESCAPE THROUGH THE GARDEN, WE JUMPED SOME WALLS & JOINED A MARCH TO DISGUISE OURSELVES.



I WAS IN LONDON, IT WAS DESTROYED BY FLOODS & THE PANDEMIC. KIND OF SWAMPY.
- STILL A 'HIP' OVERPRICED CAFE [redacted]
HAD FOUND. WAS HAVING A RANT WITH

Safiya, 26
Biochemist
22.05.2020

Harun: So where do you work and what's your role?

Safiya: I work at the Cell & Gene Therapy Unit at King's College London as a GMP (Good Manufacturing Practice) Scientist, or Gene Therapy Production Scientist.

Harun: I thought you said GNT like Gin & Tonic :)

Safiya: We work aseptically (in a sterile environment), to manufacture advanced therapy medicinal products (ATMPs), cell therapies and viral vectors used as starting materials for these products.

Harun: What's an example of gene therapy production?

Safiya: T-cells are a type of white blood cell. T-cell therapy is a type of immunotherapy that involves adapting these cells to enhance your immune system. A sample of these are taken from your blood, and they can then be genetically altered to recognise a specific target, such as a particular protein on the surface of a cancer cell.

I primarily work in manufacturing Lentiviral and rectiviral vectors as starting materials, which can then be used in clinical trials. Vectors are 'organic tools' used in molecular biology. They are families of viruses responsible for diseases such as HIV that have been modified so that they can function as carriers for other genes, in order to affect your cells to better cope with pathogens.

Harun: What do you do day-to-day?

Safiya: We work on a campaign basis. A client will make an order and we operate our schedule around that production timeline. In order to manufacture a standard vector, it takes 3 weeks to produce one batch of a product. There's a lot of preparation of materials and of the cleanrooms (aseptic laboratory), which must be maintained to a particular grade. The process itself primarily involves cell expansion (i.e. growing the cells, which we then transfect with plasmids[1]), transfection and downstream processing (to concentrate the product). A lot of our day-to-day work also involves a high volume of paperwork as the GMP field is highly regulated in order to ensure patient safety.

Harun: How has the pandemic affected your work?

Safiya: I'm now working predominantly from home, working on updating protocols (the development of our current manufacturing processes) and risk assessments (quality standards in health & safety procedures require us to review our risk assessments periodically). I am now only going in for essential faculty maintenance, especially in the cleanrooms (aseptic labs). We were redirected to manufacture test kits for Covid-19.

We've been doing this manually because it's not the typical function of our team, so we don't have automated kit production equipment.

Harun: How many kits is your lab making a day on average?

Safiya: Around 6000 initially but we have now reduced this.

Harun: Wow. What's the most you've personally made in a day?

Safiya: 1500

Harun: Are you involved in any work on the vaccine?

Safiya: We don't really work in vaccines. Although we have the sterile

facilities, we don't necessarily have the equipment or the appropriate license. Where vaccines are produced depends on the manufacturing process involved. This is regulated by the MHRA (Medicines and Healthcare products Regulatory Agency). You must be covered by a license to manufacture any medicinal product.

> Harun: How do you think it will affect your line of work in the long term?

Safiya: The majority of our activity is essential work so I don't think it will change; however previously only senior management worked from home pre-lockdown. The way in which we work will adapt, in order to reduce how often we come in. We now have to compress our workload into fewer on-site days. The way we communicate has also become much more streamlined, as we don't have the opportunity to just quickly 'catch-up' informally with colleagues in the office.

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[1] 'Transfect' is a portmanteau word combing trans(formation) and infect. It distinguishes an artificial change in cell properties caused by the introduction of DNA from an organic viral infection.Plasmids are a genetic structure in a cell that can replicate independently of its chromosomes.

Belal, 28
Foundation Year 1 Doctor
3.07.2020

Harun: So where do you work and what's your role?

Belal: I work in a district general hospital on the Isle of Wight. I was based on the respiratory/general medical ward. As FY1s we have three specialties in a year so we rotate every 4 months. (Foundation year 1 is the first year of a two-year programme for doctors who have just graduated from medical school.) Once Covid-19 kicked in all rotations were frozen. You remained in the specialty you were in at that time. The logic was that you're already accustomed to working within that specific team, so it's one less thing for the hospital to deal with when handling an influx of patients.

Harun: What do you do day-to-day?

Belal: We review all of the medical patients on a daily basis — either with a consultant or by ourselves. Medical plans are effectively put in place and we aim to treat the underlying issue and get the patient out of hospital as soon as they are fit enough. We aim to progress with the plans day-to-day, working with various members of the multi-disciplinary team.

Harun: How has the pandemic affected your work?

Belal: The adjustments demanded pretty intense planning. We were learning about the changes every day. As FY1s we felt we were being kept out of the loop a little bit. We attended group conferences and at times it felt like how you imagined military planning scenarios. It almost felt like a film.

