COVID-19 Health and Social Care Workforce Study
November 2022 – January 2023

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Phase 6: 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 and Focus Groups

Phase 6: 25th November 2022 – 13th January 2023

REPORT 6: Summary

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Summary

This is a summary report from Phase 6 of the Health and Social Care Workforce Study presenting the results from 25th November 2022 – 13th January 2023. 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), Phase 4 (data collected between November 2021-February 2022) and Phase 5 (data collected between May – July 2022) to further explore the impact of providing health and social care post-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 6 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 1,395 responses. Most of the responses came from Northern Ireland (n = 781), followed by Scotland (n = 332), England (n = 188), and then Wales (n = 94). Most of the sample were Social Care Workers (n=529), followed by Social Workers (n=340), Nurses (n=218), AHPs (n=213) and Midwives (n=29). Most respondents were female (88.3% UK-wide) with a similar gender distribution across countries. Most midwives in the sample were female (96.6%) while AHPs had the highest proportion of males (19.7%). Respondents were primarily in the 50-59 years age group (33.2% UK-wide), and most were of White ethnic origin (97.4% UK-wide). England had the highest proportion of respondents who identified as belonging to an ethnicity other than White (12.2% within England) and midwifery was the most diverse occupational group, with 6.9% of midwives identifying as not White. Over half of all the respondents worked in the community (51.5% UK-wide), with another 19.1% (UK-wide) worked in a hospital setting. Most worked in the statutory health and social care sectors (38.1% UK-wide), but over half of social care workers (59.7% of social care workers) worked in non-statutory services (private or voluntary sector, directly employed or other). Just under one-third of the study respondents UK-wide were line managers (31.1%). Most respondents were employed on a permanent basis (89.3% UK-wide) and the majority were employed full-time (75.2% UK-wide), typically working 37.5 hours per week (57.6% UK-wide). UK-wide, just over half (70.1%) of respondents said that at least some of their sickness absence was related to COVID-19 with 75.6% of nursing and 74% of social care workers having sickness related to COVID-19. Over one-half of respondents UK-

wide had either 11-20 years of work experience (28.9%) or 21-30 years (22.9%). The main area of practice was work with older people (27.8% UK-wide).

Levels of Impact

UK-wide, 2.9% reported that their service had not been impacted (services stepped down due to COVID-19) with 58.1% reporting feeling overwhelmed by increased pressures. As shown in the more detailed report, social workers and social care workers were the most overwhelmed occupational groups in terms of impact measured in this study (68.4% of social workers and 57.1% of social care workers). That said, significant percentages of respondents expressed feeling overwhelmed in all occupational groups with over 37% of respondents in each occupation group indicating such feelings.

Intention to leave Employer or Occupation

Respondents were also asked whether they had considered changing their employer or occupation since the start of the pandemic. Nearly one-half of the respondents UK-wide (43.0%) had considered changing their employer, with the highest proportion of these being from England (51.5% within England) and followed closely by Northern Ireland (43.3% within Northern Ireland). Within social work, 48.9% of respondents considered changing their employer. Over a third of the respondents UK-wide (39.6%) also had considered changing their occupation with the highest proportion of these being from Scotland (43.4% within Scotland) and followed closely by England (42.0%). Within social care workers, 44.2% considered changing their occupation during the pandemic. Respondents indicated that a pay increase (61.2%), manager support (46.2%), well-being support (41.0%), and safer working conditions (38.6%), would change their minds about wanting to leave their employer or current occupation. Most of respondents were still in the same job on the same contractual working hours (74.6% UK-wide).

Focus group and qualitative questions analysis.

On reviewing all our Phase 6 data the findings can be categorised into three overall themes. These overarching themes from Phase 6 (Nov 2022-Jan 2023) 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 issues, work-life balance, skill mix, incivility, better pay, and safe-staffing (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 have lifted, many staff have been left facing relentless pressures and demands in their daily jobs. Overall, many themes identified

in previous phases remain relevant to phase 6. Respondents placed a renewed focus on work demand and staff shortages. In response to both qualitative questions, many answers elaborated on the vicious cycle of increasing work demand following the pandemic and increasing staff shortages resulting from staff sickness absence, skill shortages, staff retention and inability to fill open and advertised job positions.

