Northern Health and Social Care Trust

Impact Research Centre

COVID-19 Wellbeing Survey

Time two Findings

Version 2: 24th March 2021

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1.1 Executive Summary

This report outlines the results of the second time point of the Northern Ireland COVID- 19 Staff Wellbeing Survey that we carried out during February 8-28th 2021. In total, 2,898 health and social care staff from across Northern Ireland took part at Time 2.

The survey included four validated psychological wellbeing measures (depression, anxiety, Post–Traumatic Stress Disorder (PTSD), and insomnia). High levels of distress within the workforce were found (depression 36%; anxiety 27%; PTSD 32%; Insomnia 28%) at Time 2, indicating that the high level of need for staff supports identifed at Time 1 persisted three months later. A small increase in the proportion of staff with moderate/servere depression was seen at Time 2. On the eight indices adopted from Pre-COVID-19 staff survey, seven showed stable results between Times 1 & 2; however, the proportion of staff who look forward to coming to work has continued to fall (Time 1 = 51%; Time 2 48%) corresponding with the increase in rates of moderate to severe depression.

Prior analysis of the Time 1 results revealed effective communication to be the most important predictor of staff wellbeing. Consequently the importance of clear, frequent and transparent communication throughout all levels in HSC organisations was highlighted in the Time 1 report recommendations section. Progress has been made in relation to this recommentation, as evidenced by an increase in the proportion of staff viewing communication on COVID-19 related matters to be effective at Time 2 (increase of 10 % points to 62%).

Consistent with Time 1 analyses, communication emerged as the strongest predictor of staff wellbeing in the Time 2 statistical models. Vaccination uptake, a new variable introduced at Time 2, did not demonstrate a signifcant relationship with staff wellbeing.

The Time 1 report revealed that a large proportion of staff were worried or very worried about the prospect of being redeployed (49%), and 38% of those who were redeployed found the role stressful of very stressful. In response to these findings we made recommendations relating to providing clear communication about expectations and workload of new roles, reassuring staff it does not increase

personal or family risk, and providing necessary training and skills to carry out any new roles. Three months on from Time 1, lower proportions of staff reported being worried/very worried about redeployment (down by 11% pts to 38%) or being stressed/very stressed once redeployed (down by 9% pts to 29%).

Our Time 1 report had a number of important recommendations and nothing in this report contradicts these original recommendations. To reiterate in the light our new data:

1. There are continued high levels of distress within the staff group and recovery may be prolonged in this respect. We recommend the continued working of the regional staff support group.
2. The fact that there has been no “vaccine bounce’ in terms of mental health and wellbeing is important. The majority of our sample had at least one dose of the vaccine but this did not impact on mental health and wellbeing measures. Organisations can’t rely on vaccination as a wellbeing strategy – multiple innovative approaches are needed.
3. Our previous report highlighted the importance of clear, frequent and transparent communication. We note that many of the organisations involved in this study have made great strides in this respect. Our Time 2 report supports the continued importance of communicating during this pandemic.
4. It is clear many organisations involved in the study have improved the manner in which redeployment is discussed and executed (e.g. clear communication, appropriate redeployment, necessary training and mitigation of risk by providing appropriate PPE and vaccination). Anxiety regarding redeployment has reduced but needs to be handled appropriately and sensitively by organisations.
5. Some staff are using and valuing the range of supports on offer. However, it is also clear that we need to continue to innovate in reaching more staff in need. Staff have given clear opinions regarding the range of future supports they think they need and this should inform future provision.
6. The physical consequences of having COVID-19 have emerged in this time point as a significant issue for some staff. It would seem important for occupational health departments in organisations to be aware of these issues

and develop appropriate responses. We will continue to monitor its possible effects on mental health in the coming survey time points.

2.1 COVID-19 Staff Wellbeing survey

The COVID-19 Staff Wellbeing survey was carried out by Northern Health and Social Care Trust (NHSCT); Belfast Health and Social Care Trust (BHSCT), Southern Health and Social Care Trust (SHSCT), South Eastern Health and Social Care Trust (SEHSCT) and Western Health and Social Care Trust (WHSCT). The study design has also been informed by representatives from Ulster University, Queen's University Belfast, the Northern Ireland Ambulance Service, and the Nursing and Residential Care home sector. The study received ethical approval from the West of Scotland Research Ethics Service. (WoSRES).