Being the only hospital on the island meant we needed to be over prepared. We'd seen pictures of Italy and London. The hospital on the Isle of Wight is very small, it only has about 250 beds. For perspective, the hospital I went to whilst at University in Nottingham had about 1,500 beds. We didn't know what to expect. Our intensive care capacity isn't large — there are only six or seven beds available. The operating theatres were changed into intensive care areas to help. We were also gathering information from other hospitals. The overall priority was creating hot and cold zones and to create an isolation ward.

Senior management cancelled elective surgery (surgery that is scheduled in advance because it does not involve a medical emergency), so that space became a general surgical ward, which became the stroke ward and the stroke ward became the isolation ward. The medical assessment unit was moved to a different ward and that ward became what we called 'hot' A&E, i.e. possibly infected / suspected Covid patients.

We had fewer patients admitted to hospital unless absolutely necessary. The focus was getting patients out as quickly as we could. They made my ward another hot ward. It was designated high-risk to handle spill-over from the ward next door. Other areas of the hospital were closed altogether. The education centre and the old medical records department were shut down. Those areas were converted into a field hospital. The army arrived and helped with its construction. This all happened around April. Fortunately the field hospital wasn't needed and the isolation ward never reached maximum capacity, although we did have a number of positive patients.

Harun: How did this affect you emotionally?

Belal: It was very intense to begin with. We were adapting to the changes every day. A Covid task force was set up while we tried to continue with our duties. The question was, 'how do we prepare ourselves?' Some of the

younger, less experienced nurses seemed more worried. There was a lot of anxiety. On the flip side people were very determined. There was an attitude of 'we're going to get through this'.

An ongoing concern was infection among our colleagues. If one of us got sick, it added pressure for the entire team. Households with more than one doctor were also broken up, so although it was necessary you also lost that comfort of familiarity. This brought its own administrative load. We had doctors on the mainland who'd typically commute over, but they needed to be housed on the island too.

As it happened, the Isle of Wight maintained a low infection rate. As a popular retirement spot, there is a large proportion of older people here so you can understand the anxiety. What alarmed me was people suddenly deciding to come down from the mainland to their holiday homes. The ferries kept operating on reduced service. Traffic disappeared, at the height of the lockdown I could get to work in fifteen minutes. Now it's creeping back to thirty or fourty.

> Harun: How do you feel the government managed the situation?

Belal: The government didn't handle it as well as it could have. Other countries did a far better job. We took it seriously too late. We were behind Italy, but then we followed their trajectory and then surpassed it. Personally I feel a second wave is very likely. We're already seeing mini-spikes every now and then, even among our own staff. A good dozen went off work sick and were self-isolating. Medical teams can't keep two metres apart and continue to do their jobs. As the weather picks up there will be non-adherence to guidelines and people will start flocking to the beach adding to the risk of a second spike.

> Harun: How was Ramadan in these conditions?

Belal: There were days when wearing the masks and PPE made me feel even more dehydrated. I had another couple of Muslim colleagues who I could break the fast with on a late shift, enjoying Iftar time. On the plus side, the days went by really quickly because we were so much busier. I did a lot of long days, twelve and a half to thirteen hour shifts. We made our own internal rota between us to help manage the time according to our different needs. Nearer the end of Ramadan, when things were easing, the days were going by very, very slowly.

> Harun: How has it affected your dreams?

Belal: I kept seeing footage from the news with hospitals flooded with patients in the corridors. I was worried that could happen here and continued to think it would be the case at some point soon.

We are now seeing the rebound effect of patients not getting medical help during lockdown, but things are picking back up again.

Khaldoon, 44
Psychiatrist
03.07.2020

Harun: So where do you work and what's your role?

Khaldoon: I'm a psychiatrist and I work in Tower Hamlets, with a community mental health team in Bethnal Green.

Harun: What do you do day-to-day?

Khaldoon: Before the pandemic a typical day would consist of seeing people in clinic (i.e. seeing people referred by their GP (General Practitioner) for an assessment), or by their psychiatrist, if they're already known by the mental health team. I would work between a dedicated walk-in centre and also see people in hospital who have mental health problems.

People admitted to hospital are typically very unwell, possibly with psychosis[1] or diagnosed with schizophrenia in the past, and have become more unwell and can't be helped in the community. Equally there might be patients in crisis — who may have made suicide attempts and are now admitted to hospital. In the hospital, most of our patients are detained, so you are seen as and are an authority figure. That is the fact of the role there. I'm part of the system in that context. But outside of it I'm not. I'm very aware it is a role. You could replace me personally and it would be the same. You could be black or white whatever — the system itself creates the power-relationship.

A lot of the time they are given medication — but that's only part of it; we also focus on containment and physical healthcare. There's also a psychologist on the ward who sees patients individually for psychological therapy.

Harun: How has the pandemic affected your work?

