UNIVERSITY OF BATH

Should I stay or should I go?

NHS staff retention in the post COVID-19 world: Challenges and prospects

IPR Report

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The conclusions and implications detailed in this report are those of the authors and do not necessarily reflect the interpretation placed on the survey findings by the project funders.

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Executive summary

Finding ways to maintain and enhance rates of staff retention is a key challenge for the NHS. The COVID-19 pandemic has intensified the focus on this issue. It is important to determine the impact of the COVID-19 experience, its secondary impacts and its legacy on the resilience of NHS staff with respect to their capacity and motivation to remain.

The foundation research on which this report is based, **Should I stay or should I go? NHS staff retention in the post COVID-19 world: Challenges and prospects**, was funded by the Economic and Social Research Council, in response to the UKRI open-call for COVID-19 public policy relevant in spring 2020.

The research aims were to provide human resource strategy and policy relevant insight into:

- The impact of the COVID-19 experiences and its legacy on employees' strength of attachment, commitment and capacity to remain in NHS employment;
- The relative salience and strength of push and pull variables on staff stay versus leave intentions and behaviour;
- What might need to change to motivate/enable current employees to remain in NHS employment; and
- The need, nature and scope for intervention to maintain/enhance retention rates.

This report provides an overview of headline findings from the NHS employee survey component of our research. To date, it has been conducted over three Waves between December 2020 and April 2022. The first two waves were UK-wide while the third survey was in England only. The survey findings are supplemented by qualitative insights from interviews with NHS staff.

Key findings

- A number of headline influences historically associated with pull effects on NHS staff retention, notably job security and intrinsic elements of job satisfaction from caring for patients, show a weakening linear trend since 2020.

- Approximately one in two respondents see themselves as remaining in NHS employment for the next five years. However, approximately one in three aspire to exit, principally to alternative employment or retirement by 2027.

- More than two thirds rated staffing levels as having worsened; half of the respondents reported a worsening of morale as well as increased stress and workload over the six months prior to April 2022.

- More than a third of respondents reported 'tiredness' and 'low energy'; approximately one in four reported 'physical exhaustion', 'mental exhaustion' and 'feeling overwhelmed' most days or every day; of these about half attributed this completely to their job.

- Employee concern over staff shortages and '(in)sufficient time to do my job properly' shows a rising (negative) trend across the three Waves.

- 'Abnormally high staff shortages', 'Not enough time to do my job properly' and 'Impact of removing COVID-19 restrictions' were the highest ranked sources of worry amongst staff in April 2022.

- There is strong evidence of high rates of under-reporting of major staff worries to line managers, notably with respect to impacts on mental health.

- The proportion of staff applying for non-NHS jobs shows a rising trend, from one in ten (winter 2020 - 2021) to approximately one in seven (April 2022). The rate for some segments, e.g. ambulance services, is markedly higher, at one in four.

- The most frequently reported reasons why staff leave NHS employment are, in order of importance, stress, shortage of staff/resources and pay. Pay has become more salient since 2020. It was ranked 8th of the 15 variables explored at Wave one of the survey, rising to joint 4th at Wave two and 3rd at Wave three.

- The proportion of staff who would recommend working for the NHS to others shows a negative linear trend, with a drop of 10 percentage points, from three out of five to one in two between 2020 and 2022. Among nurses, only two out of five would recommend NHS employment to others.

- Ratings of confidence in improvement to working conditions '…over the next 12 months' (beyond spring 2022) ranged from very low to modest across all of the criteria explored.

1.0 Background and context

In common with public health systems throughout the world, the COVID-19 pandemic placed unprecedented demands on the NHS and its workforce, giving rise to much speculation of detrimental impacts on staff health, well-being[1] and most acutely their capacity and motivation to continue working in state sector health care. Media claims of the type 'A year on from COVID-19…There will be a wave of exhausted and emotionally drained nurses leaving the profession…' (Ely, 2021, p.8), are widespread and demonstrate alignment with official sources. The NHS staff survey data (2020) shows a 44% increase in the proportion of staff reporting work-related stress, and around a fifth considering exiting NHS employment, both of which have been attributed to the pandemic experience (Anderson et al, 2021).

The issue of staff shortages and institutional capacity to meet the rising demand for care is neither new nor unique to the UK (Buchan et al, 2017, 2019; NHS Improvement, 2018, Kings Fund, 2021). Historically, the UK's institutional orientation to managing shortages has been dominated by a focus on recruitment, typically from overseas, and training of new health professionals (Storey et al, 2009). By contrast, issues of staff retention have received much less attention, leading some commentators to suggest that, historically, the Department of Health and Social Care (DHSC) and NHS employers have seemingly been content to treat strongly normed high exit rates as acceptable losses (Rowe, 2000). Recognition of the finite scope for recruitment of migrant labour and the inevitable time-lag in training new health professionals, combined with institutional worry over the likely magnitude of pandemic sponsored exits, has given rise to an unprecedented policy focus on finding ways to stabilise and enhance staff retention rates, as well as attempts to attract returnees (NHS England, 2021; NHS Employers, 2022).

This ascendant interest in finding ways to increase staff retention rates has witnessed intensified activity within DHSC and its related policy delivery functions (see for example, NHS Improvement, 2018; NHS England, 2021; NHS Employers, 2022). Answers to this question transparently hinge upon a clear and comprehensive appreciation of reasons why high numbers of staff leave and how exit rates might intersect with primary and secondary impacts arising from the COVID-19 pandemic.

1.1 Summary of established insights

The majority of established academic insights inevitably date from before the manifestation of the COVID-19 pandemic in the UK in early 2020. Focusing on NHS specific findings, given their potentially greater alignment with prevailing structures, terms and working conditions, contemporary insights point to three principal domains as relevant to staff exit decisions: extrinsic components (notably pay, configuration of work and working conditions), intrinsic job satisfaction, and strength of identification with the NHS (essentially alignment of values and sense of place).

The longstanding profile of disequilibrium over demand for care relative to delivery capacity, has produced a central focus on elements relating to extrinsic influences on job

[1] Well-being definition: Well-being at work encompasses all aspects of working life, from the quality and safety of the physical environment, to how workers feel about their work, their working environment, the climate at work and work organisation. Source: International Labour Organisation (ILO).

demands, arising from staff shortages, workload (duration and intensity of work), the configuration of work and working hours (McVicar, 2016; Bimpong et al, 2020).

Mirroring findings from other employment sectors, excessive workload has been found to decrease job satisfaction, increase the risk of work-related stress and burnout, degrade morale and work-homelife balance, challenge employee perceptions of recognition (of contribution) and give rise to notions of inequity (effort-reward imbalance), all of which have been predictively associated with staff disposition to exit NHS employment (see for example, Loan-Clarke et al, 2010; Hayes et al, 2012).

Further psychosocial insights highlight frustration over bureaucracy; dissatisfaction over standards of patient care; service delivery performance monitoring/targets; (in)sufficiency of support (institutional, line-manager and colleagues) and alienation arising from lack of involvement in decision-making (see for example, Cuningham et al, 2012; ICM, 2013; Edwards, 2021; Torjessen, 2021).

Despite its strong intuitive salience to leave decisions and routinely high profile within media accounts of, particularly, nurse retention, historically, findings on pay are mixed. Some studies have claimed it as a primary influence, whereas others report a more modest ranking. The basis for this disparity is unclear, but plausibly may owe something to methodological differences between studies, the cultural prominence of pay at the time of data gathering, respondent attribution and/or cognitive biases.

Historical evidence from the UK Labour-force survey[2] shows that the majority of transitions to non-NHS employment did not result in higher pay and that pay was routinely lower for those who migrate to non-health sector employment. This would suggest that variables other than pay have been important, possibly more important in transitions to alternative employment. This does not, however, diminish the importance of pay to NHS employees in both absolute terms and subjectively with respect to perceptions of fairness and effort-reward (im)balance between. Moreover, the historical alignment of private and public sector health care pay rates for the majority of health professions may cease to persist in the context of high labour shortages and greater freedom to pay market rates within the private sector (health and non-health employment).

1.2 Scope and focus of this report

This report provides a summary of headline findings, based upon descriptive statistical analyses of our survey of NHS employee well-being focused on motivation/capacity to remain in NHS employment following the emergence of the COVID-19 pandemic[3]. The perspective on leaving relates to exits from NHS employment, rather than internal (within the NHS) transitions, given that the former represents the net loss to public-sector healthcare capacity. Deeper, more rigorous analysis of emergent phenomena, issues and relationships has been and will continue to be the subject of presentations to health sector stakeholders, at professional and academic conferences and peer reviewed publications.

[2] The size of the NHS workforce is such that acceptable samples can be extracted from successive Waves of the UK Labour-force survey (LFS).

[3] This report summarises findings from three Waves of the survey, coving the period winter 2020 - 2021- spring 2022. A fourth Wave is scheduled for spring 2023.

2.0 A survey of NHS employees

This report summarises headline findings from a series of large-scale UK-wide[4] surveys of NHS employees, conducted between December 2020 and May 2022. The surveys were initiated as a component of the Economic and Social Research Council (ESRC) funded research '**Should I stay or should I go? NHS staff retention in the post COVID-19 world: Challenges and prospects**' (grant reference number ES/V015389/1) awarded in response to the UK Research Council (UKRC) call for public policy research relevant to the COVID-19 pandemic, supplemented by follow-on funding from within the health sector.

A key objective of the research was to gain insight into the effect of the pandemic on staff motivation/capacity to remain in NHS employment, and how the profile of issues might vary as the pandemic evolved. The question set was designed to explore the profile of variables previously identified as relevant to staff leave versus stay decisions within the COVID-19 pandemic context and its aftermath, as well as pandemic-specific features, impacts and experiences. With a view to capturing the stability and variation of response profiles over the course of the pandemic and its aftermath, the data was gathered in three Waves during winter 2020 - 2021 (Wave one), summer/autumn 2021 (Wave two) and spring 2022 (Wave three). A fourth Wave is scheduled for early 2023.

Due to the evolving nature of the COVID-19 pandemic and its aftermath, it was necessary to adopt an agile approach to the configuration of the set of issues explored at each Wave in order to capture the evolving nature of primary and secondary phenomena and their respective impacts.