The research aimed to improve our understanding of how health and social care staff in Northern Ireland have been affected by the COVID-19 outbreak, and to check if the psychological supports provided by the trusts are meeting staff wellbeing needs. The findings will be considered carefully by the trust teams involved in providing psychological supports. Following this, the results could have several implications on the psychological supports available to health and social care staff. For example, they will help us to ensure that we are providing supports that match staff needs, and will be used as much as possible to improve the effectiveness and availability of psychological support to health and social care staff. The results of the second time point of the survey (February 8-28th 2021) are presented in this report.

The survey will also run on a further two occasions (May and August 2021) This will allow us to track the impact of the COVID-19 outbreak on staff over time.

2.2 Achieved sample and 95% confidence intervals

In total, 2,898 health and social care staff from across Northern Ireland took part in Time 2 of the COVID-19 Staff Wellbeing survey. With the achieved sample, assuming 95% confidence intervals a proportion of 50% could be estimated with precision of +/-1.84%. For the smallest subsample analysis, that involving the 466 who had been redeployed, the precision level for a proportion of 50% was +/- 4.63% (95% Confidence intervals)

2.3. Analysis strategy

Any Time 1 & 2 results presented in this report are based on the cross-sectional sample which included everyone who took part at each time point (Time 1 = 3,834; Time 2 = 2,898). In Section 3.1 it is highlighted that the demographic profile of the sample was similar at Times 1 & 2, meaning any changes over time are unlikely to be due to changes in the composition of the sample. The study included a longitudinal sample (n=632) of participants who took part at both Times 1 & 2 and provided their email address at both time points allowing their responses to be linked. The majority of cross-sectional analyses presented in this report were also conducted using the longitudinal sample (excluding a few instances where the sample size was insufficient). There was a high level of conistency between the results in the longitudinal and cross-sectional results, meaning that any trends reported here are likely to reflect actual changes in Health and Social Care Staff experiences between November 2020 and February 2021 as opposed to being the result of methodological artifact. Both the cross-sectional and longitudinal analyses were taken into account in the interpretation relating to the graphs in this report.

2.4 Format of the report

Sections 3.1 – 3.10: Findings for overall sample at Time 2 are presented. In some instances both Time 1 and 2 results are presented (e.g. where there is some evidence of change over time). Where trends are stable between Times 1 & 2, only Time 2 results are presented.

Section 4.1: Psychological wellbeing data by organisation

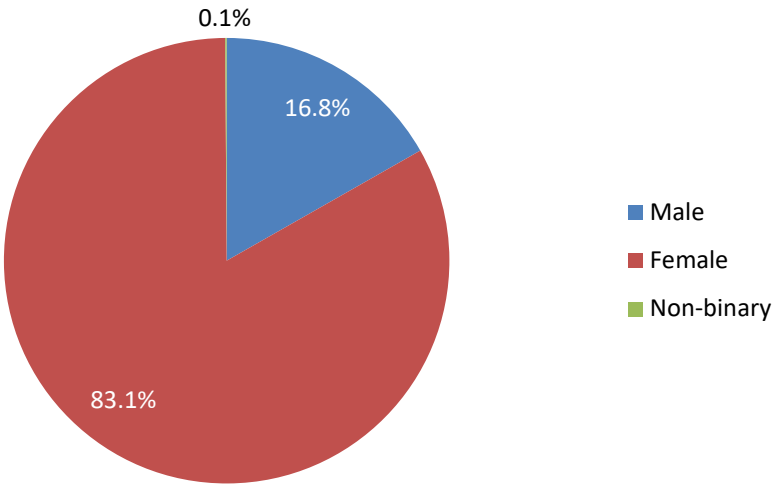
Section 5.1: Recommendations

3.1 Who took part?

Age & gender

Of the 2,898 health and social care staff that took part at Time 2, the vast majority of respondents were female (83%; Figure 1). The average age of respondent was 44 years, and the sample included individuals aged 16-71 years.