Khaldoon: A couple of weeks immediately before lockdown in March was a terrible period for us, because most of the staff team were off, actually with Covid-19, including myself. So our workforce was decimated. Then there was the stress of getting the virus, concerns about transmitting the virus, all the while not having sufficient PPE. The uncertainty of the situation led to a huge amount of stress. Every single person: nurse, doctor, porter were at extremely high levels of stress, and not only at work but due to what was happening around them — family, friends, partners — your entire support group.

I initially worked in both the clinic and the hospital. They then asked me to just be in the hospital to reduce the possibility of infection. We had patients who had to be isolated: they'd come with mental health problems, then often show Covid symptoms and then need to be isolated. Psychiatric wards are not designed for isolation from infection. We often have 'isolation rooms' within wards, as it's not uncommon for there to be outbreaks of a virus. But that's not the case on mental health wards. The mental health nurses don't have training in physical health care. So we had many who might have been out of their depth, because they have a different skill set. For example, they may not be used to measuring someone's oxygen saturation.

Some patients were extremely anxious. They were worried about getting coronavirus. For some, the pandemic had triggered their mental health crisis, while other patients, those who were very psychotic, were oblivious, they didn't know what was going on. There were even those who were manic, who thought they were invincible, who thought they could cure Covid and were on a mission to stop it.

For the last six weeks it has felt weird. The way in which it is the same as before, but we now wear masks and surgical scrubs. All the patients who are admitted are placed in isolation, then they are tested for the virus. When it's negative they come out of isolation. Because we've been doing it for a while now it seems less strange… Although in the beginning it felt so different from how we were used to practicing.

At the height of the pandemic the number of admissions was really minimised. The NHS Trust wanted to limit the number of people coming to the hospital. So there were periods when we weren't that busy. But then going back to so-called 'normal', there was a backlog of people who needed attention — and there aren't enough psychiatric beds.

I've seen people who haven't been able to see their usual psychologist or psychiatric nurse; who are reliant on that regular support to avoid becoming really unwell and now many of these people are now coming to hospital. Then you have people who have had a crisis or conditions develop because of the events of the last four months. These are the people who only now are coming to the attention of the mental health services. And everybody expects it to get worse.

Harun: How did you stay healthy?

Khaldoon: I was grateful to have a job with colleagues who are very caring. My worst time was when I was actually ill. I had a cough for five weeks and then was off for one week. I found that difficult because I was on my own. I only found out later I had the virus. You don't want to infect someone. But you also feel guilty to not be at work when you were most needed and that your colleagues might feel let down.

Harun: Were you able to work online at all?

Khaldoon: Half or sometimes more than half of the staff who work in the community were calling people at home. They weren't using video so much. For some reason video is not being used in our mental health teams.

I definitely think there will be more phone and video in mental health services. Part of the reason it hasn't happened sooner is out of confidence in or with the technology, and habit. But now they know they can do it. It's also efficient, which admittedly can be a problematic way of approaching the viability of a method — but for a lot of staff for many different reasons they prefer the option of sometimes working from home. It gives them more flexibility. However I don't see it becoming a wholesale replacement of an in-person, face-to-face service.

Harun: How did you feel about the 'Clap for the NHS'?

Khaldoon: It was awful. Politicians' energy should have been directed towards applying the right strategies. I thought it was a very cynical gesture on the part of the Tories. It actually made me very angry. Angry with the government — not at the people clapping — that they would expend their energy cultivating this — rather than address the actual issue seriously. We'd seen other countries successfully handle things. Instead our government was performing hollow briefings, which were exposed as farce. There was no testing, no proper PPE. It was obvious to all of us on the ground.

Meanwhile national inequalities came to the fore, as we saw in the higher proportion of casualties among people from minority backgrounds. My hope was that in this coming to light, health inequality would be addressed

on a wider level. But it seems the authorities are blaming minorities. It fell to BLM protests to articulate this. I went to the American Embassy protest.

Harun: Has Covid affected your dreams?

Khaldoon: It definitely has. I have a recurring desire to live in a place surrounded by green, being in a garden.

[1] NHS definition: Psychosis is when people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions).

Liam, 34
Paramedic
03.09.2020

Harun: So where do you work and what's your role?

Liam: Pre-Covid I was a paramedic assigned to a Fast Response Vehicle (FRV). I worked from Brixton Ambulance Station. I would sit alone in a car, and my role is to be a first responder to the sickest category of patients: those who have had fits, seizures, or been stabbed — anything like that.

I'd typically travel in one of those smaller yellow cars with blue lights — an FRV should be the first to get there and set up life-saving treatment. The ambulance would come after. That's what we call a DCA, or 'Dual Crew Ambulance'. There's a national commitment for the sickest patients to have an ambulance clinician with them within 7 minutes. This is important for things like cardiac arrests, as we carry defibrillators and you need to have a defibrillator within 4 minutes to improve chances of survival. This would be called a Category 1 patient. A Category 2 or 3 could include things like strokes, chest pains, elderly fallers, breathing problems, fractures and mental health problems, to name a few.

