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Challenges and lessons learnt by hospital and healthcare employers on COVID-19

The following document will provide a first insight into challenges and lessons learnt by hospital and healthcare employers, in light of the COVID-19 outbreak. First commonalities between HOSPEEM Members are presented, followed by detailed information on the respective countries. The information collected ranged from May 2020 – 11 December 2020. Links to resources and references can be found in in the end of the document.

The challenges and lessons learnt are clustered around four areas:

1. Organisational challenges in terms of health workforce and shortages;
2. Organisational challenges related to Personal Protective Equipment;
3. The organisation of training for health workforce usually not working in the ICU setting;
4. Risk assessment for the health workforce to assess their health status and "being fit for work".

Organisational challenges in terms of health workforce and shortages

- Easements/derogations from employment law/WTD (emergency laws and collective agreements) such as 12-hour shifts, overtime, rest periods, annual leave cancelled, postponed, or "encouraged");
- Increased flexibility in work organisation and building of multidisciplinary teams;
- Adoption of a competency-based approach in allocating HR, leveraging on hard skills instead of titles and academic curricula;
- A systematic review of job profiling, matching team needs with the skills and competences of personnel available to fill the posts;
- Uptake of digital technologies on-site and blended working for administrative staff;
- Medical students joining the workforce earlier;
- The retired health workforce is returning to work.

Every hospital and healthcare employer reported overall health workforce shortages. Danish Regions, **Denmark**, Zorgnet-Icuro, **Belgium** and KT, **Finland**, reported having increased flexibility for health workforce staff and more cohesive multidisciplinary teams, working outside traditional boundaries and 'work grade', also to increase the intensive care capacity. This was also seen by HSE, **Ireland** who saw that cross-boundary working[1] had become the new normal. Additionally, the staff has also been

[1] increased collaboration between primary care, secondary care, social care, and a whole range of voluntary and community groups

transferred from other working units and areas of greatest needs[2], which was also described by Zorgnet-Icuro, **Belgium**. HSE, **Ireland** reported an increase of staffing numbers by 7% since March 2020, projected to increase by an additional 10% by the beginning of 2022. It has to be noted that an unintended consequence of the pandemic is the limited cross-border mobility of newly qualified health workforce, with staff being more likely to remain in **Ireland**. COVID-19 has galvanised responses in Ireland, by creating stronger coalitions between government departments, the Board, Trade Union partners, services within the HSE, partner organisations and local communities. In an HSE Pulse Staff Survey[1], Irish health professionals reported needing better guidance and direction concerning redeployment and where staff are taking on additional roles and responsibilities. HSE, **Ireland** also introduced remote working arrangements, enabling a better work-life balance. Employing ICT is essential to engage staff that are both on-site and working from home. HSE, Ireland reported that staff and managers had been enabled and trusted to make decisions based on what is best for patients and service users at the local level.

To deal with very rapid changes in working hours and place of work in **Denmark**, a Memorandum of Understanding was developed with the professional organisations on the local level to introduce necessary adjustments in the work organisation of hospitals. Via the corona assistance job banks[2] established in the regions, additional employees have been recruited who are usually not employed in hospitals. For example, a special agreement has been reached on the employment of doctors on hourly wage terms as this is not an option within the existing agreements. The close dialogue and cooperation with the professional organisations both centrally as decentralised will therefore also be in focus in the future[3].

FIASO, **Italy**, reported that the national government published a list of temporary and extraordinary laws to suspend the ordinary recruitment procedures of the health workforce[4]. As a result, many hospitals' human resources departments and health agencies took advantages of hiring personnel with flexible contracts. Contrary to previous arrangements, medical residents also worked in the hospital, and health agencies, not exclusively in university hospitals and retired workers were called back to service as medical personnel in publicly run facilities or to keep working in private facilities under public health agency setting command.

In **the United Kingdom** (UK), NHS Employers have also enabled recently retired professional staff to re-join the workforce, through nationally and locally coordinated processes. In the summer, the details of the staff who had expressed an interest were shared within Integrated Care Systems (ICSs) or Sustainability and Transformation Partnership (STP) areas, so that local conversations about their expectations could be managed. The processes on returning varied depending on the amount of time elapsed and spent in and out of the service and profession[5]. Additionally, NHS Employers provide resources to support local employers in using temporary fast-track pre-employment checks and assurances where there is an urgent need to appoint workers and volunteers to provide emergency support in a pandemic situation, rather than using the standard NHS England & Improvement procedures. Assurance for employers and staff on indemnity and litigation issues during the pandemic is also provided, including the latest advice from NHS Resolution on the continuation of existing indemnity arrangements[6].

