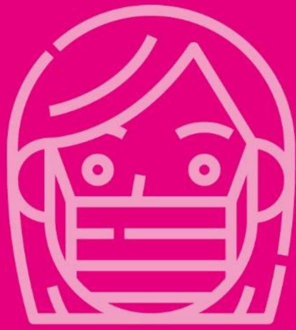

COVID-19 Health and Social Care Workforce Study
November 2020 - January 2021

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Executive Summary

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Funding Statement: This research is funded by the Public Health Agency R&D Division in Northern Ireland and supported by the National Institute for Health Research (NIHR) Policy Research Programme, through the Policy Research Unit in Health and Social Care Workforce, PR-PRU-1217-21202. The views expressed are those of the authors and not necessarily those of the funder or the NIHR Policy Research Programme.

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 November 2020 – January 2021 and the report builds upon the findings from Phase 1 of the study, which ran between May – July 2020. 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, one with health and social care managers and one with frontline workers.

Key Findings

The survey received 3499 responses, most of which were from Northern Ireland (n = 1189), followed by Wales (n = 1095), England (n = 756) and then Scotland (n = 459). Most of the sample were social care workers (n = 1253) and social workers (n = 1172), followed by AHPs (n = 638), nurses (361) and midwives (n = 75). The majority of respondents were female (88.8%), primarily from the 30-59 age group (73.2%) and the vast majority were of white ethnic origin (92.1%). The main area of practice for most respondents were adults (36.7% UK-wide) and older people (21.9% 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, nearly half (49.3%) of the respondents UK-wide felt overwhelmed by increased pressures, 46.1% felt impacted but not significantly and only 4.6% reported that their service had not been impacted and it was stepped down. Social work and nursing 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 2 (Nov 2020 – Jan 2021) are the same as those identified in Phase 1 (April – July 2020) of the study: Changing Conditions, Connections, and Communication. In relation to the Changing Conditions, respondents raised a number of concerns relating to changes in workload, work roles and working safely. Positive developments included greater flexibility about working from home. In relation to the Connections theme, respondents highlighted the importance of sustaining relationships and connections with the people they work with, both service users/patients, and team members or managers. Communication was a critical area that respondents were either concerned about, or they noted it as a strength. Having clear guidance continued to be cited as important, as was active involvement in decision-making processes.

Quantitative analyses revealed that both mental wellbeing and quality of working life deteriorated from Phase 1 to Phase 2 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. In Phase 2, we also measured three domains of burnout; personal, work-related and client related. UK-wide, a large proportion of respondents were experiencing moderate to severe levels of personal (74.7%) and work-related burnout (66.3%), whereas client-related burnout remained relatively low (19.1%). In other words, patients/service users were rarely the reason for burnout in health and social care workers.

Good Practice Recommendations: November 2020 – January 2021 Survey

The 15 Good Practice Recommendations from Survey 1 were reviewed in the context of findings from Survey 2, in the second phase of this study. These Good Practice Recommendations are organised under the main themes that emerged from the analysis of the data: Changing Conditions, Connections and Communication. 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 other 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, we hope, staff will need to feel that their needs, wellbeing and circumstances are being considered. Talking with staff and their representatives about long-term flexibilities must now start to happen at pace.

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 matter for employers to prioritise as a strategy. 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.

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. 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 great 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 second 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 will remain important. This survey indicates that the setting up of wellbeing services has been appreciated and their continuance should be assured if they are proving promising. There is a high risk that some staff will leave prematurely owing to stress or reduced work-based quality of life. This may be permanent but there would seem room for employers to remain in touch with such staff and to offer 'exit interviews' or similar in which other alternatives to exit could be mooted.

Connections

Organisational and Individual Level

1. ANNUAL LEAVE AND REGULAR BREAKS: Managers need to ensure, where possible, that staff are supported 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 – this 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.

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. Respondents provided several accounts of employers and managers signposting staff to organisational supports, counselling, mentoring or coaching supports, or Occupational Health (if required). These resources appear to need sustaining if they are to enable staff to manage the aftermath and emotional impact of working during the pandemic and its legacy.

2. 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 over-looked but who, our survey shows, have been under considerable stress themselves.

Policy and Organisational Level

3. 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 November 2020 – January 2021 survey can be found here.

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