An important consideration related to gaining insight into durability and legacy of emergent and transitory issues. For example, during the initial period of the pandemic a great deal was unknown and unknowable, giving rise to high levels of uncertainty over rates of infection (NHS staff and public), fatality rates (NHS staff and public), effective infection control, effectiveness and sufficiency of supply of personal protective equipment, public behaviour, sufficiency of treatment capacity, well-being of dependents, and more. The high and multifaceted degree of uncertainty in this period will have amplified levels of employee stress, over and above that attributable to the rise in workload. The mature phase witnessed the development of effective vaccines, enhanced availability of personal protective equipment, more complete understandings of infection control, more effective treatment and lower mortality rates, underpinned by fewer unknowns. However, uncertainty over the emergence of successive COVID-19 waves and the effectiveness of vaccines remained, and the pent-up demand for non-COIVID care increased.

2.1 Themes and topics explored

In order to capture and monitor change over the course of the pandemic, approximately 80% of the survey questions were common across each successive Wave. Approximately 20% of questions were bespoke to each Wave, being designed to capture emergent issues aligned with the profile of primary and secondary features and impacts

[4] Survey Waves one and two were UK-wide; Wave three was England only.

of the pandemic, e.g. staff vaccination, staff redeployment rates, demand for non-COVID-19 care and burnout.

A summary of the headline themes and topics that were addressed is provided in table 1.

Table 1: Survey themes & topics explored

Themes	**Topics** – Psychosocial	**Topics** – Structural
Reasons why staff stay	Job (dis)satisfaction	Workload
Reasons why staff leave	Support (institutional; managers, peers)	Staffing levels
What's got better/worse	Physical health	Working hours
Worries & concerns	Mental health	Redeployment
Confidence in the future	Morale	Exposure to COVID-19
Future work/retirement aspirations	Burnout	Standards of Infection control
Non-NHS job seeking behaviour	Recognition, reward	Staff vaccination
Strength of attachment to the NHS	Work-homelife balance	Personal protective equipment

2.2 Configuration

The survey was produced in an on-line, self-complete format, with a completion time of ~12 minutes.

2.3 The sample

A core component, common at each of the three Waves of the survey, was a sample derived from the YouGov Panel. YouGov has a panel of over a million UK adults recruited from an array of sources, including standard advertising and strategic partnerships. This yielded a UK-wide sample of ~2,000 NHS employees at Waves one and two, and an England-wide sample of ~1,500 at Wave three.

In each case, these samples were controlled by occupational group and weighted by age, ethnicity, and region. They provided good and consistent representation by occupational group, type of secondary care provider organisation (acute; mental health, community and ambulance), job band/grade and gender identity.

At Wave two, the Panel sample was boosted by parallel surveys using the same question set, in a sample of 14 NHS Trusts and via distribution to the membership of a major health sector trade union. The larger Wave two sample was designed to enhance the capacity for analytical interrogation of the data at a finer level of granularity.

The Wave three Panel sample comprised respondents from England only; boosted by parallel surveys using the same question set in three Ambulance Trusts.

The approach to sampling was designed to capture stability and change in response profiles over the timeframe for elements of the survey that were kept as constants over

the three sequential Waves covering the period winter 2020 to spring 2022. The Wave two sample allowed a deeper exploration of demographic parallels and contrasts.

Details of obtained samples at each Wave are provided in tables 2, 3, and 4.

Table 2: Employee survey samples - at Wave 1, 2 & 3

	N	Timeframe
Wave 1 - YouGov Panel (UK)	1962	Dec 2020 - Jan 2021
Wave 2 - YouGov Panel (UK)	2240	June - July 2021
NHS Trusts	3287	June - October 2021
Trades Union	8650	June - October 2021
Wave - YouGov Panel (England)	1538	April - June 2022
Ambulance Trusts (x 3)		
Total	17686	

Table 3: Sample breakdown (%) by occupation – Waves 1,2 & 3

	Wave 1	Wave 2	Wave three3
Nursing/nursing support/midwives	30	30	30
Allied health	18	15	15
Medical & dental	12	9	10
Scientific & technical	7	5	4
Ambulance	3	3	3
Clinical Management	1	1	1
Commissioning Managers	>0.5	1	1
Ancillary & support	2	2	2
Admin, technical & corporate services	27	29	28
Other	>0.5	2	3

Table 4: Sample profile (%) by type of care provider organisation

	Wave 1	Wave 2	Wave 3
Acute	59	56	57
Mental health	15	17	17
Community	16	14	15
Ambulance	3	4	4
Other	6	9	8

3.0 Employee interviews

Semi-structured telephone interviews were conducted between June 2021 and March 2022 with staff (n=65) from seven of the 14 NHS Trusts that participated in the Wave two survey. Participants were recruited via internal communications, targeted at staff in front-line, lower/middle management and senior management roles. This yielded a sample of nursing, medical, allied health and non-clinical staff from a range of grades and roles. Details of realised samples are provided in table 5.

Table 5: Interview participants (N) by type of care provider organisation

	Organisations	Staff
Acute	3	28
Mental Health	1	12
Community	1	10
Ambulance	2	15

The interviews were audio recorded and transcribed verbatim. A thematic analysis (Braun and Clarke 2006) of the interview transcripts was conducted using NVivo qualitative data analysis software (NVivo, 2020). Findings indicated the presence of five themes considered to characterise the experiences and impacts on NHS staff of working through the COVID-19 pandemic: increased workload and demands; decreased staff resources; negative impact on health and well-being; varying experiences of staff support; and reduced commitment to remaining in NHS employment. The thematic analysis will form the basis of journal publications but is presented here in summary form to elucidate on related survey findings as illustrative quotes and interpretive commentary.

4.0 Headline findings

This section provides a themed overview of headline findings from the surveys. It presents the results of the Wave three survey as the primary reference, on the basis of its contemporary relevance and as a benchmark to determine the degree of stability/change in response profiles across the three Waves, from the early to mature phases of the COVID-19 pandemic.

4.1 Reasons why staff stay in NHS employment

Respondents were presented with a list of Pull influences that have been associated with staff remaining in NHS employment, distilled from published research insights. They were asked to **'Pick up to three reasons [from a presented list] that keep you working for the NHS'**. Figure 1 provides a ranking of the relative importance ascribed to the respective Pull influences.

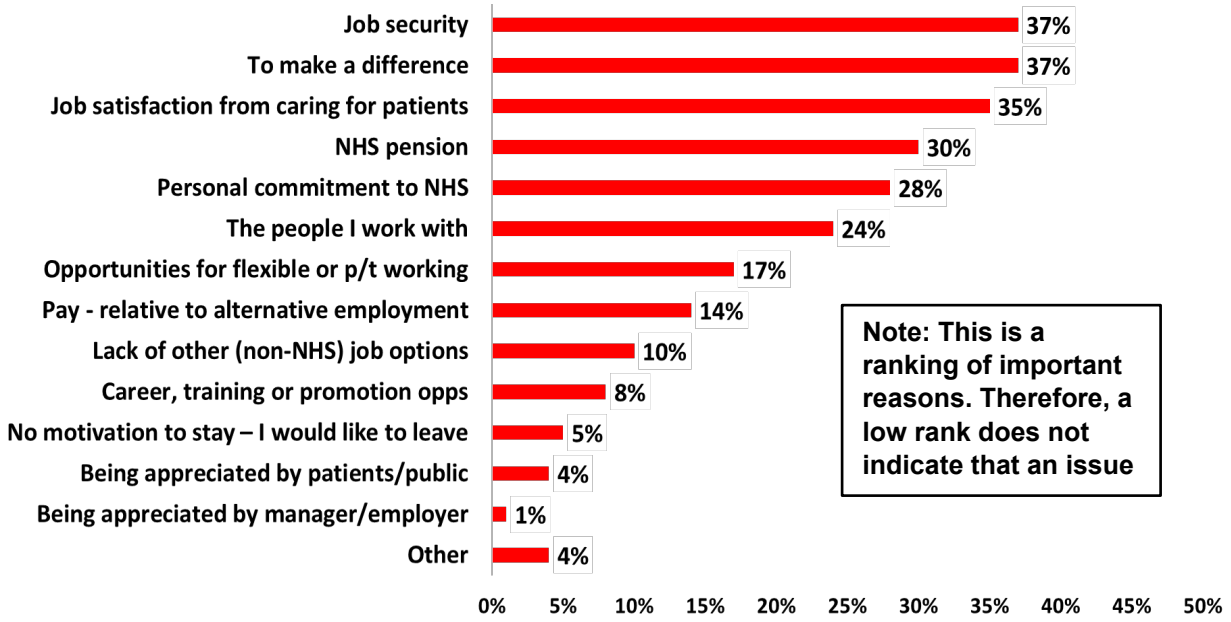

Figure 1: Reasons why staff continue working for the NHS (pull effects) - Wave three

A comparison of response profiles for the most commonly cited variables across the three Waves (figure 2) indicates a linear attenuation of the five most commonly cited pull variables: job security, to make a difference, job satisfaction from caring for patients, personal commitment to the NHS and people I work with.

The weakening of job-security plausibly reflects the greater stability of, and rise in opportunities for, non-NHS employment following the alleviation of pandemic lock-down restrictions. The following four highest ranking variables present as suggestive of a linear weakening of the pull of intrinsic motivations and strength of attachment to the NHS between winter 2020 - 2021 and summer 2022.