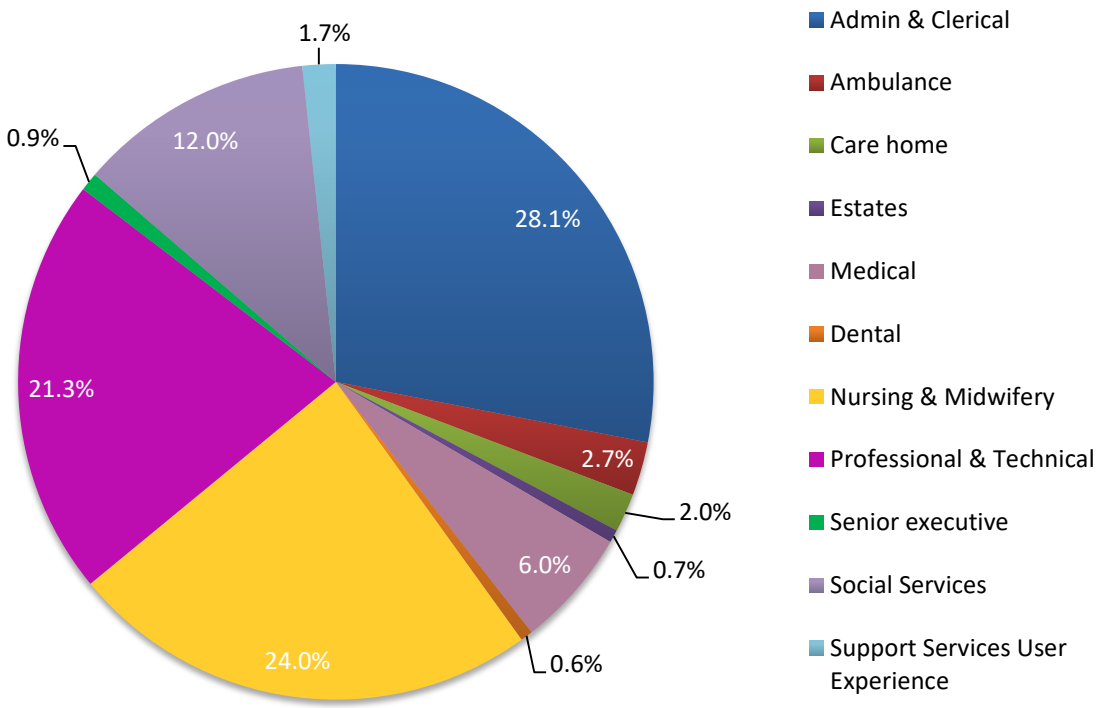
Figure 1: Gender breakdown of respondents at Time 2



Occupation

Figure 2 shows that a large proportion of the sample worked in *administrative and clerical* (28%), *nursing and midwifery* (24%), and *professional and technical* (21%) roles.