I would start every morning at Brixton Ambulance Station — picking up my vehicle. Then I'd be based on a side road near Brixton Town Hall, or sometimes Clapham. I could be sent to cover other areas like Croydon or Sydenham, for example. The London Ambulance Service operates across the city; in contrast to the police and fire service which are more borough-specific.

When you're in a Fast Response Vehicle you're a solo responder, so there can be a lot of waiting for calls. You can listen to music or read a book, until a call comes.

Harun: I heard a lot of sirens at the height of the pandemic.

Liam: Each ambulance clinician will do an 'advanced driving' course. There's extra focus on positioning in the road and what to do when you're overtaking. I still remember the first time I drove on blue lights. We have exemptions from the highway code when driving under emergency conditions (with blue lights and sirens on), such as treating a red light as a give way, for example.

Harun: And how did you get into this work?

Liam: I was a firefighter in Rye for five years. I also worked in the control room for Kent Fire and Rescue, taking 999 calls and so on. But I always preferred being out and about amongst it. The more I worked with paramedics, the more interested I became. I liked their autonomy compared to the fire service, which I found very regimented. I joined the ambulance service in 2013 and registered as a paramedic in 2017.

Nowdays, the usual entry route is via university, doing a three-year degree in paramedic science. In my case, I worked as an apprentice paramedic, while doing a part-time degree over four-and-a-half years with The Open University. The Ambulance Service also runs its own internal academy.

Harun: What did you do day-to-day prior to the pandemic?

Liam: In 2018 a mental health car was introduced, and I was one of the original paramedics to work on it. I did that for a year. The emergency services receive around twelve thousand calls a year relating to mental health, which is about ten percent of all calls. This car carried a paramedic and a mental health nurse. Initially it was just one car working

out of Waterloo. Then it grew to six cars, one of which was based at Ilford Ambulance Station. I then applied for a management role. In March 2020, I began a secondment for that position, to help manage the growth of this strand of the paramedic service from fifteen to forty-five members of staff. I also continued to cover the cars when that was needed — as well as delivering training. Because it was a pilot scheme, there was a lot of self-reviewing as well to help secure funding. I did that up until August 2020. So I was balancing the general work with the fast-response cars, and more management work.

Today I'm in a Fast Response Vehicle doing an overtime shift. It's important to me to still go out and see patients. I love seeing and assessing them. I'm due to start a new, permanent role as a manager at Greenwich ambulance station, which comes with a higher pay band and more variance in what I do, like some increased clinical skills and supporting other crews.

Harun: How has the pandemic affected your work?

Liam: I worked through SARS, EBOLA, MERS… these different diseases that we'd been warned about in the past. So we didn't think much of Covid when it was first reported. Then the ambulance service started to bring out guidance documents that kept being rapidly updated. We're now at the stage that we assume everybody has it until proven otherwise.
Early on it was: 'wear a mask for these people, but not these people'. For some patients you might not even wear gloves. Now it's mandated to wear this stuff. We were suddenly having to put on this PPE (Personal Protective Equipment) and the service was having to meet this new demand. Jumping from barely wearing a surgical mask to thinking about dwindling supplies. It's got a lot better now. We've got the right amount of kit to cover us.

On the patient side of things, we had a massive spike in what we called the 'worried-well'. You could be young, say 21, and you've just got a cough, but they had heard about Covid and were worried they might have it. This was before the testing was widely available, so they would call 999 to get confirmation or advice. We felt we had a massive spike in those. It's always tricky if you're dismissive of that though; hidden within that spike were older patients who had underlying health conditions for example.

Very quickly we were dealing with a lot more pressure. Public support helped: we were being clapped for, and given a lot of free stuff. That felt weird, as we were actually working, we had money and were given free stuff, while dependence on food banks was rising. Morale was good. Although fatigue eventually set in. On average I think the London ambulance service had about nine cardiac arrests per day, but at the height of Covid I heard this had doubled to eighteen. The days could end up being longer, as sometimes we had to have our vehicles completely decontaminated before the end of our shift. That involved taking it to one station to be deep cleaned then hand it over, but this process is a bit more streamlined now. Sometimes there weren't enough vehicles to meet the demand. But this improved when we got support from the fire brigade and medical students as drivers, which allowed us to put out more ambulances.

It was tiring keeping up with new developments daily, or looking out for new symptoms. The management put some good stuff in place. They had managers meet crews to talk through the latest changes. The NHS necessarily shifted its attitudes; there

were patients we'd usually blue light into hospital that we'd have to leave at home. This didn't always sit right with me.

> Harun: How would you personally assess the UK Government's handling of the pandemic?

Liam: In my personal opinion I don't think the government handled it particularly well. Decisions were made too late. Other decisions were more about economics; they didn't think about the human damage. The government set the pace, then Public Health England, then NHS England, before decision-making gets to the Ambulance Trust. The disease caught everyone off guard. We are one of the world's best healthcare systems. A pandemic is one of the things they have on their risk register to be prepared for.