Mental Wellbeing, Quality of Working Life and Burnout

We found that both mental well-being and quality of working life deteriorated from Phase 1 to Phase 6 of the study. When the well-being scores were converted to indicate probable or possible cases of depression/anxiety, it was found that UK-wide, 12.8% were probable (likely) cases of anxiety or depression and a further 24.0% were possible cases of anxiety or depression (Table 1.0).

Table 1.0: Categories created by Wellbeing scores.

Case of anxiety/depression	**Wellbeing scores**
Probable (Likely)	7-17
Possible	18-20

The overall Work-Related Quality of Life (WRQOL) score across the UK was 71.14 which was the lowest of all the phases (i.e., Phase 1 – 77.59; Phase 2 – 72.13; Phase 3 – 72.45; Phase 4 – 75.46; Phase 5 – 74.49). When the WRQOL scores were converted to Lower, Average, or Higher quality of working life, we found that UK-wide, 50.2% of respondents had lower quality of working life, 24.2% had average quality of working life and 25.5% had higher quality of working life in Phase 6.

UK-wide there was a significant decrease in the use of all positive coping strategies and an increase in the use of negative coping strategies such as Venting, Behavioural disengagement, and Self-blame from Phase 1 of the study to Phase 6. Between Phase 2 to Phase 6 and Phase 3 to Phase 6, mental well-being 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). There was a decrease in the overall mean well-being scores and quality of working life scores between Phase 4 and Phase 5 to Phase 6 of the study. Positive coping positive strategies such as positive reframing and acceptance were used less in Phase 6 than Phase 5.

In Phase 6, the personal burnout score UK-wide was 62.69 (Table 1.1), which is higher than the personal burnout scores in Phase 5 (61.10), and higher than Phase 4 (62.62), lower than Phase 3

(63.20) and higher than Phase 2 (61.40). The work-related burnout score across the UK was 58.33 which was higher than phase 5 (56.51), lower than Phase 4 (58.65), and Phase 3 (59.79), and higher than Phase 2 (56.73). The client-related burnout score across the UK was 30.01 which was higher than Phase 5 (25.88), Phase 4 (25.24), Phase 3 (29.46) and Phase 2 of the study (27.97).

Table 1.1: Cut-off points for Burnout scores

Level of burnout	**Burnout cut-off scores**
Low	0-49
Moderate	50-74
High	75-99
Severe	100

Respondents were asked whether they worked from home before the pandemic, more than half of respondents did not work from home at all (77.2% UK-wide). During the COVID-19 pandemic from November 2022-January 2023, 3.5% were able to work from home all the time, while 34.3% could work from home some of the time. Social workers were most likely to work from home all the time (8.6% of social workers) or some to the time (70.9% of social workers), while most social care workers (84.8% of social care workers), nurses (77.1% of nurses) and midwives (75.9% of midwives) were not able to work from home at all. Most respondents did not take up employer support (74.4% UK-wide) and Wales had the highest percentage uptake of employer support (39.4% within Wales). Social workers were most likely to access employer support (30.8% within social workers) while AHPs were least likely to access employer support with only 23.0% of AHPs taking up employer support. For those respondents who accessed employer support, the most common were manager support (48.5%), well-being support (45.4%), peer support (34.7%), and counselling services (33.2%). When respondents were asked why they had not taken up employer support, 25.8% indicated that the support was not needed, 25.5% stated that support was not accessible or at an inconvenient time, 24.8% felt the support was not needed as they had support from elsewhere, and 23.9% 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 five phases were reviewed in the context of findings from Phase 6. These Good Practice Recommendations are organised under the main themes of analysis from previous Phases: Changing Conditions, Connections and Communication, enabling comparison. Whilst some recommendations have changed in terms of priority, reflecting our research findings and the changing conditions, most of them remain similar to of earlier phases.

