COVID-19 Health and Social Care Workforce Study

16th May 2022 – 8th July 2022

Dr Patricia Gillen
Dr John Mallett
Professor Jill Manthorpe
Dr Ruth Neill
Dr Paula McFadden
Dr Heike Schroder
Dr Denise Currie
Ms Susan McGrory
Dr John Moriarty
Professor Jermaine Ravalier
Ms Patricia Nicholl

Phase 5 Executive Summary

Ulster University
Queen's University Belfast
King's College London
Northern Ireland Social Care Council
Bath Spa University
CommunityCare
The heart of your social care career
HSC Southern Health and Social Care Trust
Quality Care - for you, with you
HSC Public Health Agency

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

Phase 5: 16th May 2022-8th July 2022

REPORT 5: Summary

Dr Patricia Gillen[1,2]

Dr Paula McFadden[1]

Dr John Moriarty[3]

Dr John Mallett[1]

Dr Heike Schroder[3]

Professor Jermaine Ravalier[4]

Professor Jill Manthorpe[5]

Dr Denise Currie[3]

Ms Patricia Nicholl[3]

Ms Susan McGrory[1]

Dr Ruth Neill[1]

[1]Ulster University; [2]Southern Health and Social Care Trust, [3]Queen's University Belfast; [4]Bath Spa University; [5]King's College London

Funding Acknowledgment and Disclaimer

This study is funded by HSC R&D Division of the Public Health Agency, Northern Ireland (COVID Rapid Response Funding Scheme COM/5603/20), the Northern Ireland Social Care Council (NISCC), and the Southern Health and Social Care Trust, with support from England's National Institute for Health and Care Research (NIHR) Policy Research Unit in Health and Social Care Workforce - PR-PRU-1217-21002. The views expressed are those of the authors and not necessarily those of the funders, the NIHR or Department of Health and Social Care.

Summary

This is a summary report from Phase 5 of the Health and Social Care Workforce Study presenting the results from 16th May – 8th July 2022. This report builds upon the findings from the Phase 1 (data collected between May – July 2020), Phase 2 (data collected between November 2020-January 2021) and Phase 3 (data collected between May-July 2021) and Phase 4 (data collected between November 2021-February 2022) to further explore the impact of providing health and social care during the COVID-19 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. The Phase 5 survey data collection also involved three focus groups in which we talked with human resource (HR) staff from health and social care, managers and frontline workers (June-July 2022). We used these opportunities to gain further understanding of how the COVID-19 pandemic has affected their work and home life and impacted on their health and well-being during this most recent phase of the pandemic.

Key Findings

The survey received a total of 1,737 responses. Most of the responses came from Northern Ireland (n = 1295), followed by England (n = 205), Scotland (n = 141), and then Wales (n = 96). Most of the sample were Social Care Workers (n=730), followed by Social Workers (n=380), AHPs (n=305), Nurses (n=234) and Midwives (n=88). Most respondents were female (88.3% UK-wide) with a similar gender distribution across countries. Most midwives in the sample were female (96.2%) while AHPs had the highest proportion of males (20.3%). Respondents were primarily in the 30-59 years age group (81.0% UK-Wide) and most were of White ethnic origin (90.7% UK-wide). England had the highest proportion of respondents who identified as belonging to an ethnicity other than White (6.3% within England) and midwifery was the most diverse occupational group, with 13.0% of midwives identifying as not White. Over half of all the respondents worked in the community (54.1% UK-wide), with another 23.3% (UK-wide) worked in a care home. Most worked in the statutory health and social care sectors (65.2% UK-wide), but over half of social care workers (59.3% of social care workers) worked in non-statutory services (private or voluntary sector, directly employed or other). Just under half of the study respondents UK-wide were line managers (51.8%). Most respondents were employed on a permanent basis (85.7% UK-wide) and the majority were employed full-time (68.3% UK-wide), typically working 37.5 hours per week (52.5% UK-wide). UK-wide, just over half (52.0%) of respondents said that at least some of their sickness absence was related to COVID-19 with 76.8% of midwives and 66.5% of social care workers having sickness related to COVID-19. Over half of respondents had either 11-20 years of work experience (28.3%) or 21-30 years (25.6%). The main area

of practice was work with older people (38.1% UK-wide). UK-wide, 7.2% reported that their service had not been impacted (services stepped down due to COVID-19) with 59.4% reporting feeling overwhelmed by increased pressures. As shown in the more detailed report, nurses and midwives were the most overwhelmed occupational groups in terms of impact measured in this study (63.0% of midwives and 66.7% of nurses). That said, significant percentages of respondents expressed feeling overwhelmed in all occupational groups with over 45% of respondents in each occupation group indicating such feelings.