As a pan-London Trust we'd go to different hospitals, and each would have different strategies in different boroughs and wards. For example, in Lewisham they were using ultrasound to check patients' lungs, which by many accounts was excellent practice — but not enough of this knowledge was being transferred and shared London-wide.

> Harun: There was a lot of misinformation in circulation too…

Liam: Social media didn't help. I'd see people on my timeline post things like, 'Lemsip and a run kills Covid'.

> Harun: How did the working culture change?

Liam: Everyone had this chipper, upbeat, stiff-upper-lip. Everybody wanted to do their best. There was also a lot of unrest. Some felt that the PPE was so inadequate they were put at risk, and putting their families at risk. That damaged morale. Equipment did eventually improve.

Specific to my department, there were more mental health patients relapsing. These patients would become more and more unwell. It felt like we were seeing more and more seriously ill mental health patients.

> Harun: How do you think it will affect your line of work in the long term?

Liam: I can't see us going back to the 'good ol days' of not having to wear PPE. Maybe we were a bit lax about infection. I would literally be looking down a patient's throat without eyewear. The pandemic made us more aware that what we're doing can be quite dangerous. We'll get better at infection control. I think it has hardened the staff who worked through it. It's changed the ambulance service in London — the way our stations are set up. It's maybe catalysed some streamlining that was already in progress.

It's been the most stressful period of my career. Not so overwhelming that I can't deal with it… Some colleagues have really struggled… '90 year-old Gladys we're not going to put on a ventilator; 50 year-old Billy needs it more' — I know doctors who have had to make really tough decisions.

Jordan, 34
Secondary School Teacher
30.05.20

Harun: So where do you work and what's your role?

Jordan: I teach maths from Year 7 (11-12 year olds) to GCSE level (typically 15–16 year olds) and computer science up to A Level (typically 17–18 year olds) at a state school in Southwark.

Harun: What do you do day-to-day?

Jordan: Before schools were shut down I'd get in around 7.30am and leave around 5.30pm. I'd be teaching all day. I'm also a form tutor (responsible for a group throughout the year) so I have pastoral duties as well. I typically interact with anywhere between seventeen to two hundred kids in a day.

It's a really diverse school both in terms of ethnicity and class, which is to do with both its location and the strong reputation it has built over the last ten years. There are middle class kids from well-to-do families in Dulwich alongside underprivileged kids from estates in Southwark. Aside from the socio-economic diversity, you have foreign-born students, or those from second generation migrant families, who don't necessarily speak English as a first language.

Harun: How did they take to you when you first arrived?

Jordan: As a young Black teacher with awareness of youth culture — you know how I'm into my football, movies and anime — they assume you're from the same place as them. The school's catchment area includes West Norwood, so some of them went to the same primary school as me...but I also went to an independent school. I was comfortable in that environment as well. I'm not at odds with the teachers or the pupils.

I am uniquely positioned to deal with that kind of code-switching on an hour-by-hour basis. The school is singular in the way it serves several distinct communities. Back in the day it had this label as 'a ghetto school'. As its standards rose you had more White and South Asian middle class families attending.

Harun: How does this affect the social environment?

Jordan: My school has almost two thousand kids. When you see them milling around you get a microcosm of Britain's social divide. The middle class White kids and what we call 'Pupil Premiums' (under privileged) barely interact. Black kids are bullied by other Black kids; White kids are bullied by White kids.

The different constituencies speak differently. You have to change your references. If I'm doing a statistics lesson I might use Premier League stats or video games as a reference. The Black kids find it harder to let go of their street vernacular in my experience.

Harun: Perhaps the White middle class kids are staying in their vernacular, too. It's just not recognised as a vernacular; it's considered the standard.

Jordan: I agree. And if you're not White there's only so far to White you can get — unless you're deluding yourself [*laughs*].

Harun: How did the pandemic affect your work?

Jordan: When Covid first reached my radar around January, like for a lot of people, it wasn't clear how severe it was. As a teacher I live in a petri-dish. I'm in the midst of germs from all over the place. But I don't think I've ever taken a day off sick you know.

Then the talk started getting louder towards the end of January and

mid-February. Certain school trips were cancelled. Then in early March, a neighbouring school closed for four days because they had a case of flu — or that's what they thought it was at the time.

Then a couple of weeks later, all the schools closed[1]. The kids were convinced they were going to die and that the government didn't care about them. It was a real fear among my pupils.

Harun: School's out!

Jordan: Some children perceived it as a holiday. The divide between kids who are supported at home and those who are not is getting bigger. Some kids are thriving right now, but that's not the majority. Then you need to consider that school is a lifeline for some children. It can be their only guarantee of a few hours away from a disruptive home life and a warm meal.

Harun: So you switched to virtual schooling?

Jordan: Yes, at my school we teach through Microsoft Teams and software like *Show My Homework*. Pupils all have a school email address nowadays. They can access everything through different school internet platforms. They can message the teacher if necessary — and at my school we have regular scheduled lessons that are live broadcasts.