Changing Conditions

Organisational and Individual Level

1. RETENTION & RECRUITMENT ISSUES NEED ACTION:

It is noted that recruitment and retention are impacted by a range of issues evident in the findings across the six phases including but not limited to terms and conditions, flexibility in working, management and team support, supportive supervision, and workplace culture. However, retention and recruitment have become more significant issues over the period, with huge knock-on effects in terms of staff workload and welfare as well as service quality. Indeed, there seems to be a "vicious cycle" developing whereby the effects of staff attrition on colleagues lead to further staff departures. At the same time, it is also noted that changing economic conditions are currently impacting retention and recruitment, especially the cost-of-living increases which can precipitate staff departures. These are the "push" factors. At the same time, there are "pull factors". As the economy opens, post-pandemic, there is greater availability of alternative employment, some offering greater flexibility and higher remuneration. Furthermore, and not unrelated to economic change, the education sector reports significant decreases in students taking up places in many areas of health and social care which will impact recruitment soon. Therefore, the need for action on retention and recruitment has developed greater urgency.

2. **STAFF WELL-BEING SUPPORT REQUIRES RETHINKING**:

Related to retention issues, Phase 6 confirms previous phase findings that a large proportion of health and care staff are experiencing moderate to severe levels of burnout, and reduced well-being, with evidence that some absence was a result of stress, placing an additional burden on remaining staff. The setting up of well-being services and other forms of employer help, while appreciated by many, does not meet the needs of others. Specific strategies need to be developed by employers to ensure support is both accessible and appropriate. 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. 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.

3. PLANNING NEEDED FOR HEALTH AND SAFETY PREPAREDNESS:

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 is required. This is the responsibility 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.

4. NEW STRATEGY NECESSARY FOR TRAINING FOR 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

5. TERMS AND CONDITIONS REGARDING ILLNESS REQUIRE UPDATING:

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. Phase 6 findings indicate the large numbers of staff considering

changing employer or even changing profession. 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 also 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 in phase 5. While frontline staff may be the target for such initiatives, we note the reports of stress in the findings and risks of burnout among managers and these need to be addressed.

6. **RESEARCH NEEDED ON CHANGE IN ORGANISATIONAL STRUCTURES:**

In our first survey report we called for research on patient and service user outcomes to see whether organisational structure changes involving reductions in hierarchy permitting greater autonomy, which operated by necessity during the height of the pandemic, can make a positive difference to service quality on an ongoing basis. We also suggest that local forums 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.

7. **TOXIC WORKPLACE CULTURES MUST BE ADDRESSED:**

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.

Organisational Level

8. **PUT 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.

We recommended that policies about working from home (if appropriate) should be fair and seen to be fair. 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 Level

9. ANNUAL LEAVE AND REGULAR BREAKS NEED ATTENTION:

Managers still need to ensure 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 practise what they preach as manager stress and burnout is clearly evident in this study, and such stress can impact on how managers can support others. In our sixth survey the issues of not taking breaks were less evident, however many reported working increased hours of overtime due to short staffing, and it is noted 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.

Organisational Level

10. SUPPORTIVE INDIVIDUAL SUPERVISION NEEDS TO BE IMPLEMENTED FOR ALL:

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. 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

11. IMPROVED ORGANISATIONAL SUPPORT REQUIRED:

Phase 6 findings indicate the large numbers of staff considering changing employer or even changing profession. 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 notably 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 in phase 5. While frontline staff may be the target for such initiatives, we note the reports of stress in the findings and risks of burnout among managers and these also need to be addressed.

12. TEAM SUPPORT NEEDS STRENGTHENING:

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.

13. CONCERTED EFFORTS NEEDED TO UPGRADE RESOURCING AND INFRASTRUCTURE:

The unprecedented demands on the health and social care sectors over the past three years 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 swift and sustained attention. This has implications for the wellbeing of both the health and social care workforce and wellbeing and safety of the people that use health and social care services.

The full report from the November 2022-January 2023 survey can be found online at www.hscworkforcestudy.co.uk

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