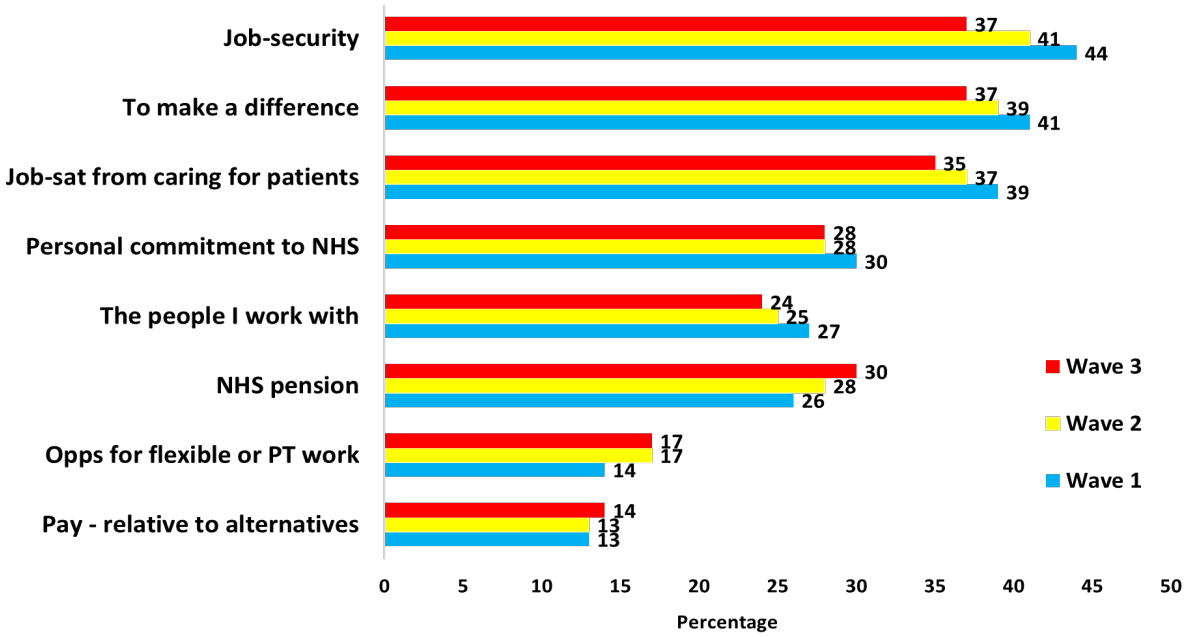

Figure 2: Reasons why staff continue working for the NHS (pull effects) - Comparison of Waves one, two and three

4.2 Reasons why staff leave NHS employment

Respondents were presented with a list of widely cited push precursor influences on staff exit from NHS employment. They were asked '**How important are each of the following reasons to explain why staff who do your type of work leave the NHS?'** referenced to a four-anchor scale (not at all important, not very important, fairly important, very important). Figure 3 shows the proportion of respondents that rated each variable as very important at Wave three.

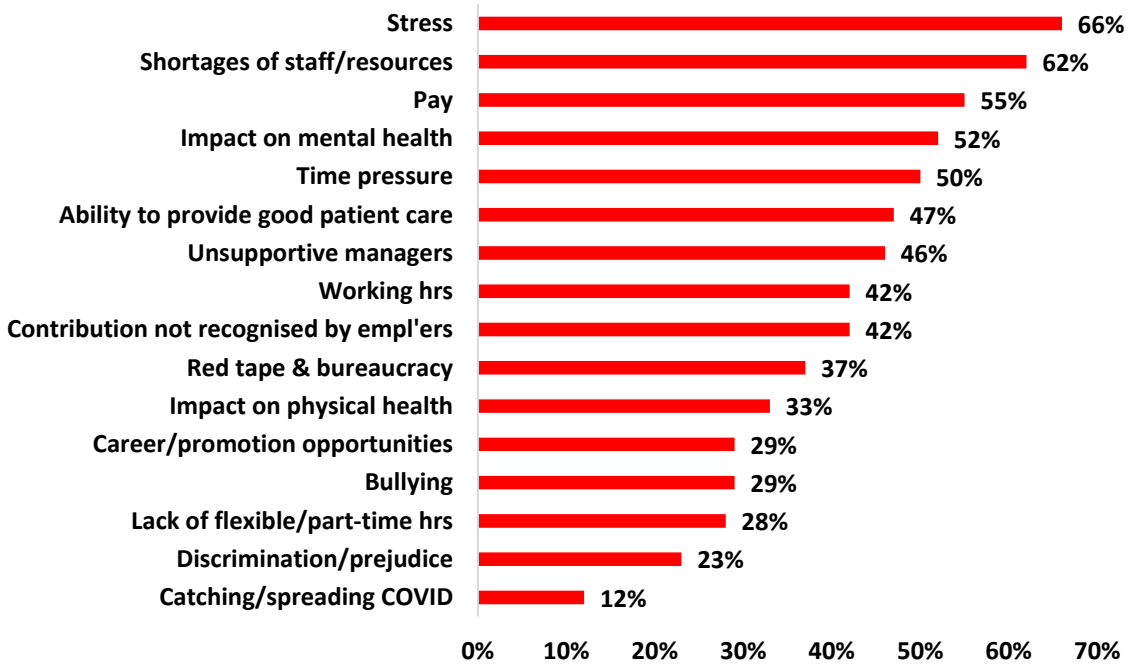

Figure 3: Reasons why staff leave NHS employment (push effects) – Wave three

Comparison of the very important ratings at Wave three with Waves one and two (figure 4) indicates a linear amplification of the push effect of stress, shortages of staff/resources, impact on mental health, time pressure, contribution not recognised by employers, ability to provide a good patient/service user care, working hours and, most markedly, pay. The implication is that the push effect of these variables as precursors to exit is rising, rather than decreasing, since 2020 and the first wave of the COVID-19 pandemic.

There does, however, appear to have been some stabilisation with respect to support from line managers, and attenuation of catching and spreading COVID-19 as a consideration, the latter plausibly reflecting deceases in perceived threat following the availability of vaccines and reduced mortality rates due to advances in treatment.

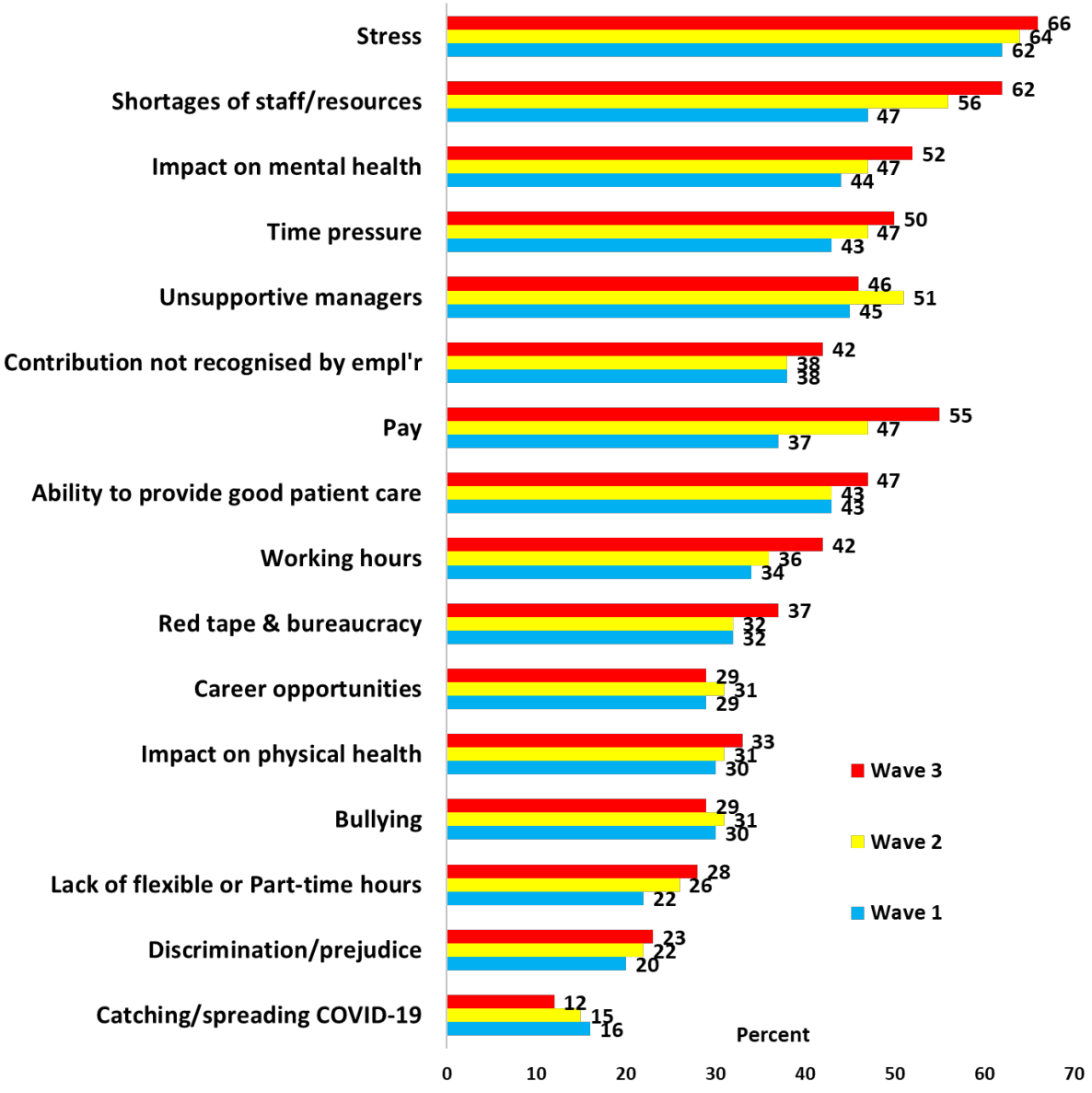

Figure 4: Reasons why staff leave NHS employment (push effects) - Waves one, two and three

4.2.1 Decreased staff resources

There were widely encountered claims from interviewees that staff shortages were present and problematic prior to the emergence of COVID-19, but became amplified by primary and secondary impacts arising from the pandemic, i.e. rises in rates of demand for (COVID and delayed non-COVID) care; staff absences (due to COVID and job demands related impacts on staff health and well-being).

"The staffing challenge has always been there, I think they were heightened during the pandemic, and I think they're still there...." (Acute Senior Manager)

"We're having a real staffing crisis within the organisation and that's because lots of staff are saying that they feel burnt out, they're looking to go work in other organisations or they're leaving nursing or for other professions." (Community Manager)

There were widespread reports of staff and services feeling overwhelmed to a degree significantly beyond that which they had experienced historically, with sentiments conveying the impression of staff feeling powerless to manage or redress the situation.

"... there's a growing sense of fear about how we're going to be able to manage and how we're going to be able to sustain the standard of care that we're delivering... we're so overworked and we're so overrun and caseloads are so huge we can't deliver that so then you get an increase in the backlog of other patients behind them and it just gets more and more overwhelming but having that staff load and recruiting more staff would really help." (Mental Health Nurse)

"I think we're in the most challenging position we've ever been in from a safe staffing perspective." (Acute Senior Manager)

4.3 Health & well-being

4.3.1 Ratings of psychosocial variables

At Wave three respondents were asked to rate the extent to which the psychosocial variables had changed over the preceding six months (November 2021 to April 2022). **'For each of the following, has the situation got better, got worse or is it unchanged?'.** Figure 5 depicts the most frequently cited issues and the percentage of respondents who reported that the respective issue had got worse (the balance of responses in each case relates to the proportion of respondents who reported no change or improvement).