Figure 2: Occupation breakdown of respondents at Time 2

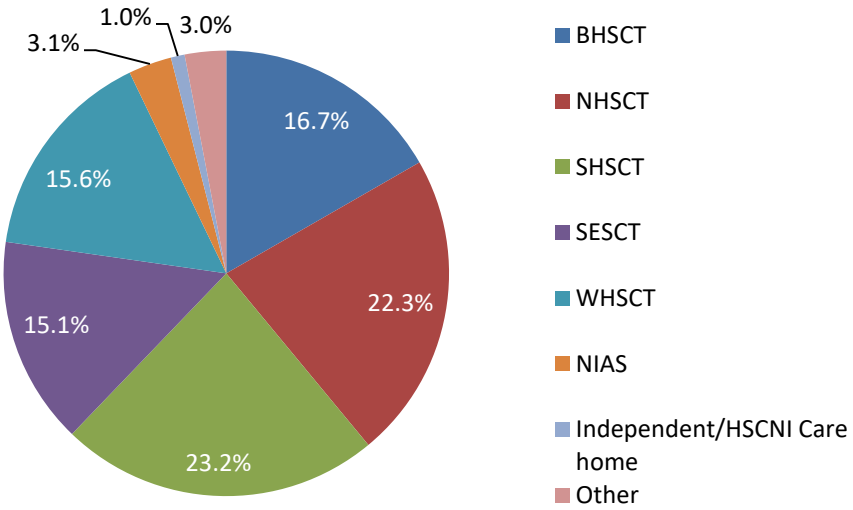


HSCNI Trust/Organisation

The HSCNI Trust/Organisation that the respondents reported belonging to is shown in Figure 3. Of the 2,898 participants, the numbers of staff who took part in each Trust at Time 2 are as follows: SHSCT (n=672); NHSCT (n=646); BHSCT (n=484); WHSCT (n=452); SEHSCT (n=437); NIAS (n=91). As the six trusts vary considerably in size, to put these figures into context approximate response rates (i.e. proportion of staff who took part) for each trust were computed based on staffing figures reported in the 2019 HSCNI Staff Survey Report (NISRA, 2019). Based on these figures, at Time 2, NIAS had the highest response rate (6.9%), followed by NHSCT (5.0%), SHSCT (5.3%), WHSCT (3.9%), SEHSCT (3.6%), and BHSCT (2.0%). Compared to Time 1, very similar response rates where found for NIAS (down by 0.2% pts), NHSCT (up by 0.2% pts), SHSCT (down by 0.7% pts). A reduction in response rate of one percentage point or more was evident for SEHSCT (down by 2.3% pts), WHSCT (down by 1.7% pts), and BHSCT (down by 1.3 % pts).

Detailed descriptives by HSCNI Trust/organisation are presented in Section 4.

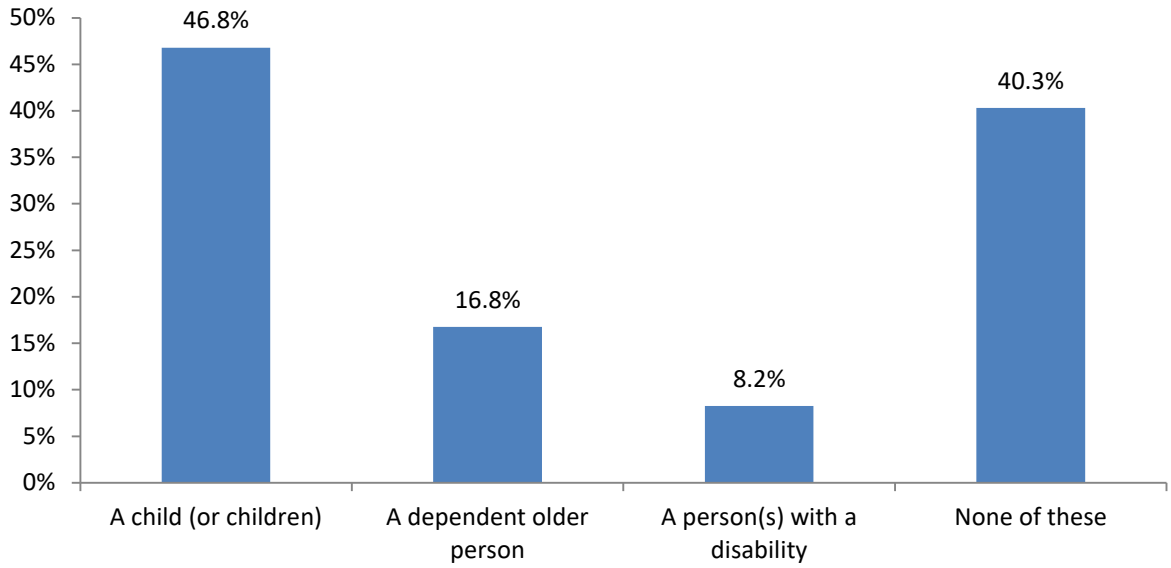
Figure 3: HSCNI Trust/Organisation of respondents at Time 2



Dependants

The majority of respondents (60%) identified at least one dependant that they had caring responsibilities for (Figure 2).