But not everyone is tuning in — some just don't turn up. If they do I can see their work, but not every student has a smartphone or a laptop. If that's been the case we've arranged a school laptop for them. For it to work, though, there still needs to be support from the kid's family. Some children have that support, others don't. They may even be actively discouraged or intentionally distracted. In a physical classroom the teacher is the mediator of attention. The gap between children from different socio-economic groups is getting wider, so it will be a big issue when they return back to the school classroom.

Harun: How have you been able to support students that you thought were vulnerable?

Jordan: I made individual phone calls, usually a couple a week. I chase up on anyone who's not responding to any of their teachers. Sometimes a pupil might not be at one class, but as staff we're talking between ourselves to get an overall picture.

Harun: How do you feel when you read that public schools such as Eton are not resuming until the autumn?

Jordan: Unfortunately it's different for comprehensive schools. They have to get back. For our kids it's health or education. We can't have both. Some of our kids suffer when the school is closed in the way that a wealthy middle or upper class child will not. And that health is multifaceted: it's mental health, more space for exercise, better diet…that's all being weighed against the impact of Covid. There are probably less difficulties for a child attending Eton or a similar school that mean they don't suffer as much out of school.

Harun: So how will it work with two thousand pupils?

Jordan: The plan is to stagger the classes. So you won't have the entire school body back on site.

The classes will also be halved, some pupils coming in the morning, the others in the afternoon. I'm still skeptical about social distancing in this environment. You try getting horny teenagers to social distance [laughs]. All they do is hug. That's the one thing that defies all the class and race groupings. The

boys will dap each other. Girls will hug girls. Boys will hug girls.

Harun: How will it affect your teaching longer term?

Jordan: I think the school will push for more use of technology. That won't change so much for me personally — I've always implemented different technologies when it made sense.There are certain things they are going to want to continue to do, like 'flipped learning'[2], or independent learning approaches. Some of the systems should have already been in place, as the technology is there, such as extra lesson support via video conferencing.

Harun: Do you think the virtual classroom is the future?

Jordan: I hope not. Part of teaching is modelling social behavior. To try and be a role model, in other words.

Harun: Teaching is more than the delivery of lessons.

Jordan: Yeah. We call it 'modelling' because they learn from our behaviour too. Part of being in the classroom is being distracted and still finding ways to focus. For both teacher and pupil there are visual, gestural, tangible aspects of communication that help with learning and teaching. For the kids there's also the practice of community itself, navigating a complex social space, making friends. Face-to-face communication — that's different from playing Fortnite (an online video game) or FIFA.

Harun: So school life in London is a kind of rehearsal for city life?

Jordan: Learning to deal with differences. They won't all have the opportunity to, for example, live in Japan and learn the language, which was something I did — to really be out of their comfort zone. Without school there's the potential of staying in your comfort zone, which still happens to a degree in their informal time. But through classes, sports teams, schools trips, they must interact.

Harun: How was it to be fasting over lockdown?

Jordan: Coming into Ramadan I was expending less energy. If my schedule allowed it I could have a nap at home, although on weekends boredom makes the time go slower. Unlike Tasnim I'm not by myself, I live with Muni. But when it came to Iftar that social aspect was completely removed. I didn't grow up with that, but Munira is used to it. The biggest issue was Eid, because we couldn't really celebrate. That was difficult.

Harun: How has the pandemic affected you?

Jordan: I'm not sure, to be honest. I think it has definitely alerted me to how fortunate I am to be in the position that I am. I also think that the pandemic has allowed me to reflect on my goals and what direction I want my career to go in. As someone who is interested and experienced in IT and communications technology, I think that the potential for improving the quality of education through their use is being highlighted by what we are seeing right now. Obviously there have been teething problems and certain things that need to be ironed out, but I think on the whole this has been a moment of growth-out-of-necessity for the education sector.

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[1] By 20 March, all schools in the UK had closed to all children except those of key workers and children considered vulnerable.

[2] 'Flipped learning' is a model of pedagogy that involves a class engaging in discussion and developing shared understanding around a topic, with the guidance of the teacher. A new topic is introduced in the time traditionally reserved for homework, often through curated web seminars.

Natalie, 30
Children's Social Worker
22.05.20

CW: This interview contains descriptions of the complex experiences of vulnerable children in care, including some mention of abuse; and the role of a carer in this process.

Harun: So where do you work and what's your role?

Natalie: I work as a social worker in the Children and Family Service for an Inner London council borough. I specialise in care for 'Looked After' children. I also recently gained a postgraduate qualification as an Advanced Practitioner / Practice Educator. This is where I supervise students training to be social workers.

Under the Children and Family Service umbrella there are 'first response' social workers, whose focus is children in immediate need or at imminent risk of harm. When they come into the care system they are assigned to a Looked After Children social worker, which is where I come in. I'm a 'corporate parent'[1] for children from 0–18. For example, if they need a medical operation, I would be the one that grants permission.