Two thirds of respondents reported a worsening of staffing levels over the reference period. More than one in two reported worsening of workload, stress, morale, and recognition of contribution by the government.

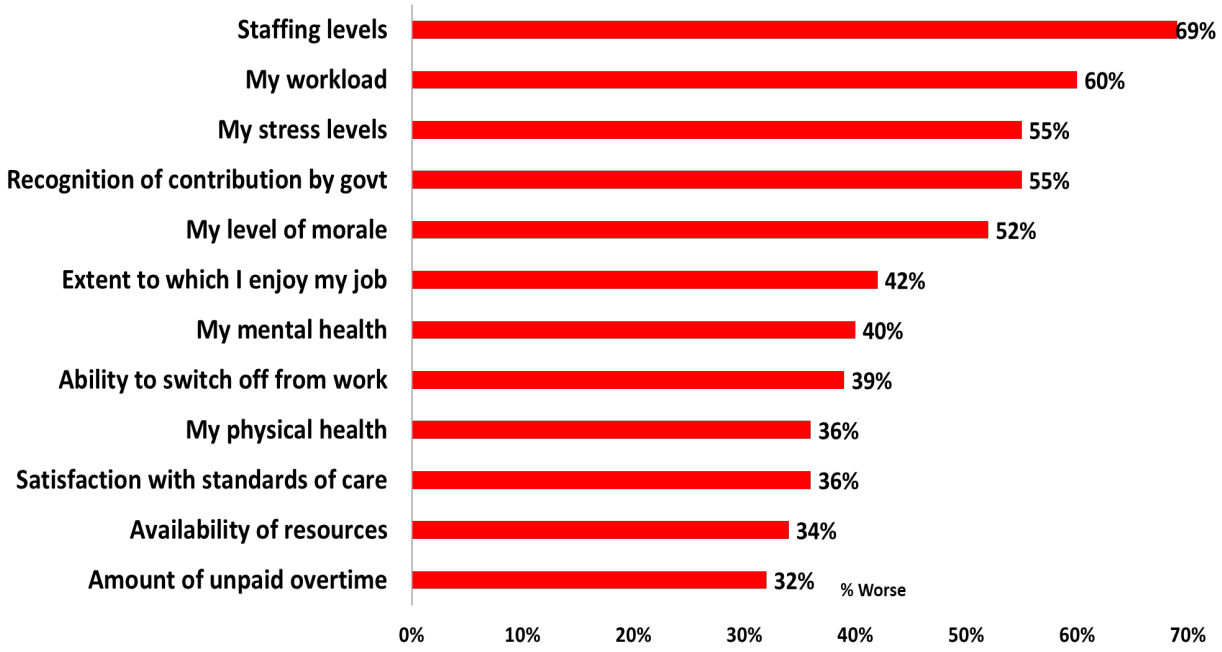

Figure 5: Proportion of employees rating psychosocial variables having got worse between November 2021 and April 2022

4.3.2 Increased (additional and new) workload and job-demands

Interviewees reported a significant increase in physical and emotional demands arising from the initial institutional reaction to the COVID-19 pandemic threat in early 2020. Specifically, this included redeployment of staff to new and sometimes unfamiliar roles and unfamiliar (physical, social and technical) environments, as well as new ways of working to accommodate pandemic infection risk-controls and abnormal levels of team-member inconsistencies due to shielding and sickness absence. Rates of redeployment (routinely involuntarily), from suspended services to front-line COVID-19 care, including intensive care units (ICU) were, understandably, highest within acute settings.

> *"A lot of our theatre teams ended up being redeployed to Covid areas...So, I mean some of them have been absolutely traumatised." (Acute Doctor)*

A widely encountered sentiment was of staff reporting that their pandemic workload and redeployments left them feeling that they were operating at the boundary of (in some instances beyond) their competence, with potentially negative impacts on their sense of self-worth, psychological stress and worry over professional vulnerability.

> *"We were doing things that we weren't competent or confident in doing, and that caused quite a lot of 'moral injury' to myself and others. ...getting in the way and feeling like you're useless. ...you're put into an environment where you feel you don't know anything." (Acute Nurse Manager)*

"...we've got lengthy waits at hospitals...staff aren't trained really to provide that kind of nursing support on the back of a vehicle...so I think it's pushed our staff into situations that they're just not comfortable with and is creating just frustration and anxiety." (Ambulance Senior Manager)

There is evidence that rates of negative impacts on well-being were greatest amongst groups such as allied health and nursing support who were involuntarily redeployed to COVID-19 care. Rates of disposition to exit NHS employment appear to be amplified for this cohort (see figure 13).

However, it should be noted that not all redeployment experiences were negative. For example, one nurse interviewee reported that the intrinsic satisfaction gained from her intensive care unit redeployment made this her future career choice, one that they probably would not have made otherwise.

Emergency ambulance crews also reported increases in physical and emotional demands, ranging from practical issues, such as the ability to deliver the appropriate care when wearing PPE, to abnormally challenging non-technical elements, notably having to manage the amplified emotional status of patients' relatives.

"There has been a lot of trauma but probably not in the way we'd always thought [of] trauma. I mean I've spoken to colleagues who've said one of the worst things for them was taking a patient into hospital and telling the relatives to give them a kiss 'goodbye' and you knew that that patient wasn't going to survive and their relatives couldn't go and visit them and that would be the last moment they were seeing them alive." (Ambulance Paramedic)

The mature phase of the pandemic (2021 onwards) witnessed the emergence of a different facet of the challenge of managing public expectations. Both clinical and support staff working in direct contact with the public and patients recounted challenges in managing expectations and behaviour arising from pandemic risk control measures, e.g. home visits, use of PPE, telephone (rather than face to face) appointments.

"So, the clerical team as well and across the whole medical and nursing teams as well, there's an increase in verbal abuse to the team members." (Acute Senior Manager)

The issue of volume of work was a common feature of accounts during the mature phase of the pandemic (post 2020), in instances where care organisations had to balance COVID-19 care and pandemic risk management arrangements with addressing the backlog of delayed non-COVID treatment. Here employee accounts convey the impression of powerless resignation to what is viewed as a relentless rise in demand for care.

"There's a mountain of work to deal with now in terms of elective recovery…demand is rising on top of the backlogs." (Acute Senior Manager)

"The way I'd describe it as is relentless. It's call after call… You just don't get the chance to reflect on a call you've taken, because as soon as you've finished that call you're on with your next call." (Ambulance Call Handler)

4.3.3 Prevalence of symptoms of burnout

At Wave three (only) respondents were asked a new question **'Over the last six months** [November 2021 to April 2022]**, to what extent have you experienced the following?'**, with reference to a list of commonly cited symptoms of burnout. Figure 6 shows the proportion of respondents who reported experiencing the respective symptom most days or every day.

Approximately one in three respondents reported feeling very tired or drained and experiencing low energy. Around one in four reported mental exhaustion, physical exhaustion, negative feelings and feeling overwhelmed, most days or every day.

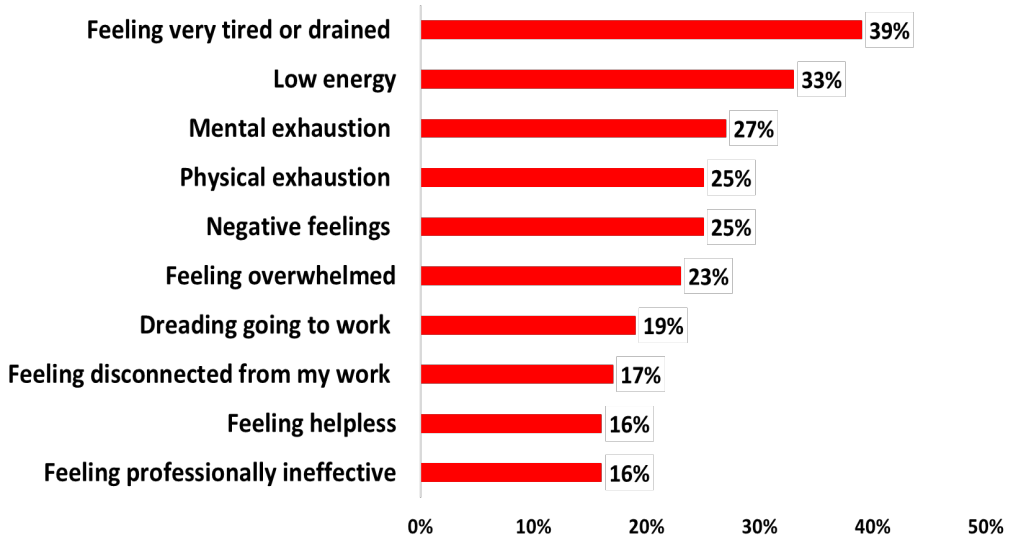

Figure 6: Proportion of staff reporting experiencing symptoms of burnout 'most days' or 'every day'

4.3.4 Impacts on health and well-being

During the initial phase of the pandemic, the unknown and unknowable elements regarding the magnitude of impacts on the public, the personal risk of contracting and spreading COVID and the risk of long-term effects (long-COVID) were a notable source of anxiety. As the pandemic entered its mature phase, the focus of COVID-19 specific health-impact related anxiety attenuated, and workload demands became a more prominent focus in staff accounts of impact on their health and well-being.

"I know from looking at our sickness levels and absence levels. The reason has now shifted from being COVID-related, we're seeing a lot more stressed, anxiety, worry related issues." (Ambulance Manager)

"I think now, I think the impact on people's mental health and physical well-being is greater than the impact of COVID." (Acute Manager)

Interviewees portrayed a work environment of relentless demands for care and insufficient staffing levels contributing to high stress, low morale and burnout.

"I do a lot of the supervision and there's not one person that's said "I'm not tired" or "I'm not really fed up…" I think everyone's said that, even support workers or the nurses. And not just junior nurses, senior nurses as well." (Mental Health Nurse)

Relatedly, staff expressed concerns about the standard of care they and their colleagues were able to deliver under the prevailing working conditions. In particular, we encountered reports of worry about an increased likelihood of making errors due to the time pressure imposed by the abnormally high work rate.

