COVID-19 Health and Social Care Workforce Study

24th November 2021 - 4th February 2022

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Executive Summary

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

Phase 4: 24th November 2021 – 4th February 2022

REPORT 4: Summary

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Summary

The Research Team is delighted to present the report from Phase 4 of the Health and Social Care Workforce Study (November 2021-February 2022). The last two years have seen unprecedented demand on health and social care workers due to the ongoing COVID-19 (SARS-CoV-2) pandemic. This study builds upon the findings from the Phase 1 (data collected between May – July 2020), Phase 2 (data collected between November-January 2021) and Phase 3 (data collected between May-July 2021) surveys and focus groups to further explore the impact of providing health and social care during the COVID-19 (SARS-CoV-2) pandemic in the United Kingdom (UK). The study focuses specifically on the experiences of nurses, midwives, allied health professionals (AHPs), social care workers and social workers. A Survey (24th Nov 2021- 4th February 2022) followed by focus groups with human resource (HR) staff from health and social care, managers and frontline workers sought to gain further understanding on how the COVID-19 pandemic has affected their work and home life and impacted on their health and wellbeing during this most recent phase of the pandemic.

Key Findings

The survey received a total of 1,758 responses. Most came from Northern Ireland (n = 795), followed by Scotland (n = 492), England (n = 376) and then Wales (n = 95). Most of the sample were AHPs (n=573), followed by nurses (n=361), Social Workers (n=349), Social Care workers (n=333) and midwives (n = 142). Most respondents were female (82.0%), primarily from the 30-59 age group (82.8%) and the vast majority were of white ethnic origin (93.0%). Over half of all the respondents worked in the community (53.3% UK-wide), while 30.4% (UK-wide) worked in a hospital. Most respondents were employed on a permanent basis (91.1% UK-wide) and the majority full-time (72.7% UK-wide), typically working 37.5 hours per week (60.4% UK-wide). A large percentage of respondents UK-wide had either 11-20 years of work experience (27.1.0%) or 21-30 years (23.5%). The main area of practice for most respondents were older people (34.7% UK-wide) and adult services (23.4% UK-wide). Overall, respondents have been working significantly more hours of overtime since the start of the pandemic. During the COVID-19 pandemic, 20.0% of respondents were able to work from home all the time, while 33.5% could work from home some of the time. Social workers were most likely to work from home all the time (34.7% of social workers). Respondents were also asked about the impact of COVID-19 on their work. UK-wide, only 2.9% reported that their service had not been impacted (services stepped down due to COVID-19) with 59.8% reporting feeling overwhelmed by increased pressures.

Responses to open-ended questions and the focus group discussions were analysed to identify common themes. Overall the themes identified in Phase 4 can be summarised into three overarching themes, **known as the "3 c's" in the previous three reports– changing conditions, communication and connections –** as well as views on health and wellbeing, career outcomes and work-life balance. Responses revealed that the health and social care workforce is continuing to struggle with the changes due to the COVID-19 pandemic. These changes have increased work demands, increased staff burnout and stress, reduced staff morale and job satisfaction. The lack of support and recognition for this workforce is now beginning to take its toll on already exhausted workers with greater peer and management support needed. Changes to working conditions have been frustrating for employees due to problems retaining staff and difficulties recruiting new staff. With the increased workloads and changing working patterns, managers and HR professionals have been dealing with the brunt of staff frustrations and backlash; this, alongside a lack of recognition and understanding, needs addressing as this pandemic continues.

Findings revealed that both mental wellbeing and quality of working life deteriorated from Phase 1 to Phase 4 of the study. 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 fewer positive coping strategies (e.g., active coping, positive reframing) and more negative coping strategies (e.g., self-blame, behavioural disengagement and substance usage). Burnout was measured from Phase 2 onwards. In Phase 4, the personal burnout score across the UK was 62.62, which is higher compared to 61.4 in Phase 2 of the study but lower than 63.20 in Phase 3. There was a **significant difference in personal and work-related burnout from Phase 2 to Phase 4** ($p<.05$) but not **client-related burnout** ($p > .05$). Nearly two-thirds of employees did not take up employer support (62.0% UK wide), with Northern Ireland having the most respondents not likely to take up employer support (77.2% within Northern Ireland). Allied Health Professionals were most likely to take up employer support (49.5% within AHPs) while social care workers were least likely (26.0% within social care workers). Respondents who answered yes for wanting to leave their employer and occupation had lower wellbeing and work-related quality of life scores but higher burnout scores than those who did not intent on leaving their employer or occupation ($p<.001$).

Good Practice Recommendations:

The Good Practice Recommendations from the previous three phases were reviewed in the context of findings from Phase 4. These Good Practice Recommendations are organised under the main themes of analysis from previous Phases: Changing Conditions, Connections and Communication, with the addition of a work-life balance section in the recommendations made in this phase.