Harun: Do you stay with a child over many years, or for a set period of time?

Natalie: The council tends not to change social workers for young people unless that social worker leaves. It's all about continuity. I've worked with this council for coming up to six years now. Of my eighteen children, ten I've had from the very beginning.

In terms of building trust with a child it's important to be predictable. If they have the sense you might leave in the next two months, they can swiftly shut down.

Once a child is in the council's care their placement could be with a foster family, a semi-independent placement (i.e. a placement in a shared house with other children and staff), a residential, commonly called 'children's homes' or with a connected family member (e.g. an aunt, or grandparent). When a child moves to a new a placement, in the first year I am legally required to see them every four to six weeks. After a year of being in placement if they are settled I will see them every three months. Day-to-day the foster carer is required to log the child's activity, and they are also assigned a separate social worker who liaises with them.

Harun: You originally trained as a nurse, right?

Natalie: Yes. I practiced for a year. It was during that time that social work appeared on my radar. While I was nursing children in hospitals, I'd get really attached and then they'd move on. Occasionally social workers would come in and engage with the children. I was drawn to the longer-term relationships they had. I became interested in understanding attachment theory and child development. I found all of this missing from nursing. I'd be on a seven hour shift and then a new set of children came in. I get more satisfaction from this.

The daughter of one of my neighbours had trained as a social worker, so I shadowed her for a few days and it confirmed the direction I wanted to take. I went back to uni to retrain and got a degree in social work from Middlesex University.

Harun: Over the last few months did you have an urge to return to nursing?

Natalie: I never had the impulse to go back. What I'm currently doing is equally valuable. But my training as a nurse has been invaluable. Especially if one of the children is taken to hospital, I understand those procedures as I've worked on the other side.

For example, having dealt with burns

and hot liquids it's made me alert to abuse that some colleagues might overlook. There was a case in which the guardians claimed a kid had spilt a hot drink on himself, but the burns were on his shoulder and back. I knew that wasn't likely based on his height, the location of the cabinet and their description. The drink would have fallen on his chest rather than his back. My manager gave me the green light to investigate further, and my suspicions were confirmed.

Harun: What do you do day-to-day?

Natalie: We are required to think about each individual child as you would your own child. This care is then divided into different categories, for monitoring purposes: education needs, health needs, emotional wellbeing, their needs for contact with their birth family, their placements or accommodation needs, and their financial needs.

Every child has a personalised care plan. This is reviewed every six months by an independent reviewing officer. It's how they determine if I'm doing all that I could and should be doing for that child.

The majority of my case load is under-16s. When they become older teenagers, acquire more agency and start to go missing and so on it's intense. Fortunately many of the carers are very capable.

If one of the kids has been excluded from school, I may have a meeting at their school. You have to see their form teacher face-to-face twice a year. Statistically, educational attainment is lower for a child in care, so there is extra support and I work to make sure that's offered and taken up. I make sure they've had their teeth and eyes checked. It's making sure the child is being cared for better than they would be if they were with their birth family.

I'm also required to see the children alone, one-to-one, so that they can express any concerns that they have. There's a lot of paperwork. Reports for all of the headers: education, health, accommodation and so on. No day is really the same. Each child will have different needs on different days. Three of my children may have been arrested so I'll be at a police station; or I could be at a school playing a board game.

Internally we have a three-hour team meeting every Wednesday; we talk through a number of our cases together, share knowledge and different strategies in a process of group support and learning.

It's a requirement of our local authority for each child to be discussed with a four-week rotation. There are different panels for different things, for example, there's one for placements that have broken down.

There are legal responsibilities for each child. I go to court more often than I care to remember. It's usually with birth families, who want the child back in their care. This is usually a 26 week court process. So we in turn are obliged to self-monitor and record our own work every step of the way.

Harun: How has the pandemic affected your work?

Natalie: It's more intense across the entire network of carers and social workers. Regardless of the type of placement, everyone is experiencing the same pressures of being away from friends or family, not being able to go out, and restraints on what you would normally do. The children are experiencing this too.

Many of our kids can be quite defiant

in nature; they will go out and will do what they want. With no school, more confinements, there's more conflict. If a child is smashing his room every day your tolerance level comes down quickly. Among my eighteen children, four placements have broken down during lockdown.

So I've had to find families who will welcome a child into their home,one who might have been out not keeping themselves safe, they may have Coronavirus. They've had to take what they're given — which is not ideal — and I can't go to visit, unless it's very serious. There is a colour-coded risk assessment in place and if a child is on 'red' you have to see them in PPE. If they're 'amber' you might have to see them. 'Green', you can do a virtual visit.

That said, it's strengthened the conviction that this is the career for me.

Harun: And do the Wednesday team meetings still happen?

Natalie: Yes, on Google Hangout. The paperwork hasn't stopped, all the individual risk assessments are just as necessary.