"The service we're delivering isn't ideal. We're not doing the job that we'd want to do. It feels unsafe, and I think patients and relatives are also feeling that." (Acute Doctor)

"For me as a nurse, I think my worry is about making mistakes when you're busy." (Acute Nurse)

4.3.5 Varying experiences of support for staff

A corollary of the pandemic was reported to be that of the abnormal working conditions prompting the introduction of an array of well-being support initiatives by NHS employers, thereby raising the profile and level of resource dedicated to staff support above pre-pandemic levels. While this presented as broadly welcomed, we encountered a number of reports of staff experiencing difficulty in finding the time to access the services on offer due to the magnitude of demand for care.

"I think the pandemic has highlighted things that we sort of just accepted as it's part of the job… I think well-being is certainly something that is more, we're more aware of it." (Mental Health Manager)

"There are [well-being] things there and I know how I can engage with them, I just haven't found the time." (Acute Nurse)

"My current Trust, I think, for the first time have really started to recognise the effect on people's mental health. Again, with the limited resource they have, I think they've done a great job at trying to set up services…The only problem is you can't get to them because it's too busy." (Acute Doctor)

Reports of tensions between the need for Trusts to balance efforts to promote and support staff well-being with meeting operational demands were encountered across a range of professions/job roles and grades.

"Whilst there's quite a lot of health and well-being support available, the reality of the situation is that the pressure still comes down to actually deliver things." (Community Senior Manager)

"That pressure has then been there for them to pick up extras and do extras. 'We'll pay you an extra £15 an hour on top of your overtime rate, on top of this to get you to come in'. So, I think with one hand been pushing down the well-being route. But with the second hand they've been saying 'but whilst you're in that can you also pick up that extra shift'." (Acute Senior Manager)

Respondent accounts pointed to significant variability in levels of support from managers. Where support was rated as good this presents as having a counterbalancing influence on negative impacts arising from high/excessive workload. Conversely, insufficient, or absent, support was cited as a corrosive influence on well-being and morale.

"A lot of people are feeling the pressures from management support, or lack of… it's quite difficult to communicate and raise your concerns in terms of what's happened during the day, why you've made certain decisions. That's a bit of a worry sometimes because sometimes you need that reassurance from your manager…your peers are your bit of support." (Ambulance Emergency Care Assistant)

The conflict between operational demands and supporting staff appeared to be a particular challenge for front-line/middle managers.

"I think my team leader does her best, she goes online, but I think she's equally demoralised by the whole thing…I feel team leaders are stuck between a rock and a hard place. They get it from us, and they get it from the top." (Community Health Visitor)

"Managers are stretched and also burned out so the quality of their engagement with staff is probably not where we would want it to be…and I think that is leading to an overall sense of them feeling under-valued really." (Ambulance Senior Manager)

Levels of informal support from co-workers was widely identified as valuable. However, inevitably its quality and availability is likely to be highly variable. Moreover, its availability is subject to structural influences, e.g. opportunities for interaction bounded by (abnormally high) work-rate; stability of work-team membership composition (due to redeployments/absences); strength of established relationship with co-workers (which can be predicted to be lower for the redeployed, remote/home workers and lone workers). COVID-19 infection control arrangements also reduced access to communal welfare facilities e.g. cafeteria and rest rooms, further limited opportunities for informal interaction/support available under normal working conditions.

"So, we worked in a collaborative fashion and we were supportive to each other…and on the whole there's a lot of goodwill and you pull together, don't you? That's what nurses do." (Mental Health Nurse)

"We took people out of their normal roles and redeployed them into critical care and into theatres. We've learnt a lot from that experience because we took people away from their normal mechanisms of support, their peers, their friendship groups, and dispersed them around the hospital…That had a huge impact on people." (Acute Senior Manager)

"I had only a crew mate to speak to who in my case usually was a complete stranger. When we got to hospital there was no chatting to other crews… normally we'd perhaps go in, be allowed into the nurses' rest room, get a drink, make a coffee and if you'd had a bad job or you could go to one of the toilets. Well, all that was barriered off." (Ambulance Paramedic)

4.4 Concerns and confidence over future working conditions

4.4.1 Worries and concerns

At each Wave[5] staff were asked **'To what extent are the following currently a worry for you?**', referenced to a 10-point scale (1 - not at all worried, to 10 - extremely worried), for the array of variables depicted in figure 7.

[5] Note: The impact of removing COVID-19 restrictions was added at Wave three to reflect Government policy changes to risk mitigation measures.

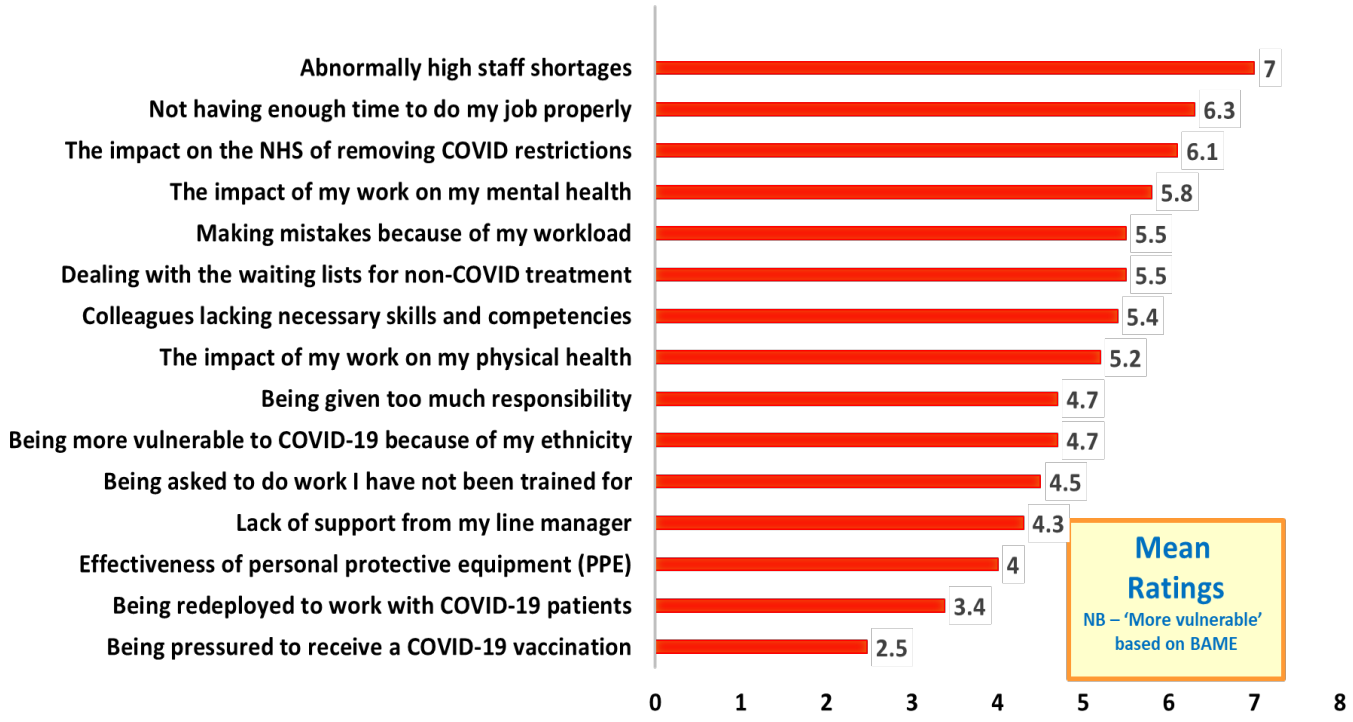

Figure 7: Ratings of worry over working conditions - Wave three

The mean ratings for eight of the 15 variables explored were above the mid-point of the scale at Wave three, suggesting the presence of a notable degree of worry over these issues. The three highest rated sources of worry were 'Abnormally high staff shortages', 'Not enough time to do my job properly' and 'Impact of removing COVID-19 restrictions'.

Comparison of ratings at Wave three with Waves one and two (figure 8) indicates a stable or worsening profile excepting 'Availability of personal protective equipment', 'Redeployment to COVID-19 patient care' and 'Pressure to receive a COVID-19 vaccination'.

There is no indication of a global effect of attenuation of the degree of staff worry between the initial and mature phases of the pandemic. A number of issues are suggestive of a rising profile for the degree of worry, notably with respect to staff shortages and colleague skills/competence.