Changing Conditions

Organisational and Individual Level

1. HEALTH AND SAFETY: In Phase 1, we recommended that for those staff who need to be in the workplace, social distancing, hand washing, and appropriate Personal Protective Equipment (PPE) should be available. Infection Prevention and Control ((IPC) were then a major challenge and employers needed to alleviate concerns about spreading infection in workplaces while increasing access for members of the public, patients, service users, and their families. Employers now need to ensure that there are plans for other possible crises, such as fire and flood, as well as global, national or local outbreaks of viral infections. These are the responsibilities of authorities but need to take into account the experience and views of frontline workforces by listening to their advice and suggestions.
2. TRAINING FOR REDEPLOYMENT, SKILL MIX AND SKILL ACQUISITION: While redeployment of staff is now infrequent, all training and development will need to equip staff with the ability to, where possible, perform multiple or new roles. Strategies to accomplish this are needed. These training and development efforts need to involve employers, professional bodies, regulators, workplace unions, educational and training bodies, and service users and patient groups. Evidence is needed about what sort of training and system change should inform these developments and guide commissioning decisions.

Policy and Organisational Level

3. 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.
4. 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 using the experience of the pandemic

to inform these deliberations. We are hopeful that the national inquiry into the management of the pandemic will consider these questions.

5. STAFF WELLBEING AND RETENTION: Our fourth survey confirms that a large proportion of staff are experiencing moderate to severe levels of burnout and some will need time to recover from a prolonged period of unprecedented stress and pressure or may feel that moving jobs will assist. Taking holidays, being recognised and feeling appreciated remain important. The setting up of wellbeing services and other forms of employer help, while appreciated by many, did not meet the needs of others. The 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. In addition, sharing of staff support initiatives that have been proven to be helpful for staff need to be encouraged, such as 'in-reach services' and wellbeing appraisals as highlighted in the HR Focus Group. While frontline staff may be the target for such initiatives, our study reveals the risks of burnout among managers.
6. CHANGE OF CULTURE: Workplace bullying and what might be called a toxic work culture were highlighted by some respondents as reasons for staff leaving. There is increasing evidence of the presence of bullying as endemic in many health and social care workplaces. Concerted efforts that are resourced and sustained over time are required to address this behaviour and system failings.

Work-Life Balance

Organisational Level

1. PUTTING INTO PRACTICE THE ADVANTAGES OF MORE FLEXIBILITY IN EMPLOYMENT: During the pandemic most employers 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. Flexibility continues to be highly valued by staff with a recognition that homeworking is not available to staff in all roles. As the level of the pandemic subsides, staff will need to feel that their needs, wellbeing and circumstances are being considered. Firming up policy and procedures with staff and their representatives about long-term flexibility in working hours and location must with start to happen, with those involved in student or trainee education preparing the workforce of the future for these different ways of working within agencies and organisations.
2. EQUITY IN HOME WORKING WHEN POSSIBLE: We recommended that policies about working from home (if appropriate) should be fair and seen to be fair in our first report. We are now

seeing that home working is mainly role dependent, with hybrid models of working, such as part home working/part in office increasingly adopted. Employers need to offer choices to individual workers where the job can be done at home but must also consider the team or work unit effect. Our findings of increasing levels of anxiety and depression suggest the value of Human Resources (HR) staff support for managers in addressing mental health risks and noting them at early stages though online communications.

Connections

Organisational and Individual Level

1. ANNUAL LEAVE AND REGULAR BREAKS: Managers still 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. Managers, of course, need to practice what they preach.
2. CONNECTION: Evidence-based good practice guidance on communication to meet the broad range of health and social care staff could be assembled by national bodies with strong input from the frontline. Our surveys were 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. MANAGEMENT VISIBILITY: Managers should be visible, either in person (if possible) or virtually, so that staff feel they are as valued and that work pressures are understood. They, the managers, should also be valued explicitly and have opportunities for peer support and professional development.
4. 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. This recommendation stands.

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; as noted above some staff feel that their needs are not being met and need to be asked what else can be done. Discussion with primary care colleagues about local supports that may be more accessible to health and social care workers would seem timely and may be more acceptable to some than employer provision for a variety of reasons.

2. COMMUNICATION: Both corporate and employer communications are appreciated but timing and amount were thought by some to be onerous during the height of the pandemic. It continues to be important that communication is relevant and timely particularly as hybrid working looks set to continue for some staff.
3. TEAM SUPPORT: Team or peer support are critical to coping, wellbeing and morale. Ideas about how to sustain a positive team culture and climate should be nurtured to provide support to all team members including managers whose needs appear often overlooked but who, our research shows, are under considerable pressure themselves. Meaningful interaction with colleagues may be helpful in fostering good working relationships and anti-bullying cultures. Students and newly qualified or newly appointed staff may need specific assistance to feel part of teams and contribute to them.

Policy and Organisational Level

4. RESOURCING AND INFRASTRUCTURE: The unprecedented demands on the health and social care sectors over the past two years have exposed 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. Indications that the pandemic has increased people's desires to do work that is meaningful should not be thwarted by negative experiences of health and social care work.

The full report from the November 2021-February 2022 survey can be found online at www.hscworkforcestudy.co.uk

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