FEHAP, **France**, reported that for the first wave, regions did not face the same proportion of COVID-19 patients, but deprogramming decisions were made at the national level. In these circumstances, a portion of the health workforce was available and could be reassigned to other facilities[7]. For that reason, a national platform was created to help reinforce the health workforce and materials. FEHAP also created a platform during the second wave in October 2020. Additionally, a childcare system was

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[2] Occupational health, public health services, testing and tracing, community assessment hubs, specialist teams, public helpline, nursing homes and residential facilities

set up for the children of hospital staff. All FEHAP members are subject to the **French** private law that provides a strict framework to employers. To face health workforce shortages, employers can, therefore ask employees to work overtime and conclude fixed-term contracts under specific conditions or temporary agency contracts. **French** "private" labour law was partially adapted for the crisis, under conditions of negotiation with social partners. In certain instances, social partners were able to negotiate and conclude a collective bargaining agreement (at the sectoral or company level) to provide new rules on annual leaves. Without such a collective bargaining agreement, employers must require employees' agreement to cancel or postpone annual leaves. To derogate the French Labour Law without the need for a collective bargaining agreement could offer more flexibility to healthcare facilities. FEHAP and other federations asked to have adaptations of working time rules. The **French** member experienced a lack of attractiveness in the healthcare sector due to its pay and working conditions. After the COVID first wave, the French government decided to provide an extraordinary bonus[8].

NVZ, **the Netherlands** shared information on an accelerator *ZMT* which summarised the lessons learnt into six areas: vision and leadership; support your employees; clear guidelines; flexible workforce; solidarity and digital care. Additionally, the Dutch government started various initiatives to address health workforce shortages[9]:

Extra Hands for Care"[10]	**Campaign**	**National Care Class[11]**
• Citizens without a health background can register to help; • Organisations can submit requests for additional employees.	• Calling on former healthcare professionals to temporarily contribute to the health sector; • Employers in other sectors are asked to support employees who are willing to work in the health sector temporarily.	• Scaled up to 1000 people per week within 12 weeks to perform supporting activities in health care institutions; • Short courses for security guards in healthcare care institutions are being developed.
Engaging non-practising nurses[12]	**Collaboration between healthcare facilities[13]**	**Exploring regional flexible healthcare workforces**
Former nurses with an expired certificate are allowed to work under specific conditions.	Healthcare institutions are working together to increase the number of hours that part-time healthcare professionals work.	Professionals work in various institutions and domains and can be deployed where they are most needed.
Adaption of the training programme	**Zorginspirator[14]**	**Health workforce retention[15]**
Training programme for renewing certification for nurses is adapted to fit the level of knowledge of former nurses.	A national platform for attracting and motivating health care workers.	The effects of COVID-19 on the themes of healthy working and fair employment practices in the healthcare sector and found seven accelerators for the improvement of healthy working in healthcare[3].

The **Swedish** employer SALAR reported that the spread of COVID-19 had posed entirely new challenges to health care, among others the redirection and re-prioritisation of staff, care, and other resources; staff loss due to sick leave; recruitment, borrowing, adjustment and rapid training of staff. During the crisis, Swedish hospital employers have worked with different scenarios and based on this, taken several measures to ensure good and sustainable staffing, such as within the framework of the collective agreement, recruitment of staff, use of staffing pools and borrowing of staff from private

[3] Build a healthy organizational climate; strengthen the mental fitness of the healthcare professional; strengthen cooperation across the boundaries of institutions and domain; increase the number of hours that part-time healthcare professionals work; continue decreasing bureaucracy and protocols; continue technological innovations; increase craftsmanship, appreciation and participation

care providers or from, for example, companies in the life sciences area. Additionally, to cope with the pressure on healthcare, employers have offered part-time staff to step up full-time. They have also relocated staff to direct resources to the most affected businesses, ordered overtime, on-call duty, and emergency services and in some cases taken back already granted vacations. The collective agreement provides an opportunity for the employer to temporarily give employee tasks that are usually outside the work obligation in the employment contract through a temporary appointment. It made it possible for employers to allow staff to work with other tasks and in activities other than where they usually work[16].

In **Belgium**, several stakeholders updated their guide on hospitals' procedure to approach a patient with possible / confirmed COVID-19[17], which also include guidance for health professionals. The guide states that in very exceptional cases, but only if all other measures to deal with a possible shortage of personnel have already been taken, asymptomatic but test-positive care personnel can be asked to come to work.