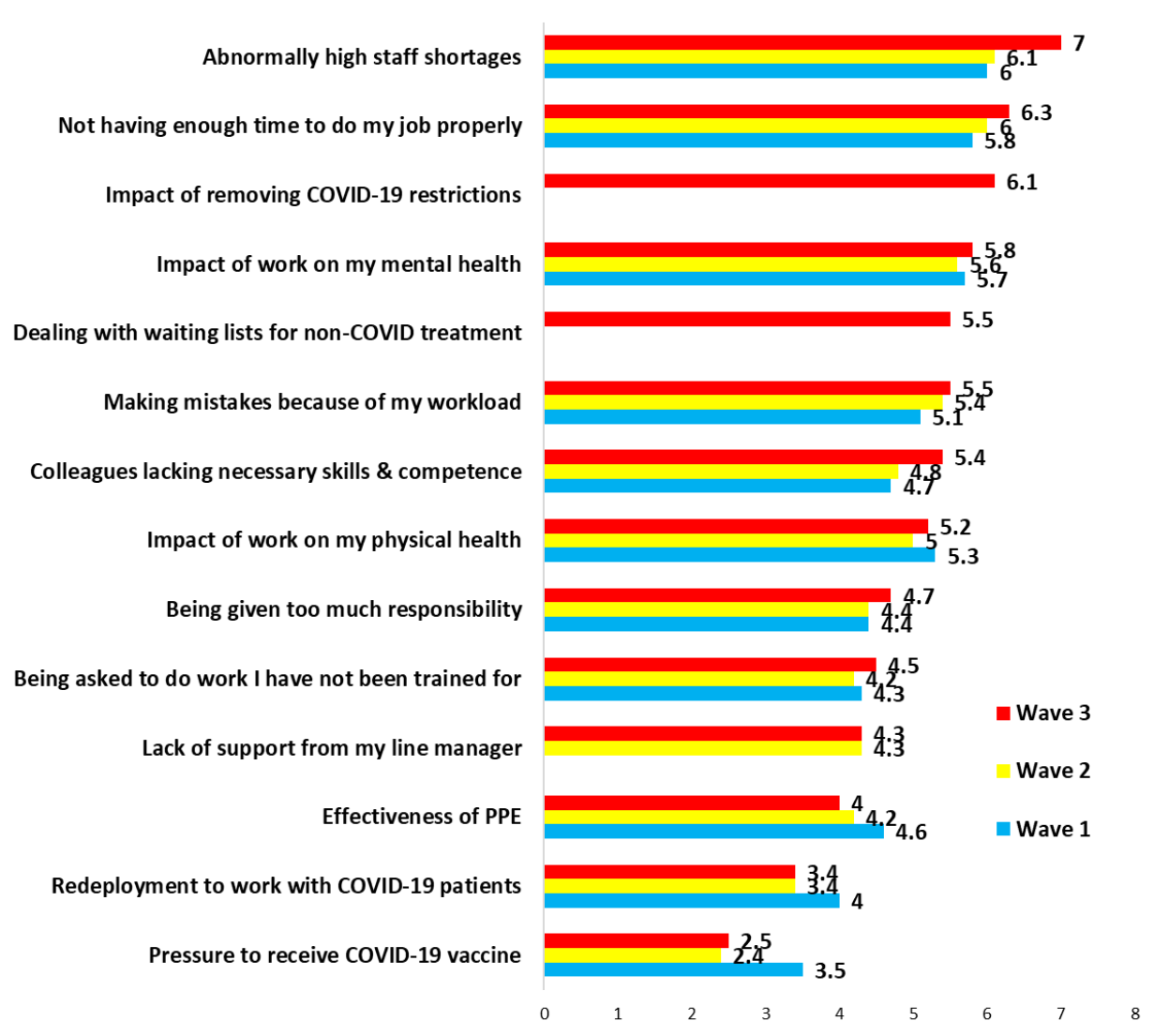

Figure 8: Ratings of worry over working conditions – Waves one, two and three

Rates of under-reporting of worries present as high, an arising implication being that a significant proportion of staff concerns are both unrecorded in official sources and potentially left to incubate. For example, 30% of all respondents reported high worry over the impact of work on their mental health but did not report this to their line manager. The most commonly encountered responses convey an impression of resignation to prevailing working conditions and capacity to influence this.

Respondents who reported a high worry rating (6+/10) were asked the supplementary question **'Have you raised your worries about this issue with your line manager?'**. Figure 9 shows the most commonly cited reasons given by respondents at Wave three for **not** reporting their concerns to their line manager. A perturbing finding is the implication that ~1:7 of staff who **expressed high worry over working conditions but had not raised this with their line manager** due to concern over how they might be labelled.

Figure 9: Most common reasons why staff do not report their worries and concerns to their line manager (base: all who a had significant worry they had not raised with their manager, N = 813)

4.4.2 Confidence over future working conditions

At Wave three only (new item) in response to the question **'Thinking more generally about the next 12 months, how confident are you about the following issues?'**, respondents were asked to indicate their level of confidence in the realisation of each of a set of 12 statements. Each statement relating to future working conditions and related psychosocial elements was referenced to a four-point scale (Not at all confident: 0; Not very confident: 1; Fairly confident: 2; Very confident: 3). Figure 10 gives the mean rating on the scale for each variable.

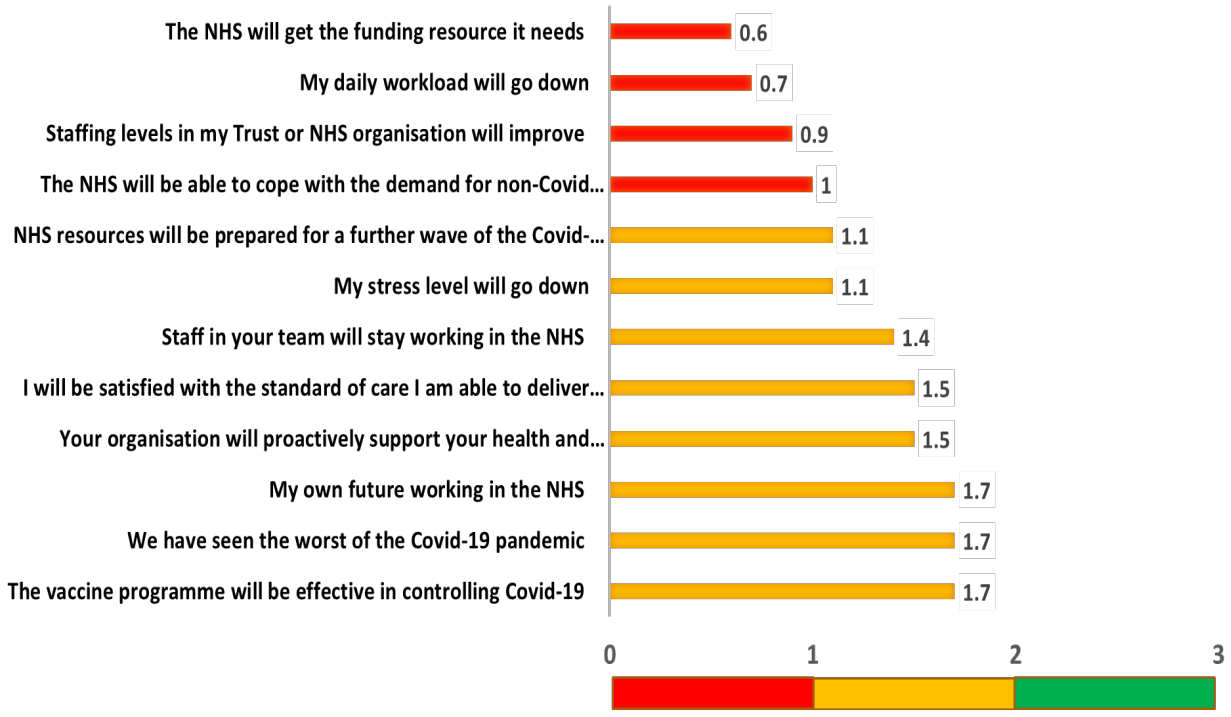

Figure 10: Confidence in future working conditions and my well-being

Levels of confidence varied by issue, but each contributed to a global profile indicating very low to modest confidence in improvement of working conditions over the subsequent 12 months. The lowest (most negative) ratings related to judgments of sufficiency of funding, increases in staff numbers, reductions in individual workload and concern over capacity to meet the demand for non-COVID-19 care. None of the issues explored received a rating of high confidence in improvement over the next 12 months.

4.5 Stay verses leave intentions and behaviour

4.5.1 Future employment aspirations

Respondents were asked about where they would like to be (in employment terms) in five-years-time, what steps, if any, they have taken towards non-NHS employment during the previous six months, their rationale for seeking alternative employment, and whether they would recommend a job in the NHS to others. Responses to the question **'Which of the following best describes what you would like to be doing five years from now?'** yielded the profile depicted in figure 11.

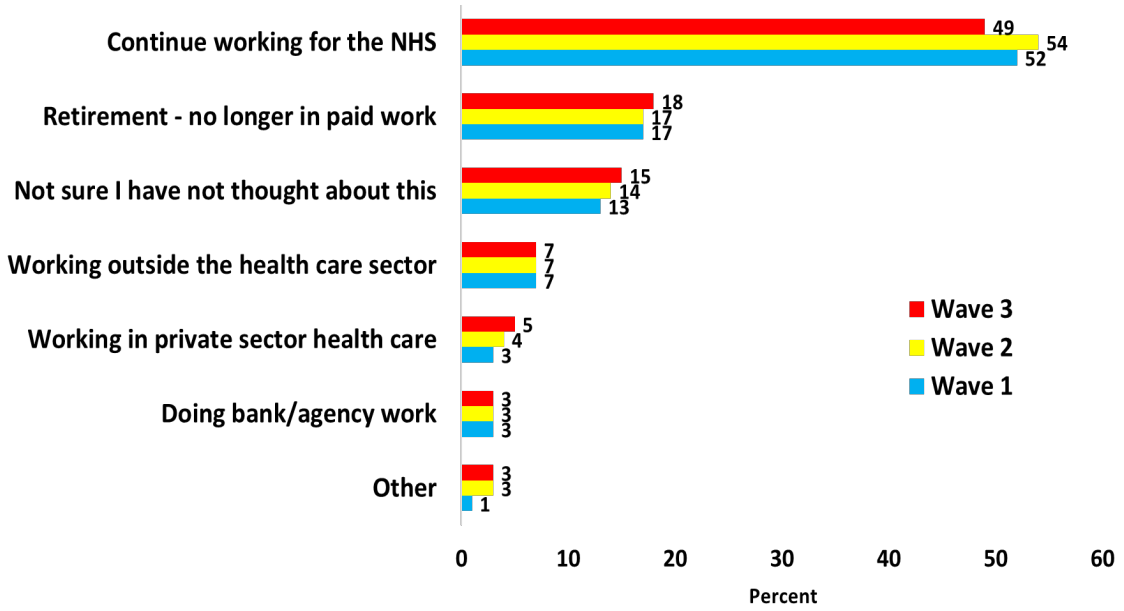

Figure 11: Where would you like to be (in employment terms) five years from now?

In recognition of the proneness of questions relating to intention-to-quit to over-estimate potential exit rates, the output from this question should be viewed as more robust in relative (between Waves) than absolute terms, i.e. it is likely that greater than ~1:2 current employees will remain in NHS employment in 2027. Treating any inherent bias as a constant over the three Waves, reveals a high degree of commonality/stability in the response profile. Potentially, of note, however, is the five-percentage point reduction in the proportion of respondents who aspire to remain in NHS employment between Waves two and three. Also worthy of note is that a proportion of nurses aspiring to stay in NHS employment within five years (44%) is lower than the global (all-staff) NHS figure. This appears to be attributable to a higher proportion of nurses hoping to retire by 2027, which in some degree likely reflects the skewed age profile (high average) of the NHS nurses.

4.5.2 Behavioural precursors to exit

In pursuit of a potentially more objective behaviour-based[6] insight into potential rates of staff exit in absolute terms, respondents were asked **'What steps (if any) have you taken towards non-NHS employment in the last six months?'** Response options were referenced to a six-anchor behavioural ladder (Guttman type) scale, spanning the range from talking to others about non-NHS job opportunities to being offered a job outside the NHS; figure 12.