Figure 4. Caring responsibilities of respondents at Time 2



Profile of the sample over time

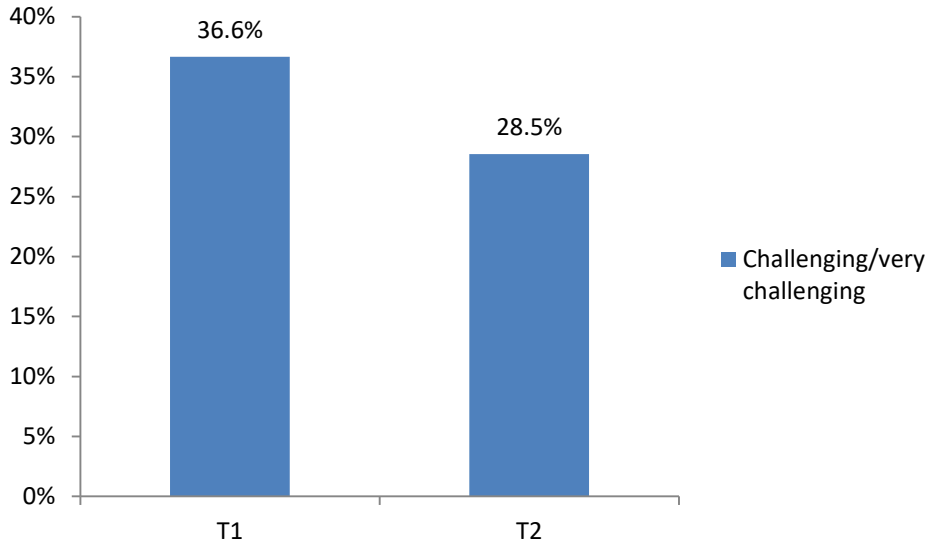
The Time 1 and 2 samples had very similar characteristics across the following demographics: gender, age, occupation, banding, education level, dependants, and marital status. The only exception was HSCNI/organisation – the response rates for some Trusts were lower at Time 2.

3.2. Looking after Dependants during the COVID-19 outbreak

Amongst Health and Socia Care (HSC) staff with children who took part at Time 2 (n = 1,356), 55% reported that it was challenging or very challenging to provide home schooling in the three months prior to the survey (before February 2021).

Figure 5 shows that the proportion of HSC staff with children who found it challenging or very challenging to arrange childcare dropped from 37% in the period before Time 1 to 29% in the three months before Time 2 (Figure 5).

Figure 5. Proportion of respondents who found it difficult to arrange childcare prior to Times 1 & 2

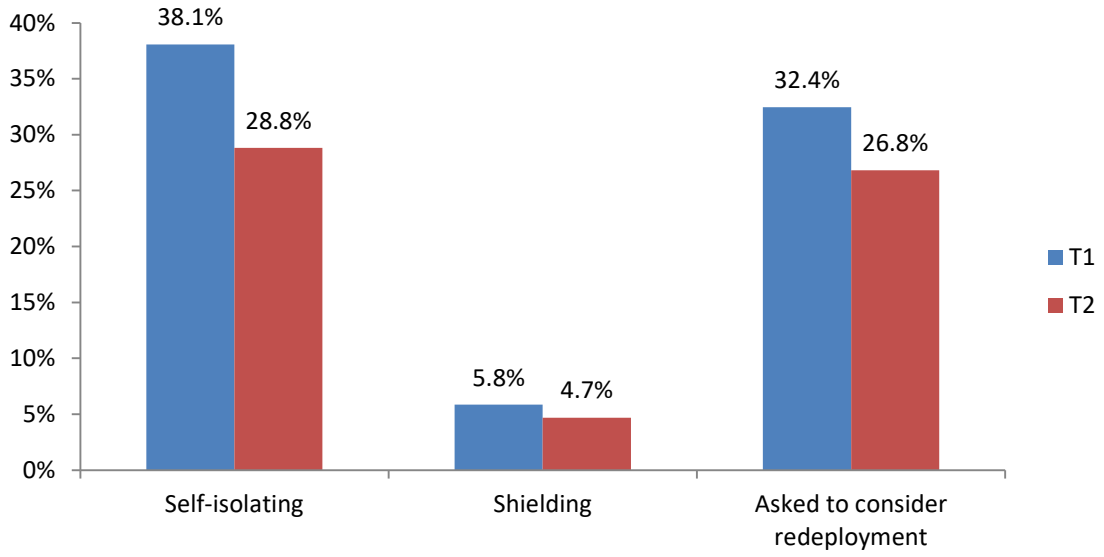


3.3 Changes in work patterns

The Time 2 survey looked at the impact of the COVID-19 pandemic on HSC staff work patterns. Specifically participants were asked if in the three months prior to Time 2 they had worked from home, self-isolated, shielded, or considered a redeployment opportunity; 48% of staff reported having worked from home at some stage during this period.

Compared to Time 1, at Time 2 there was a decrease in the proportion of HSC staff who had been self-isolating, shielding or asked to consider a redeployment opportunity (Figure 6).

Figure 6. Working arrangements during the COVID-19 outbreak at Time 2.



