



Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic

10th May - 2nd July 2021



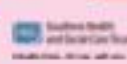
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Findings from a UK Survey



Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic: Findings from a UK Survey

Phase 3: 10th May 2021 – 5th July 2021

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Executive Summary

The aim of this study was to explore the impact of providing health and social care during the COVID-19 pandemic in the UK on the health and social care workforce, including nurses, midwives, allied health professionals (AHPs), social care workers and social workers. The data was collected during the period of May – July 2021 and the report builds upon the findings from the Phase 1 survey (data collected between May – July 2020) and Phase 2 (data collected between November – January 2021). The data came from a survey questionnaire, which measured mental wellbeing, quality of working life, burnout and ways of coping in the UK health and social care workers. Open-ended questions sought further detail from respondents to contextualise the quantitative findings. Two focus groups were also conducted in June 2021, one with health and social care managers and one with frontline workers.

Key Findings

The survey received 2,721 responses, most of which came from Northern Ireland (n = 1116), followed by Scotland (n = 745), England (n = 539) and then Wales (n = 321). Most of the sample were social care workers (n = 853) and social workers (n = 753), followed by nurses (n = 566), AHPs (n = 378), and midwives (n = 171). The majority of respondents were female (86.8%), primarily from the 30-59 age group (83.7%) and the vast majority were of white ethnic origin (89.5%). The main area of practice for most respondents were adults (37.0% UK-wide) and older people (22.9% UK-wide). Overall, respondents have been working more hours overtime since the start of the pandemic compared to before. When asked about the impact of COVID-19 on their work, more than half (62.1%) of the respondents UK-wide felt overwhelmed by increased pressures, 34.5% felt impacted but not significantly and only 3.4% reported that their service had not been impacted and/or that it was stepped down. Social care workers and social workers were the most impacted occupational groups.

Responses to open-ended questions and the focus group discussions were analysed to identify common themes. The overarching themes that emerged in Phase 3 (May 2021 – July 2021) have similarities to the themes identified in Phase 1 (April – July 2020) and Phase 2 (November 2020-January 2021) of the study; **Changing conditions, communication and connections**. In relation to the Changing Conditions, respondents reported that their services were (again) affected by staff shortages, leading to increased workloads, burnout and impacts on health and wellbeing. Positive developments included greater flexibility about working from home and a better work-life balance. In relation to Communication, respondents highlighted that communication with employers and managers had worsened since the beginning of the pandemic. Respondents reported both negative and positive experiences around moving from face-to-face interaction to communicating on the phone or online. Connections were highlighted by respondents as something that constantly changed during the pandemic, with relationships with colleagues and managers worsening as the pandemic continued. Additionally, those who had been redeployed by managers also struggled at times to maintain their routines for work life balance because of new work schedules alongside other home commitments.

Quantitative analyses revealed that both mental wellbeing and quality of working life deteriorated from Phase 1 to Phase 3 of the study and respondents appeared to be using positive coping strategies (e.g., active coping, planning) less and negative coping strategies (e.g., venting, self-blame) more to deal with work-related stressors. Between Phase 2 and 3 both mental wellbeing and quality of working life increased slightly and most respondents appeared to be using less positive coping strategies (e.g., active coping, positive reframing) and more negative coping strategies (e.g., self-blame, behavioural

disengagement and substance usage). Burnout increased between Phases 2 and 3, in Phase 3 UK-wide, a large proportion of respondents were experiencing moderate to severe levels of personal (78.1%) and work-related burnout (70.9%), whereas client-related burnout remained relatively low (78.4%). In other words, patients/service users were rarely the reason for burnout in health and social care workers.

Good Practice Recommendations: May-July 2021 Survey

The 15 Good Practice Recommendations from Survey 1 and 2 were reviewed in the context of findings from Survey 3, in the third phase of this study. These Good Practice Recommendations are organised under the main themes the analysis of phase 1 and 2 data: Changing Conditions, Connections and Communication with reflections on health and wellbeing. They are then further categorised at an individual, organisational and policy level.

Changing Conditions

Organisational and Individual Level

1. HEALTH AND SAFETY: Our first survey noted that for those staff who need to be in the workplace, social distancing, hand washing, and appropriate Personal Protective Equipment (PPE) should be available. We are now at a time where additional virus risk, such as flu, is being considered as also possible to emerge in the coming months. We suggest that employers will need to help alleviate concerns about spreading infection in workplaces and through contact with members of the public and patients/care users. Workplaces need to ensure that there are plans for any unforeseen developments as well as possible crises, such as fire and flood, as well as national or local outbreaks of viral infections.

Organisational Level

2. PUTTING INTO PRACTICE THE ADVANTAGES OF MORE FLEXIBILITY IN EMPLOYMENT: During the pandemic most employers have provided, as far as possible, increased flexibility around working hours, location of working, while recognising additional childcare or other caring responsibilities of individual members of staff to support the workforce. For some, they were not easy to provide, but our surveys have revealed that flexibility was valued when it could be offered. As the level of the pandemic subsides, staff will need to feel that their needs, wellbeing and circumstances are being considered. Talking with staff and their representatives about long-term flexibility in working hours and location must now start to happen at pace with employers demonstrating greater trust in staff to get on with their job when working from home.