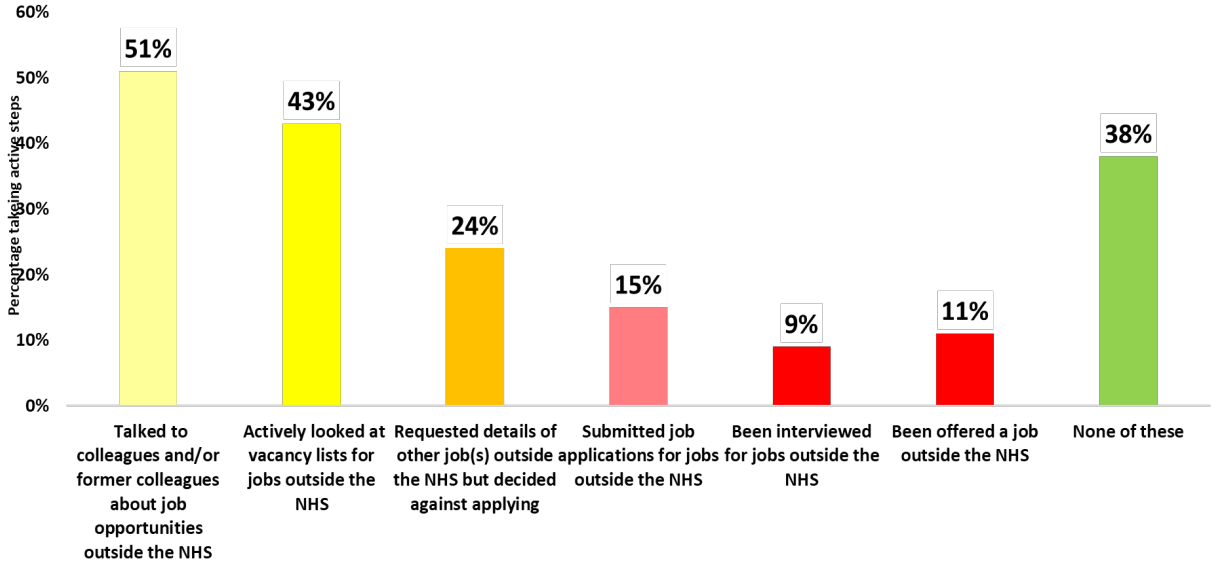

Figure 12: Proportion of staff engaging exit behaviour(s) in previous six months – Wave three

Approximately 1:2 respondents reported having discussed non-NHS job opportunities with a colleague. 1:4 had requested details of a (at least one) non-NHS job, and about 1:7 had submitted an application. Deeper examination of the proportion of respondents who reported having submitted a non-NHS job application within the reference period, revealed that the global rate of 15% obscures notable variability across a range of employee demographics (figure 13). The rate for the ambulance sector and amongst recently-joined staff across the NHS, was markedly higher at 1:4. Non-nursing/medical staff redeployed to COVID-19 care or to other duties as a secondary impact of the pandemic also exhibited a higher rate, of 1:5[7].

[6] There are strong grounds for regarding retrospective behaviour-based measure responses as stronger and more reliable predictors of future behaviour than prospective forecasts of intentions.

[7] Categories: aged under-30, under three years in the NHS and redeployed are not mutually exclusive.

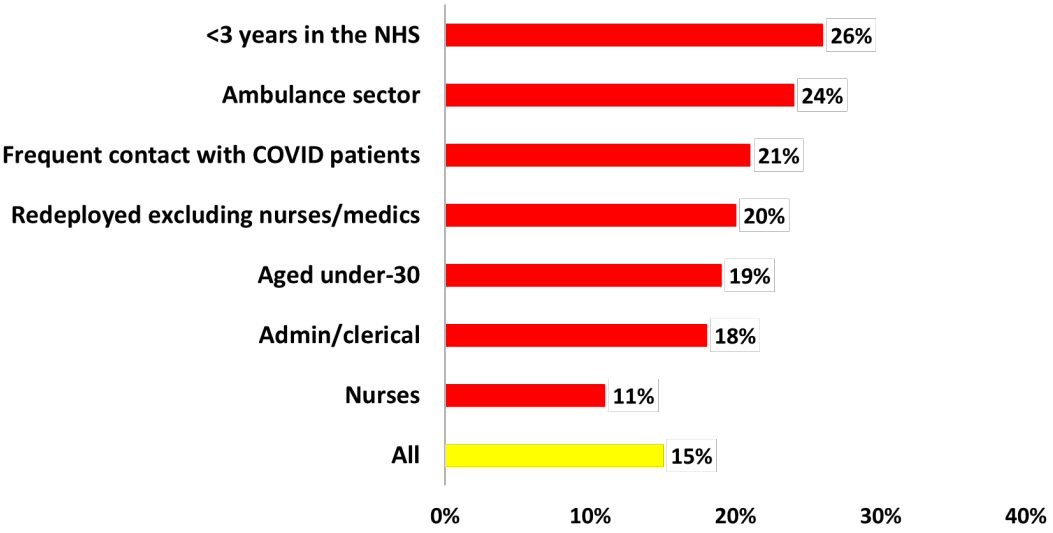

Figure 13: Demographic contrasts in rates of submission of non-NHS job applications – Wave three

Comparison of the response profiles across the three Waves of the survey revealed a linear rise in rates for each step on the exit-ladder.

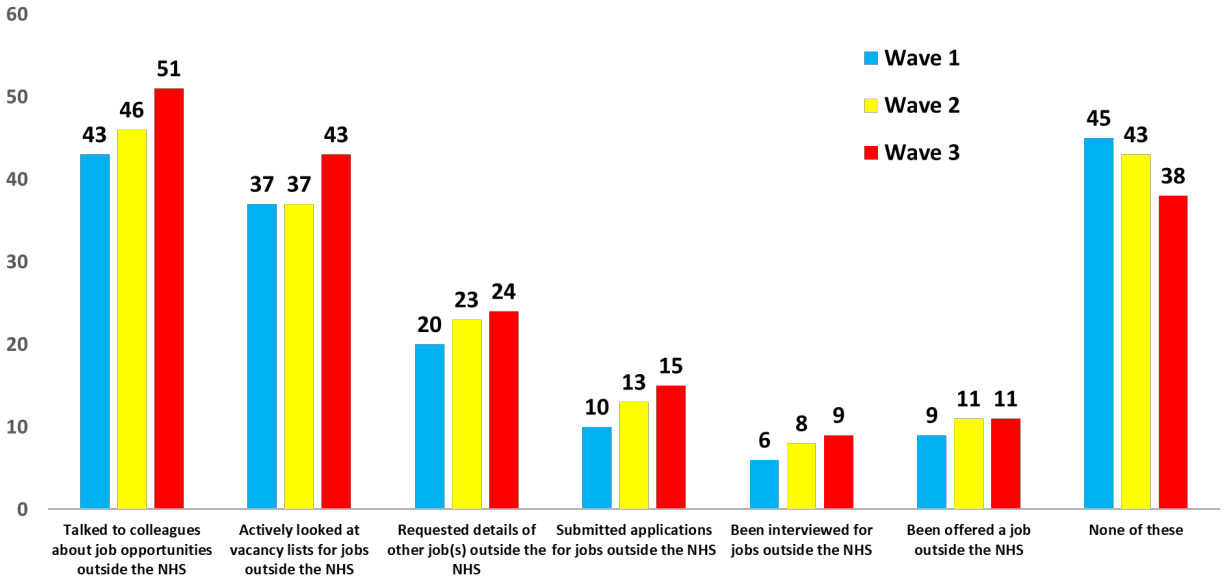

Figure 14: Percentages of staff engaging in exit behaviour(s) in previous six months – Wave three, two and one

The proportion of staff exhibiting precursor-to-exit behaviours is suggestive of a trend of rising interest in seeking non-NHS employment and, by inference, weakened attachment to the NHS since 2020, as indicated in reasons given for why staff leave NHS employment (see section 3.2). There was a five percentage point rise in the proportion of respondents who reported having submitted a non-NHS job application between 2020 and 2022.

Comparison of the response profile for staff who reported (at Wave three) having applied for a non-NHS job, with those who had not, during the previous six months with responses to the question **'How '(very) important' are the following to explain why staff who do your type of work leave the NHS?'** (see figure 2) shows a more negative profile for applicants (figure 15).

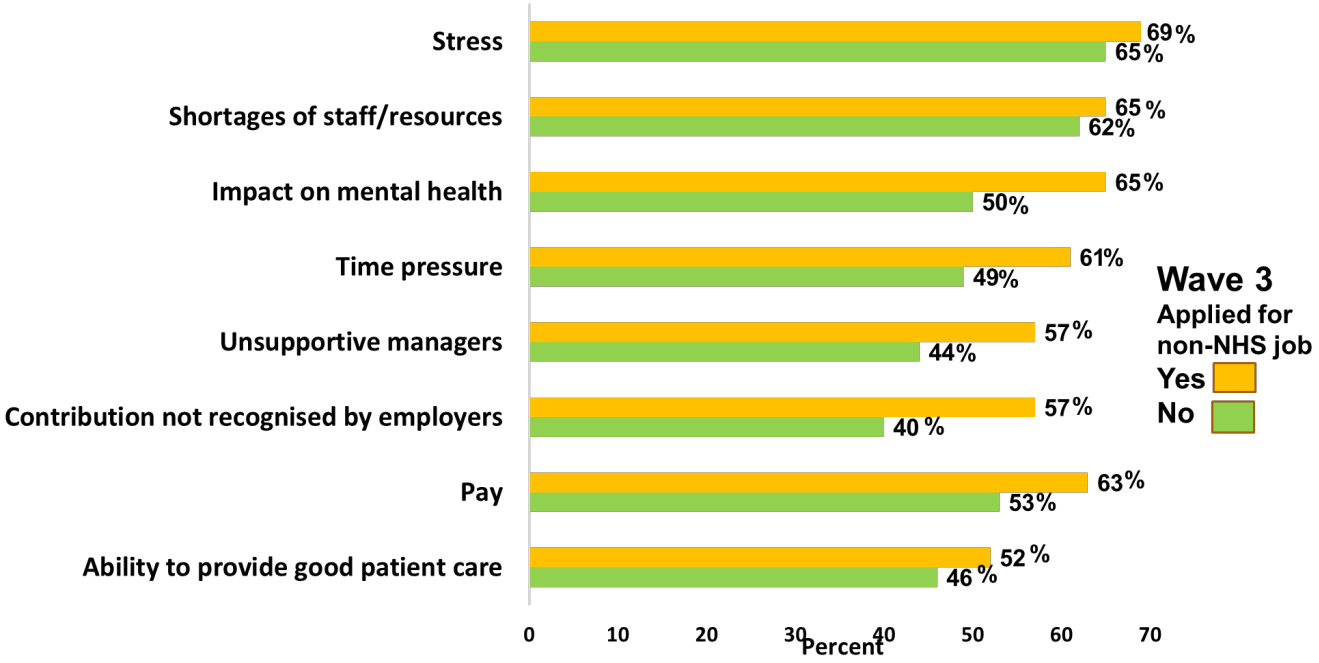

Figure 15: Reasons why staff leave – comparison of non-NHS job applicants with staff who had not completed a non-NHS job application in the previous six months - Wave three

The most marked contrasts between respondents who have applied for a non-NHS job and those who had not at Wave three is in respect of ratings of contribution not recognised by employers, unsupportive managers, mental health and time pressure.