Harun: Are there parallels with reports of rises in domestic violence under lockdown?

Natalie: Children who self-harm have been on the increase and there's nowhere for them to go. There's been a significant increase in young peoples' mental health problems, and an overall increase in crisis situations.

In the semi-dependent setups, if staff are overworked and 'on' around the clock, they're more likely to snap. That kind of thing has a domino effect. A child might say 'my foster carer shouted at me': 'She slammed the door'.

Harun: So this changes your role?

Natalie: There's an element of you having to be a crisis worker, rather than focus on continuity, because that may have collapsed. There is a dedicated 'Crisis Team' for under-18s, but that service doesn't necessarily translate over a video call. It's also much harder with video to get a sense of what's happening. You may not catch a subtle gesture, or I typically watch if a child flinches at a certain word. 'What is it about a particular word that makes you uncomfortable?' I might miss these cues. I feel powerless. I went to Croydon University Hospital yesterday to see a kid there who'd had a breakdown. He's eleven.

If your childhood has been disruptive you're less able to tolerate uncertainty. The possibility of overdoses is more prevalent. If I have a tough day, I've got my sister and cousins. I'll do a Friday night quiz with your sister. I have anchors. These young people don't always have that.

I've had to adjust. One foster carer is vulnerable to Covid infection. I'm doing shopping for them, topping up their electric, I'll go to a food bank for them. People are in crisis. This is way beyond my job description. I don't know what to call it, I'm doing something else, I'm responding to the crisis as best I can.

Harun: Have there been any good sides to the virtual visits?

Natalie: I have more time with the kids I visit because I'm not having to factor in travel. I've done baking over Skype, messed about with make-up, done drawing competitions. They just want my time. If they want to talk rubbish for an hour, let's do that. I wouldn't usually have the time to do that because I have to get home to R (Natalie's son).

I've been fortunate that R can go to his dad's or stay with mum. If I've had to make a visit then I'm super careful and put my clothes in the washing machine straight away. He's really into baking too and cooking, he helps me practice recipes.

> Harun: How do you think it will affect your line of work in the long term?

Natalie: Our office is open plan, so there'll need to be some spatial adjustments. I'm hoping they see the benefit of saving time to do more things online, if a child is on 'green', instead of a six-hour round visit to Stoke. This also makes time for other visits elsewhere, or multiple visits if necessary. Even little things like not travelling into work during rush hour means I don't start the day frazzled. It shouldn't have taken a pandemic to recognise the benefits of being more flexible with our time.

> Harun: How does change come about in that working environment?

Natalie: The director of the Children's Family Service is doing fortnightly drop-in sessions, listening to practitioners and what they experience. The head of service in turn feeds back to a steering group.

> Harun: How do you deal with this emotionally?

Natalie: The extreme situations are not frequent. Once they had shut our office and we had to minimise our visits. I could not relax. There was one case that just kept playing on my mind. I couldn't let it rest so I left for South London to do an unannounced visit. It was an instinctive thing.

This child is cared for by his grandfather. When I get there they weren't even there. They were staying with another child who had been arrested for downloading child pornography. We issued proceedings.

There are a lot of sleepless nights for me, even though the service runs 24/7 and there's an overnight team. People on the out-of-hours team say our unit can take up fifty percent of the night — we have 45 young people in our unit, but as overnight is for the whole service it shows how much disruption there is in my unit. I've taken those sleepless nights as a sign of a commitment to the job, but your mind can't stop thinking about a child. If you observe a child has been self-harming you can reason with them, talk through why they felt it was their only course of action. With distance this is harder.

For staff they offer yoga, they offer mindfulness. You are also required to have a supervisory discussion with your manager one-to-one, periodically. There's also a 24hr phone line for emotional wellbeing. If you say, 'I am struggling, I'd like therapy', they have clinicians who can help you find services in your local area.

In 2018, one of my young people with ADHD was sexually abused by his mum. He attacked me. He was nine at the time. When I left I called my mum and my sister. My manager gave me the day off work. It was only when one of the clinicians asked if I was ok that I realised how much I was holding in. I remember that day so clearly, I remember what I was wearing.

Kids might call you a bitch. Push you away. You keep your composure. 'Model-the-model' they call it. They will push you away and push you away, but if you don't turn up one time they will ask, 'why aren't you there?'

> Harun: Has the pandemic affected your dreams?

Natalie: It's definitely affected my dreams. I'm worried about losing the children, I worry about them more than I usually would. I might be the only person who sees them. Some schools are not doing video calls with young people, so they don't see them at the moment. What if I miss a sign? Their faces appear in my dreams all the time. We have conversations in my dreams. When I stop dreaming of them, that's when I may need to rethink if I'm still invested.

[1] When a child comes into care, the council becomes the 'Corporate Parent'. Put simply, the term Corporate Parent means the collective responsibility of the council, elected members, employees and partner agencies for providing the best possible care and safe guarding for the child.

Interviews with Critical Workers (2020). Harun Morrison.