Following conditions to be satisfied:

- Personnel who are required to be able to guarantee minimum basic care;
- The decision is always taken in consultation with the management and the hospital hygiene department;
- These staff members may only be deployed for the care of COVID-19 patients in a COVID-19 unit;
- Staff members can never be obliged to work during their isolation period;
- Contact with other persons and colleagues must be avoided. The COVID-positive employees use a separate entrance, separate dressing room, if possible separate relaxation rooms, own transport (no public transport), etc.

In Zorgnet-Icuro, **Belgium**, reflections on COVID-19[18], one of the cornerstones looks at the health workforce. Similar to the experience of other hospital employers that had to deal with adjusting work contacts and arrangements, the introduction of "career savings" system may be considered to rethink the extra days of leaves of the health workforce. The **Belgium** government has created more flexibility in the employment law: While usually overtime/extra hours is/are only allowed in specific situations well-defined in the labour law, now employees can voluntarily work 200 extra hours, without a parafiscal charge on the salary for these hours, but also without compensatory rest. While students previously could only work 475 hours /year without their parents losing their childcare benefits, this ceiling is temporarily lifted. The **Belgian** government now also accepts that annual leave that could not be taken in 2020 can be transferred to 2021. Commitment to projects that promote the implementation of innovative work organisation in healthcare facilities. To overcome health workforces shortages and at the same time address unemployment of workers in sectors such as HORECA, the **Belgian** government and employers have identified a number of (non-care) tasks or that workers from other sectors could pursue, thus allowing the health workforce to concentrate on their care responsibilities.

Organisational challenges related to Personal Protective Equipment

- In Spring 2020, overall PPE shortages;
- Improvement during autumn when countries started producing their PPE;
- Quality concerns
- Guidance on the use of PPE needs to be consistent (gender, beards, hijabs, turbans…)
- Increased cooperation between healthcare facilities.

Challenges varied between HOSPEEM Members. Whereas KT, **Finland**, and HSE, **Ireland**, FEHAP, **France** reported Personal Protective Equipment (PPE) shortages in the spring […] the situation has improved since the national production of PPE has started, supplementing imported supplies[19]. Zorgnet-Icuro, **Belgium**, KT, **Finland** and NAHCO, **Lithuania** mentioned some quality concerns of received PPE.

The **Italian** National Institute of Health published and updated the indications for rational use of protection devices and equipment in healthcare and sociosanitary activities[20]. These indications are based on the scientific knowledge available on the transmission of the COVID-19 infection and are also referred to international recommendations in this field. Based on the precautionary principle, both surgical and filtered-face masks are used. Action to minimise contacts and frequent interactions among healthcare staff and COVID-19 patients is required in emergency conditions and any cases of high concentration of COVID-19 patients. In the first wave of the pandemic outbreak, the emergency pressure combined with the potential lack of equipment meant that PPE was made available according to priority criteria to operators with the highest occupational risk. Main organisational challenges related to the diagnosis process and care of patients, requiring the reorganisation of hospital activities. In cases of verified shortage of protective equipment and medical devices, an extraordinary validation procedure has been agreed by the Central Government in order to decrease the time required for compliance with the relevant European requirements (unchanging compulsory technical and quality standards). Distributions of loans have been authorised to PPE and devices manufacturing companies[21]. FIASO, **Italy** noted that the equipment provision needs to be organised more for emergency situations and less with 'cost-containment' in mind. A national plan for industrial production and the provision of essential equipment and devices is being envisioned[22].

Together with the Confederation of Medical Specialists Organisation, the **Dutch** government published guidelines on the use of PPE in hospitals[23]:

What the Dutch government wants to preserve	What the Dutch government wants to put more effort into
Cooperation between government, acute care providers, PPE providers and healthcare institutions to ensure that healthcare staff can work safely, and patients are not infected;	Clarity on role and responsibility of the PPE national coordination centre on the one hand and the healthcare institutions on the other hand;
Involve as much knowledge and experience from the field as possible in issues related to procurement, production, distribution, quality, information, and appropriate and reasonable use of PPE in different settings.	A better understanding of the future demand for PPE, the consequences for the PPE national coordination centre and improving communication about this matter to healthcare parties, other parties, and civilians;
Maintaining a base stock for sudden extra demand or sudden shortages. Building a national production capacity.	Better communication and instruction on the use of PPE for healthcare professionals, caregivers, patients, and volunteers.
	Proportional distribution of PPE within (the Kingdom of) the Netherlands.