4.5.3 Reduced commitment to remaining in NHS employment.

There were widespread claims amongst interviewees that the increase in job-demands arising from primary and secondary impacts of the COVID-19 pandemic have prompted staff to consider their motivation and capacity to continue working in the NHS. The coping strategies of some that enabled them to remain can be characterised as reducing their exposure to prevailing working conditions, e.g. declining opportunities to take-up overtime work, or transitioning to part-time hours.

"Why am I, giving my soul to the NHS... Why don't I just slow down and look after myself a bit better...reducing my hours or going towards more non-clinical roles is something I've very much looked into." (Acute Doctor)

"I've been chatting to my manager about dropping hours." Ambulance Paramedic

"We have seen a drop off in overtime uptake because staff are just exhausted. We're now seeing that massive drop off and we're struggling to get shifts covered that we need to cover." (Ambulance Manager)

"I always used to stay late, work really late…I would cancel leave and come in for things. I don't do that anymore." (Acute Manager)

For those expressing an intention to leave NHS employment and/or commenting on the leave intentions of the colleagues as consequence of prevailing job-demands/working conditions the principal destinations cited were a move to private health care, non-health sector employment or retirement.

"I feel it's aged me! I really, I feel like the last 18 months has really aged me, physically and mentally. I'd probably, if I was able to retire, I'd probably retire now." (Ambulance Paramedic)

"I know there's a lot of staff that have left but stayed doing something clinical, still using their paramedic skills. But then equally there are quite a lot of staff who've just gone and done something completely different…I personally applied for jobs outside of the NHS and the public sector in completely unrelated fields." (Ambulance Paramedic)

"I know a lot of the adult [-care] nurses in A&E that were not reliant upon their job for financial reasons so have just quit, handed their notice in and said enough is enough I'm not working like this anymore." (Acute Nurse)

"The saddest thing for me is talking to our trainees, many of whom are planning to change their career completely, or don't really want to work in acute medicine anymore." (Acute Doctor)

In the context of the challenges of working through the pandemic period, reward and recognition and perceived effort-reward imbalance presented as particularly prominent issues. There was notable dissatisfaction, most apparent amongst frontline staff regarding their most recent pay offer(s).

"I think the paltry offer of the pay rise has been an impact." (Community Health visitor)

"I'd say all of my team are frustrated with the 3% pay rise and no real recognition for the nurses and ODPs [operating department practitioners] and nursing assistants and what they did and went through and still do." (Acute Manager)

The interviews conducted late 2021/early 2022 also witnessed the emergence of concerns amongst managers that ongoing rises in the cost-of-living will affect their

ability to retain staff who may be able to attract better pay or conditions outside of the NHS.

> *"When you've got the likes of a social care worker earning less than someone who's working in a supermarket it's really tough to attract people into those roles." (Acute Senior Manager)*
>
> *"I think that's going to be an issue now for us, our ability to retain people who are kind of on a fixed level of income as the rising cost of living happens." (Ambulance Manager)*

4.5.4 Recommending working for the NHS to others

With a view to capturing affective sentiments on their experience of employment in the NHS, respondents were asked to indicate their level of agreement with the statement **'I would recommend working for the NHS to others'**, referenced to a five point agree/disagree scale. At Wave three the all-staff agreement rate was 51%, however, the rate for nurses (41%) was 10 percentage points below the global value.

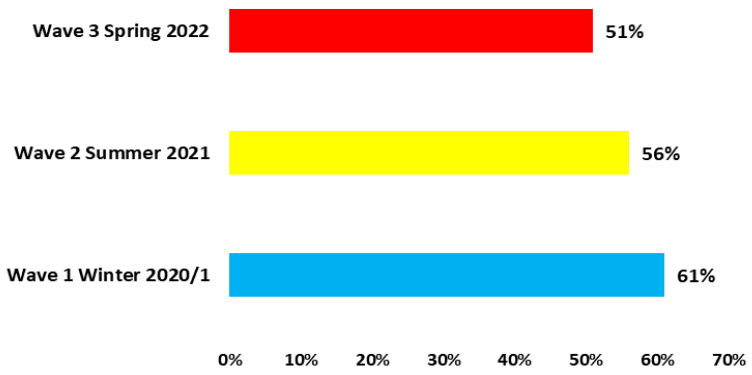

Figure 16: Proportion of staff who would recommend working for the NHS to others – Wave three, two and one

Examination of the profile of positive (net agree) responses across the three Waves of the survey indicated a negative linear trend, with a drop on 10 percentage points between 2020 and 2022. The proportion of respondents who gave a positive response at Wave three had diminished from 3:5, in winter 2020 - 2021 to 1:2 by spring 2022.

5.0 Main findings

While some specific issues show evidence of attenuation/improvement since the winter of 2020 - 2021, e.g. decrease in staff worry over availability of personal protective equipment and pressure to receive a COVID-19 vaccination, the dominant profile of responses across the three survey Waves is one of, at best, stability and, at worst, more negative ratings. An arising conclusion is that impacts on staff well-being and their motivation/capacity to remain in NHS employment during the initial acute phase of COVID-19 do not appear to have diminished. Rather, for an array of fundamental issues, the profile has become more negative over the period of maturation of the pandemic and its secondary impacts.

While questions might be raised regarding the atypical working conditions when our winter 2020 - 2021 baseline data was gathered, the ensuing period points to weakening of a number of headline pull influences that have historically been associated with positive effects on NHS staff retention. Notably, core components of intrinsic job-satisfaction, caring for patients, to make a difference present as eroded and weakened in the presence of extrinsic elements producing high worry over standards of patient care, insufficient time to do their job properly and making mistakes.

While the reduced pull of job security may reflect increased opportunities for alternative employment as the economy has opened-up during the mature phase of the pandemic, decreases in ratings of elements relating to intrinsic job-satisfaction present as fundamental. The negative profile of ratings of working conditions, and concern over standards of patient care gives rise to the inference that the arising impacts conspire to frustrate the primary motivation of care providers. Beyond concern over impacts on patients, worry over making mistakes embodies the potential to amplify worry over personal/professional vulnerability.

The consistently highest rated employee worries and concerns were, respectively, abnormally high staff shortages, not having enough time to do my job properly and impacts of work on my mental health. The profiles of these variables showed a rising (negative) trend from winter 2020 - 2021 to spring 2022. Impacts on mental health, however, was displaced from third to fourth highest worry at Wave three the variable The impact of removing COVID-19 restrictions which was added to the spring 2022 survey.

In April 2022, more than 2:3 respondents rated staffing levels as having worsened since November 2021. 1:2 reported a worsening of morale, stress and workload over the same period. Ratings of confidence that working conditions would improve over the next 12 months (beyond spring 2022) ranged from low (negative) to modest across each of the criteria explored.

Of an array of variables widely associated with employee burnout, around 1:3 respondents reported tiredness and low energy. ~1:4 reported physical exhaustion, mental exhaustion and feeling overwhelmed, most days or every day. Of these ~1:2 attributed this completely to their job in the NHS and almost all respondents said their work played at least some part.

The most commonly cited push influences on staff leaving NHS employment at Wave three in April 2022 were, respectively, stress, shortage of staff/resources and pay. A

notable change since 2020 was the ascendant profile of pay. It was ranked eighth of the 15 variables explored in winter 2020 - 2021, rising to joint fourth at summer/autumn 2021 and third at spring 2022.

The proportion of respondents who reported having applied for non-NHS jobs in the preceding six months at each Wave showed a rising trend. The rate was 1:10, rising to 1:8 in summer 2021 and 1:7 by April 2022. The rate for some segments of the NHS labour force is markedly higher, for ambulance services it was 1:4 and for staff aged under 30 years and non-nursing/medical staff redeployed to COVID care it was 1:5 (April 2022). These and other evidence of structural/experiential demographic differences in leave versus stay orientation point to the potential gains from a bespoke segmented approach to intervention activity aimed at increasing retention rates.

The proportion of staff who would recommend working for the NHS to others shows a negative linear trend, with a drop of 10 percentage points, from 3:5 to 1:2 between 2020 and 2022.

6.0 NHS human resources policy implications

Our survey focussed on contextual influences on staff attitudes, behaviour and resilience. Specifically, it offers insight into shared threats to staff well-being and their motivation/capacity to remain. It reflects alignment with the risk management systems tradition and evidence-based approaches to organisational learning to inform decision-making by identifying phenomena and priority issues for intervention.

The survey findings indicate a trend of a rising rate of NHS staff actively engaged in steps towards seeking non-NHS employment. The most salient push effects appear to be attributable to staff shortages and related impacts, in particular increased workload and associated stresses on those who remain. In essence a potentially vicious circle, if current exit rates persist or rise in the context of high/rising patient demand for care. The bounded scope for increasing staff numbers in the short to medium term, given the finite latitude for recruitment from overseas and time-lags associated with training of health professionals suggests that intervention to support established employees in ways that encourage/facilitate them to remain in the NHS is of central importance.

From the perspective of intervention aimed at stabilising/enhancing staff retention rates, it is also important to note that while there is overlap, the list of reasons why staff leave (push) and stay (pull) variables are not a simple mirror image of each other. A comprehensive perspective on intervention likely needs to find ways to both mitigate the former and propagate the latter.

An implication of the substantial rates of staff under-reporting of worries and concerns over working conditions and their personal well-being is that these issues can incubate. This has potential negative implications for individuals, but also for service delivery and future capacity. Viewing worries and concerns as detrimental to staff well-being and precursors to exit, means that failure to capture this lead-indicator data represents the loss of a potentially important source of organisational learning, i.e. incubating issues may go unaddressed until they reach a critical status.

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