On reviewing all of our Phase 5 data the findings can be categorised into three overall themes. These overarching themes from Phase 5 (May-July 2022) have similarities to the themes identified in the previous Phases We continued to group these under **the "3 c's" used in the previous reports– Changing conditions, Communication and Connections.** The focus groups also discussed staff health and well-being, staffing challenges, work-life balance boundaries, coping and support (Table 3.11 in the main report). We found many in the health and social care workforce are continuing to struggle, and while many are returning to a 'new normal' as restrictions lift, many staff have been left facing relentless pressures and demands in their daily jobs. Staff are furthermore dealing with changing public perceptions that sometimes have given rise to negative attention and comments directed at the workforce. Additionally, many are now facing struggles with coping and a lack of motivation when away from the workplace. A vicious cycle of staff shortages, alongside the lack of recognition and increasing staff frustrations, is leading to exhaustion and burnout for many. The disruptions to working conditions have affected valued connections with patients/service users and have changed the workplace climate.

.

We found that both mental well-being and quality of working life deteriorated from Phase 1 to Phase 5 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 5 and Phase 3 and Phase 5, both mental well-being 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). There was a decrease in the overall mean well-being scores and quality of working life scores between Phase 4 and Phase 5 of the study. Positive coping positive strategies such as active coping and planning were used more in Phase 5 than Phase 4, however, the other positive coping strategies declined, while the negative strategies of self-blame, behavioural disengagement and substance use increased over this period. In Phase 5, the personal

burnout score UK-wide was 61.10, which is lower that the personal burnout scores in Phase 4 (62.62), Phase 3 (63.20) and Phase 2 (61.40). The mean work-related burnout score across the UK was 56.51 which was lower than all previous phases. The mean client-related burnout score across the UK was 25.88 which was higher than Phase 4 (25.24).

Respondents were asked whether they worked from home before the pandemic, nearly three-quarters of them did not previously work from home at all (72.5% UK-wide). During the COVID-19 pandemic period from March 2022-July 2022, 7.1% were able to work from home all the time, while 43.8% could work from home some of the time. Social workers were most likely to work from home all of the time (18.5% of social workers) or some of the time (66.1% of social workers), while Nurses (63.2% of nurses) and Social Care Workers (62.0%) were not able to work from home at all. Most respondents did not take up employer support (72.4% UK-wide), although Wales had the highest percentage uptake of employer support (29.1%). By occupational group, AHPs were most likely to take up employer support (26.6% within AHPS). Midwives were least likely to take up employer support (75.9%). For those respondents who took employer support, the most common forms of this were manager support, well-being support and flexible working hours. When respondents were asked why they had not taken up employer support, 30.3% indicated that the support was not accessible or took place at an inconvenient time, 27.1% stated they had support elsewhere, 26.5% felt the support was not needed and 16.1% stated other reasons. Respondents who stated that they were intending to leave their employer and occupation reported lower average well-being and work-related quality of life scores and higher burnout scores than those who did not intend to leave their employer or occupation ($p<.001$).

Good Practice Recommendations:

The Good Practice Recommendations from the previous four phases were reviewed in the context of findings from Phase 5. 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 of this fifth phase.

Changing Conditions

Organisational and Individual Level

1. HEALTH AND SAFETY: In Phase 1, we 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. This Recommendation still stands and requires 'Safe Systems at Work' level of risk

management and strategic investment in emergency supplies of PPE in non-pandemic times, to ensure preparedness for future pandemics, fire, flood, or other disasters. In Phase 5, Infection, Prevention and Control (IPC) continues to be a major challenge for some staff. Employers are responsible for alleviating workforce concerns about spreading infection within workplaces, while increasing access to care and treatment for members of the public, patients, service users, and their families. These are the responsibilities of employers and authorities, but the experience and views of frontline staff need to inform and guide specific interventions and policies, based on accurate research and knowledge from the workforce. Employers also need to feel confident that the advice they are giving is as accurate as possible and to share this openly.

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 expectation and ability to, where possible, perform multiple or new roles. Therefore, strategies to accomplish this are needed. The training and development needed must involve employers, professional bodies, regulators, workplace unions, educational and training bodies, and service user 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 adequacy and coverage of Statutory Sick Pay for their staff. This Recommendation stands. We now add to this some evidence that sickness rates remain high and, with the temporary arrangements for COVID-19 absence generally having been withdrawn by health and social care employers, we believe it is important to address the reasons for absence, including the impact of Long Covid on the health and care workforce.

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 as operating by necessity during the height of the pandemic 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 and will forward our reports to the inquiry.