3. TRAINING FOR REDEPLOYMENT, SKILL MIX AND SKILL ACQUISITION: We found that training and development to equip staff with the ability to, where possible, perform multiple or new roles were under-developed and suggest that this becomes a strategy for employers to prioritise. This will need to involve employers, professional bodies, regulators, workplace unions, educational and training bodies, and service users and patient groups. Good evidence about what sort of training and development works well would be further helpful. Some respondents in Phase 3, felt that they had gained from redeployment in relation to team working and type of work they were undertaking.
4. EQUITY IN HOME WORKING WHEN POSSIBLE: We noted that policies about working from home (if appropriate) should be fair and seen to be fair in our first report. Home working will need to be considered as well as office or care/treatment settings' impact on outcomes and productivity. Also as home working is often role dependent, clarity and consistency around for whom and when homeworking may be facilitated is important with hybrid models of working, such as part home working/part in office made available where possible. Our survey identified a risk that the connections with managers, supervisors and colleagues were declining in amount and quality when the initial novelty of home working wore off. Employers will need to address not only choices among individual workers but also the team or work unit effect. This will apply to managers as well as professionals working in desk or face to face patient/user engagement. Our findings that there were increasing levels of anxiety and depression may impact on staff willingness to go back to offices and attend in person large meetings as well as individual face to face encounters. Human Resources (HR) staff will need to support managers in addressing a positive return of being physically present at work where necessary.

Policy and Organisational Level

5. TERMS AND CONDITIONS GENERAL: We noted in our first report that employers in the health and social care sector should address the coverage of Statutory Sick Pay for their staff. This recommendation stands.
6. FLATTER HIERARCHIES: In our first survey report we called for research on patient and service user outcomes to see whether greater autonomy and flatter hierarchies make a positive difference to service quality. We suggest that local forum and national planning consider the right balance between clinical or professional judgment and guidelines. We recommend that any inquiry into the management of the pandemic consider these questions.

7. **STAFF WELLBEING AND RETENTION:** Our third survey confirms that a large proportion of staff are experiencing moderate to severe levels of burnout with a need for time to recover from a prolonged period of unprecedented stress and pressure. Taking holidays, being recognised and feeling appreciated remain important. This survey indicates that the setting up of wellbeing services while appreciated by some did not meet the needs of others. The high risk remains that some staff will leave prematurely owing to stress or reduced work-based quality of life, with some evidence that this is already happening. Employers need to be proactive in understanding why staff are leaving and what if anything can be done to change their decision, such as offering more flexible working hours or a change in place of work.

Connections

Organisational and Individual Level

1. **ANNUAL LEAVE AND REGULAR BREAKS:** Managers need to ensure, where possible, that staff are supported, enabled and encouraged to take leave and breaks, and where possible, arrange for their work and responsibilities to be covered.
2. **CONNECTION:** There should be development of evidence-based good practice guidance on communication that meets the broad range of health and social care services by national bodies with strong input from the frontline. Our survey was electronic, and we recognise that staff with limited IT skills may need support in developing online communication skills. Also some staff have limited access to computers and work email during work time – both of these are important contributors to staff engagement and connection and could be audited by employers.

Organisational Level

3. **COMMUNICATION:** There is room now to consider corporate and employer communications – our findings show that these are appreciated but timing and amount can seem onerous. It continues to be important that communication is relevant and timely.
4. **MANAGEMENT VISIBILITY:** Managers should be visible, either in person (if possible) or virtually, so that workers feel they are as valued and that work pressures are understood. They, the managers, should also be valued explicitly.

5. SUPPORTIVE SUPERVISION: Staff concerns need to be addressed whether they are individual concerns or those that can be discussed in peer or group supervision. This point applies to managers and those who supervise managers.

Communication

Organisational and Individual Level

1. ORGANISATIONAL SUPPORT: Respondents provided several accounts of employers and managers signposting staff to organisational supports, counselling, mentoring or coaching supports, or Occupational Health (if required). However, while these resources need sustaining if they are to enable staff to manage the aftermath and emotional impact of working during the pandemic and its legacy; some staff are not finding that their needs are being met and need to be asked what else can be done.
2. TEAM SUPPORT: Team support and camaraderie are noted by the workforce as critical to their coping and wellbeing. Ideas about positive team culture and climate should be nurtured and cultivated to provide support to all team members including managers whose needs appear often overlooked but who, our survey shows, have been under considerable stress themselves.

Policy and Organisational Level

3. RESOURCING AND INFRASTRUCTURE: The unprecedented demand on the health and social care sectors has shone a light on the chronic under-resourcing of staff and infrastructure. Concerted efforts are required to make work within the Nursing, Midwifery, AHP, social care and social work sectors an attractive option, with pay and working conditions requiring sustained attention.

The full report from the May-July 2021 survey can be found online at www.hscworkforcestudy.co.uk

The research team would like to thank all participants who contributed to this research.