In the **UK**, hospital employers should ensure that their staff are kept informed of the latest infection control guidance and adhere to hand washing and PPE protocols. From 15 June 2020, all hospital staff in England are required to wear surgical face masks at all times[24]. The government published guidance which has continuously been updated[25], together with a range of resources including a communications toolkit[26]. Regarding the supply of PPE, employers should ensure they have adequate supplies of PPE and keep up to date with the latest advice on the supply of PPE[27] from NHS England and NHS Improvement. The Danish Regions noted that there is a need to ensure a more robust supply of equipment, protective equipment, and critical medical equipment as a more strategic approach to the supply of critical medicines.

Between the end of April and September 2020, the **French** Government did not provide enough PPE to assure full protection because these equipment were subject to rationing. As a result, during the first wave of the pandemic, health workforces were highly contaminated due to an insufficient number of appropriate protection masks. To face an unprecedented crisis, the **French** Government now recommends having a 3-week PPE stock, subject to monitoring. Besides, there was also a lack of

medicines and equipment. Relocate these assets on the European territory would benefit the entire health care sector.

Zorgnet-Icuro, **Belgium** shared that in the second half of 2020, all health care facilities were asked to provide a stock that meets their needs for three months. Additionally, in the meantime, all governmental agencies (federal, Flemish) organised themselves to have a strategic stock. There is a good work-around to help health care organisations with PPE at the moment of shortages, outbreaks. While it is essential to have a strategic stock in healthcare organisations as well as on a governmental level, most procedures are in place, but a follow-up will be necessary.

The organisation of training for health workforce usually not working in the ICU setting

- Other staff were trained for ICU setting at the workplace;
- The rapid adoption of technology in facilitating learning;
- The right balance has to be found in terms of length and quality of training;
- Better training on infection control/hygiene for care home staff;

KT, **Finland**, reported that staff had been transferred from other working units and areas of greatest needs. Staff had also taken on additional roles and responsibilities, whilst staff were trained for work in an ICU setting at the workplace. Many members, such as the **Danish Regions** noted that there is still a need for a system that supports rapid conversion and upgrading the qualifications of employees for other tasks and functions. The **Danish** member, however, noted that good collaboration with professional organisations enabled the conversion. HSE, **Ireland**, witnessed rapid adoption of technology and an increase in eHealth solutions, whereas staff identified the benefits of new ways of working while also acknowledging that in most instances, blended approaches are required.

In **the Netherlands**, the government published a plan on the training for (potential) workforce in the ICU-setting, including elements of 1.) training various ICU to support workers; 2.) training workers for COVID-19 hospital wards; 3.) training ICU-nurses for supervision and consultation role; 4.) 6-month training for basic acute care; and 5.) increase training capacity. This will allow facing the ICU workforce shortages due to the COVID-19-crisis[28].

In **Belgium**, most of the hospitals used in-house training. The healthcare workers who were not used to work in the ICU setting were accompanied by ICU nurses/doctors in the form of a “buddy training”. The staff that made the transfer to ICU (non-ICU workers), often already worked on a ward that was more technical. Also, the staff who worked in the operating room were transferred to ICU because the regular schedule was transformed. Overall, the hospitals were satisfied with the way of working. The challenge that employers experienced was the lack of time and urgency in the project.

In a report published in July 2020, SALAR, **Sweden** notes that doctors with related specialities have been quickly trained so that they can strengthen the staffing in intensive care.[16]

FEHAP, **France,** reported that in each ICU setting, help was provided by the health workforce usually working in intensive care units and six months retired doctors and caregivers who used to work in ICU settings. Furthermore, professionals who are not used to work in the ICU setting received fast track training[29]. The **French** Government provided educational tools on a national website to help hospitals and healthcare facilities. Health workforce training to work in ICU was discussed between FEHAP, **France**, and other federations. As a result, the federations requested shorter technical training for experienced nurses already working in the different establishments and an adjustment of the professional standards. Private federations request the same rules as the public sector for nurses and

assistant nurses' apprenticeship training to help facilities recruit additional professionals. Finally, the career development path is a central question in the private healthcare sector in France.

Risk assessment (RA) for the health workforce to assess whether they are fit for work

- Risk assessment has been strengthened, in particular for vulnerable groups;
- Adjustments are being made throughout the risk assessment cycles;
- Transparent and open communication with the health workforce as key for successful risk assessment

Responses varied between HOSPEEM Members. KT, **Finland** shared information on the employer-specific assessment of risk[30], which outlines that if an employee belonging to the risk group is concerned about the risk of infection in the workplace, they can be referred to the occupational health services. The occupational health care helps with risk assessment, and the parties involved negotiate and agree on possible changes in work arrangements or tasks. This is in line with Zorgnet-Icuro, **Belgium**, response who noted that every organisation has to collaborate with an external service for health and safety on the floor, who assess the risks on the workplace. Based on this assessment, the employer has to decide who can work where.

