COVID-19 Health and Social Care Workforce Study May-July 2020

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Executive Summary

In December 2019, a novel coronavirus emerged (COVID-19) which was quickly designated a pandemic with all countries urged to take 'urgent and aggressive action' (WHO 2020). Worldwide social and economic disruption for governments and their citizens followed with a rising death toll and efforts to prepare, protect and treat citizens impacting across all sectors in society. While it was clear that trying to fight this pandemic is everybody's business (WHO 2020), the task of caring for affected individuals and their families in the UK has fallen to an already greatly pressured, understaffed and underfunded health and social care sector, and those who work within it.

In April 2020, funding was secured from Northern Ireland Social Care Council (NI SCC) and the Southern Health and Social Care Trust to support the dissemination of an online survey to nurses, midwives, Allied Health Professionals (AHPs), social care workers and social workers in the UK, with support from other funders following. The aim was to explore the impact of providing health and social care during a pandemic on the UK health and social care workforce. A survey questionnaire measured Well-being, Quality of Working Life, and ways of coping whilst working during the pandemic. Work and home life segmentation was also explored. Additional open-ended questions sought further detail from respondents on how the pandemic had affected their work and work setting, what employers had done to support their staff, lessons that could be learned for future pandemics and 'normal' health and social care provision. The perceptions of health and social care workers about the 'Clap for Carers' initiative were also garnered.

Key Findings:

The survey received 3290 responses; of the responses 1897 were from Northern Ireland, 1062 were from England, 146 were from Scotland and 185 were from Wales. Most of the sample were social workers (1282) and social care workers (1245), followed by AHPs (388), nurses (199) and midwives (190). The difference between the country responses rates and professional occupational rates are explained by some respondents not indicating which country they were from.

https://www.oecd.org/gender/data/women-are-well-represented-in-health-and-long-term-care-professions-but-often-in-jobs-with-poor-working-conditions.htm

In line with OECD (2020) figures on the over-representation of women in the health and social care workforce, most of the respondents were female across all professions, and all midwives that responded were female. Respondents were mainly in the 30-59 age bracket. The fewest number of respondents were aged 16-19 or over 60 years. Respondents in Scotland were generally younger than those in the other countries of the UK, whereas those from England and Wales were older. The majority of AHP and social worker respondents fell into the 50-59 age bracket, whilst the other professions were mainly in the younger 40-49 age range.

Almost one quarter (24.1%) of the respondents worked with older people. These were mainly based in Scotland, however nearly a third of respondents from Northern Ireland worked with older people. Very few (0.5%) respondents reported that they had come out of retirement to support the workforce during the COVID-19 pandemic. Most respondents were employed on a permanent basis although Northern Ireland had the largest proportion of agency staff at 6.2% while Wales had the lowest level of agency workers at 0.5%. Scotland had the highest number of part-time workers, making up just under one third (31.2%). Midwives were most likely to be employed part-time than other professionals. Most respondents worked full-time, typically 37.5 hours per week. Respondents in Northern Ireland worked the highest number of hours' overtime. Nurses and social care workers worked the most overtime.

Free text responses were analyzed to identify themes which related to 'Changing Conditions', 'Connections' and 'Communication' associated with working during the pandemic. These themes related to work context and working conditions as well as relationships with managers, colleagues and service users/patients, and in particular to the ways in which communication took place. A full report of findings is included in the main report and the key 'Good Practice' recommendations that have emerged from those findings and included in the main report.

Good Practice Recommendations:

Improving Work Context and Conditions

1. Employers need to provide as far as possible increased flexibility around working hours, location of working, and recognition of additional childcare or other caring responsibilities to support the workforce during a pandemic or other crisis. The nature of a pandemic means that these are not easy to provide, of course, but communication and understanding of their importance will help staff feel that their needs, wellbeing and circumstances are being considered. Talking with staff and their representatives about this would be one first step.

2. Training and development to equip staff with the ability to, where possible, perform multiple or new roles should be commissioned and rolled out. While this form of skill mix might be thought vital during times of high service demand where low staff levels affect the availability of critical skills within teams, it might also be helpful during 'normal' service delivery. This will need attention from employers, professional bodies, regulators, educational and training bodies, and service users and patient groups.

3. Some respondents called for more involvement in decision making, more autonomy and flatter hierarchies to equip staff with the ability to make faster, well-informed decisions in times of crisis. This was also thought to improve service delivery during normal service delivery times. Research is needed on patient/service user outcomes to see whether this view is borne out by the evidence. It would need to be integrated with the current reliance on evidence-based guidelines.

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4. Policies about working from home (if appropriate) should be developed and equitably applied to avoid division and discontent and undermining of leadership and organisational commitment. If staff request or are asked to work from home, they should be able to access equipment and technology support, to have relevant expenses met, and to be assured of supervision and peer support.

5. For those staff who need to be in the workplace steps should be taken to ensure social distancing, handwashing, use of sanitisers for shared equipment and use of large spaces to reduce the risk of viral spread. Workplaces need to ensure that there are plans for any crisis, such as fire and flood, not just pandemics. The flexible use of rota systems could assist in the number of employees needing to be present at one time and could be undertaken quickly in any crisis with the development of technology.

6. The "Clap for Carers" campaign may be an opportunity to re-examine both the societal recognition of the work done by health and social care workers but to also increase funding and the deployment of NHS and social care services, as well as the pay of health and social care workers (and making pay, terms and conditions fair for all).

7. Employers in the health and social care sector should ensure that their staff should not have to solely rely on Statutory Sick Pay in the event of illness. Policy and practice around staff sick pay should be reviewed and ameliorated urgently where necessary by employers.

8. Further consideration is needed about the most effective way of supporting and deploying temporary or agency staff who may have limited sick pay entitlements to Statutory Sick Pay (SSP). This could reduce the risks of staff going to work when unwell or infectious and does not, of course, apply only to the COVID-19 context.

9. Plans to obtain and sustain supplies, and to deploy appropriate PPE, should be developed by employers and public health bodies at times of crises such as pandemics for staff in direct contact with people. Such plans should be regularly reviewed by a regulator.

Improving Connections and Communication

1. Connection to colleagues and managers is critical during a pandemic or any other crisis, and regular and frequent communication is required, in person or virtual, to increase personal and professional connection and employee engagement and organisational commitment. This needs to be tailored to the needs of the service, the team or individuals. There should be development of evidence-based good practice guidance that meets the broad range of health and social care services by national bodies.

2. Employers are accountable and hold corporate responsibility for ensuring that employees are provided with up to date guidelines. Any change to guidelines should be monitored by those holding management responsibility to interpret changes and guide staff and other managers on best practice recommendations. This should result in clear messages and reduce the risk of contradictory or confusing guidance.

3. Managers should be visible, either in person (if possible) or virtually, so that workers feel they are as valued as those in management positions.

4. Staff concerns for service user or patient wellbeing needs to be taken seriously by management and evidenced by opportunities to discuss individual concerns in peer or one to one supervision. Staff empathy is an important driver for motivation, job satisfaction and commitment and needs fostering.

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5. Managers need to ensure where possible that staff are supported and encouraged to take leave if possible or to carry it over without penalty in crisis situations.
6. Staff concerns about contracting infections should be viewed as an indication of their commitment to their job and concern for the wellbeing of their families and themselves. Staff's concerns should be listened to and reasonable actions taken to alleviate concerns.

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