At Time 1 around half (49%) of individuals who were asked to consider redeployment reported having felt worried or very worried about the prospect of having to take up new duties as a result of the COVID-19 outbreak (Figure 7). When HSC staff were asked to report levels of worry related to redeployment in the three months prior to Time 2, high levels of worry were much less common (38%).

Figure 7. Views on redeployment at Time 1 & 2

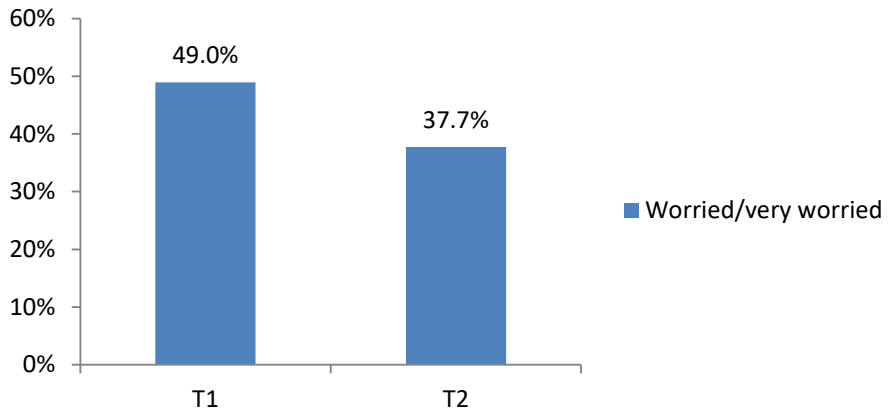
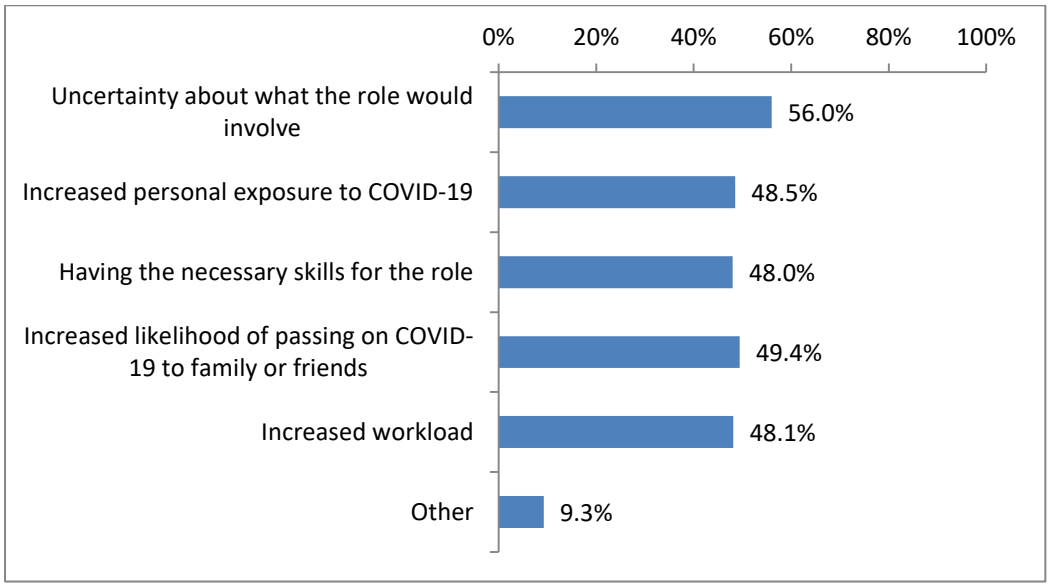


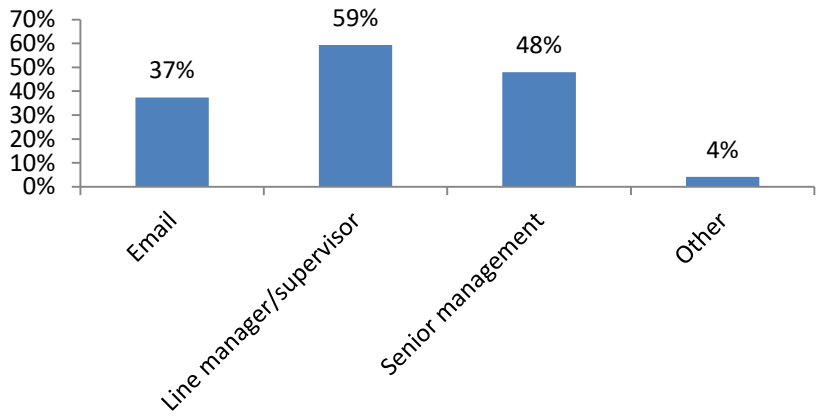
Figure 8 shows that redeployment concerned staff in many ways at Time 2 including uncertainty about what the role would involve (56%), increased personal exposure to COVID-19 (49%), having the necessary skills for the role (48%), increased likelihood of passing on COVID-19 to family or friends (49%), and increased workload (48%).