In regard to risks of COVID-19 infection, **French** employers are encouraged to work with staff representatives, occupational health services and employees, to regularly update their document for the assessment of the occupational risk. This document notably provides a risk evaluation for employees' health and safety, and inventory of identified risks in each work unit and an action plan. As part of the action plans, the information about hygiene rules was reinforced in healthcare facilities, about "barrier gesture" and the use of PPE. Moreover, the **French** government recognised that some people who may develop a severe COVID-19 infection were considered vulnerable. At the beginning of the crisis, employees recognised under the vulnerable groups were put on sick leaves. Now, they can only ask to benefit from a "part-time activity" if they cannot telework nor be provided with reinforced protection measures. Employers take their decision with occupational health services.

It should be noted that in **France,** medical information is strictly confidential to the employer. It is also prohibited to conduct a risk assessment based on characteristics like ethnicity, gender, religion. FEHAP, **France**, wants to redesign risk prevention and the work organisation by including new ways of work linked to the digital transformation (telework and teleconsultation, for example). The **French** health workforce is subject to psychological risks due to decisions made during this crisis, the amount of work and the number of deaths they had to face. A national assistance number is now available for health workforce to discuss these subjects. **France** will also have to deal with the psychological health of the overall population following the COVID-19 crisis.

FIASO, **Italy** noted that there are three types of factors that have been taken into account when conducting RA: 1.) preliminary factors such as analysis of the epidemic context in the specific working environment and observation of home-workplace transportation; 2.) **circumstantial factors**, such as essential services provision and identification of more risky phases according to specific tasks, presence of protection and security measures already set up and availability of PPE and sanitation procedures; and 3.) Personal factors, including workers health status, a medical assessment conducted by medical personnel at the employer's expense. The **Dutch** government and Confederation of Medical Specialists Organisation developed two guidelines 1.) when (not) to allow healthcare professionals to work[31], and on when (not) to allow vulnerable healthcare professionals to work[32].

In the **UK**, it is recommended that employers **undertake the following steps**[33], in addition to targeted discussions with staff representatives and workers in higher risk areas:	
Reflect on the intelligence available regarding their organisation. This would include data on absence due to COVID-19, any worker deaths due to COVID-19, staff survey data;	Consult with staff networks and trade unions regarding the approach to be taken to risk assessment and agreeing on how a continued dialogue can be maintained;
Communicate to all workers, whatever their professional background or work area, describing the approach being taken to risk assessment, reassuring them as to the nature of the assessment being undertaken and the support available to them. The organisation's policy regarding confidentiality should be clearly stated (and complied with);	Share the agreed local risk assessment tool or guidance with all team members to help them identify whether they are in an at-risk group;
Explain the need for staff to discuss with their manager any concerns as a result of the risk assessment guide or any concern or anxiety they might have (and offer them alternative routes of support before these discussions);	Agree with alternative routes through which individuals might raise concerns or flag the need for a risk assessment discussion;
Guide those managing services regarding the follow-up conversations about risk with their team members, including the potential responses to protect or support staff;	**Review and repeat risk assessments** as necessary in line with individual circumstances, emerging evidence, and national guidance.

Additionally, aspects such as vulnerable workers, black and minority ethnic staff, pregnancy, age, underlying health conditions, weight, disability, gender, religion, or belief need to be taken into account when conducting a risk assessment. Organisations should gather the relevant information as outlined above, through one-to-one conversations with their teams. Those managing services should listen carefully to concerns and provide support and consider adjustments or redeployment for any staff who are identified as being at greater risk.

Adjustments may include:	
Limiting the duration of close interaction with the patient (for example, preparing everything in advance away from them);	Providing surgical masks for staff members for all interactions with patients or specimens;
If possible, maintaining a two-metre distance from the patient;	Redeploying staff to a lower risk area;
Avoiding public transport/ rush hour through adjustments to work hours;	Advising staff to leave the area for 20 minutes when AGP is undertaken on suspected/ confirmed COVID patient;
Asking patients to wear a mask for staff member interaction;	Encouraging remote working;
Asking that only the patient is in attendance for home visits/ outreach where possible.	Varying work patterns.

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