5. STAFF WELL-BEING AND RETENTION: Our fourth and now our fifth survey confirmed that a large proportion of health and care staff are experiencing moderate to severe levels of burnout, and reduced well-being (evidenced by reported levels of anxiety and depression). Affected employees will need time to recover from a prolonged period of unprecedented stress and pressure or may feel that moving jobs and/or reducing hours will assist. Absence levels due to stress were evident in our study and the pressures these are placing on remaining staff could potentially cause irreparable strain on systems, services and patient or user outcomes. Staff need to be supported to take breaks, including holidays, be recognised and feel appreciated. It is important that they feel a sense of purpose in moving back to the office and benefitting from peer support.

   The setting up of well-being services and other forms of employer help, while appreciated by many, did not meet the needs of others. Accessibility, in relation to the timing of available support as well as this having an 'in person' option, is important. Many did not feel online options were helpful and think these can be tokenistic. If well-being is not managed strategically, the risk remains that some staff will leave prematurely owing to stress or reduced work-based quality of life. 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 days, or a change in place of work. This applies to older workers since the loss of their experience can affect new colleagues and students. In addition, sharing of staff support initiatives that have been proven to be helpful for staff needs to be encouraged, such as 'in-reach services' and 'well-being appraisals' as highlighted by the HR Focus Group. While frontline staff may be the target for such initiatives, we note the risks of burnout among managers and these need to be addressed.

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 their employers or professions. There is increasing evidence of the presence of negative workplace behaviour including perceptions of bullying in many health and social care workplaces. This may in part be due to both internal responses to pressures manifesting as incivility from co-workers, managers and external pressures from a frustrated, stressed and distressed public. Concerted efforts that are resourced and sustained are required to address these behaviours and system failings, some of which need to start with education and training for staff and awareness raising for patients/service users as well as fairness and mutual regard.

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 and location, often recognising additional childcare or other caring responsibilities of staff. Flexibility continues to be highly valued by staff. As the present level of the pandemic subsides, and employers seek to encourage home-based staff to return to their offices for at least part of their working week, staff need to feel that their individual well-being 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 be embedded within organizational Human Resource policies, , including, for example, more part-time working options. For students or trainees, there is a need to prepare this workforce of the future for 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. Home working is mainly role dependent, with hybrid models of working for some, 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 (through online communications) if people are working at home or relatively independently. The high levels of depression and anxiety we found in this phase may make working from home seem attractive but there are risks of losing social contacts and stimulation.

Connections

Organisational and Individual Level

1. ANNUAL LEAVE AND REGULAR BREAKS: As previously noted, 'Staff Well-being and Retention' 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 as manager pressures and burnout is clearly evident in this study, and such stress can impact on how managers can support others. In our fifth survey the issues of not taking breaks did not appear so problematic, but one point of caution is that increases in the cost of living may

prompt more staff to do further overtime or shifts and so not benefit from breaks or time away from work.

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. Some staff have limited access and/or permission to use computers and work email during work time – both of these are important contributors to staff engagement and connection and could be addressed by employers.

Organisational Level

3. MANAGEMENT VISIBILITY: Managers should be visible, either in person (if possible) or virtually, so that staff feel they are 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 personal concerns or those that can be discussed in peer or group supervision. This point also applies to managers and those who supervise managers. This Recommendation stands. The presence of depression and anxiety among many staff noted in this present survey should be addressed in supervision with offers of help extended and these important opportunities to discuss individual well-being should not be missed. Therefore, while there is a move towards group supervision for some staff groups, individual supervision sessions should also be available.

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, or Occupational Health advice and help (if required). However, 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. Furthermore, supports must be accessible – for example, not just online. As noted previously, many staff feel that their needs are not being met and it is critical that this matter is addressed strategically for workforce sustainability. Discussion with primary care colleagues about

local supports that may be more accessible to health and social care workers than those that are employment-based would seem timely and may be more acceptable to some than employer provision for a variety of reasons.

2. COMMUNICATION: It continues to be important that communication is relevant and timely, particularly because hybrid working looks set to continue for some staff and because possible new variants of the virus may develop.

3. TEAM SUPPORT: Team or peer support is critical to coping, well-being and morale. Ideas about how to sustain a positive team culture and climate should be nurtured so that support is available to all team members including managers whose needs appear often overlooked but who, our research shows, are often under considerable pressure themselves. Meaningful interaction with colleagues may be helpful in fostering good working relationships and promote kind, civil 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. It is not a good foundation for their careers if they are working with colleagues who are feeling burned out, depressed or anxious. Employers need to understand that time and energy invested in helping new team members to integrate into their teams will ultimately reduce their workload and stress level; without this, new members may just leave.

Policy and Organisational Level

4. RESOURCING AND INFRASTRUCTURE: The unprecedented demands on the health and social care sectors over the past two years and more have exposed the chronic under-resourcing of staff and infrastructure. Staff shortages and vacancies are of rising concern. Concerted efforts are required to make work within the health and social care 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 May-July 2022 survey can be found online at www.hscworkforcestudy.co.uk

The research team thank everyone who contributed to this research.