Figure 8. Concerns about redeployment at Time 2



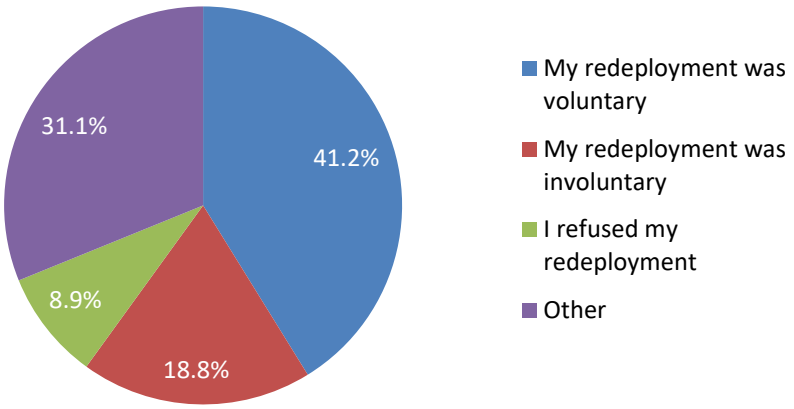
At Time 2 participants who had been asked to consider a redeployment opportunity in the last three months were asked where that request came from. Most reported receiving the request from their line manager/supervisor (59%); however, requests via email from their organisation (37%) or from their senior management (48%) were also very common (Figure 9).

Figure 9. Who asked the participant to consider a redeployment opportunity at Time 2



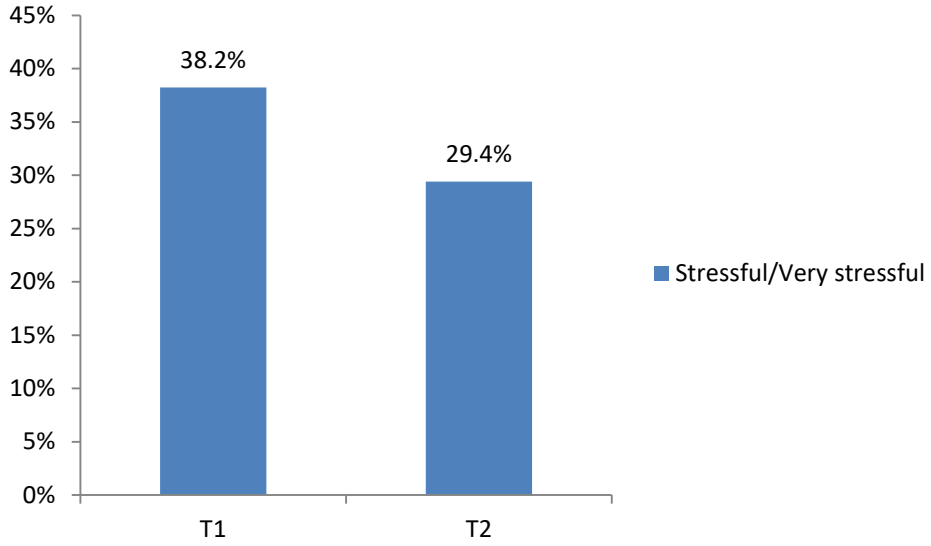
The majority of staff asked to consider a redeployment opportunity in the last three months ended up in that role either on a voluntary or involuntary basis at Time 2 (60%; Figure 10).

Figure 10: Outcome of redeployment request at Time 2



Of those who were redeployed (n = 863) prior to Time 1, 38% found their new role stressful or very stressful (Figure 11). For those who were redeployed in the three months before Time 2 (n=466), high levels of stress during their redeployment were less common (29%).

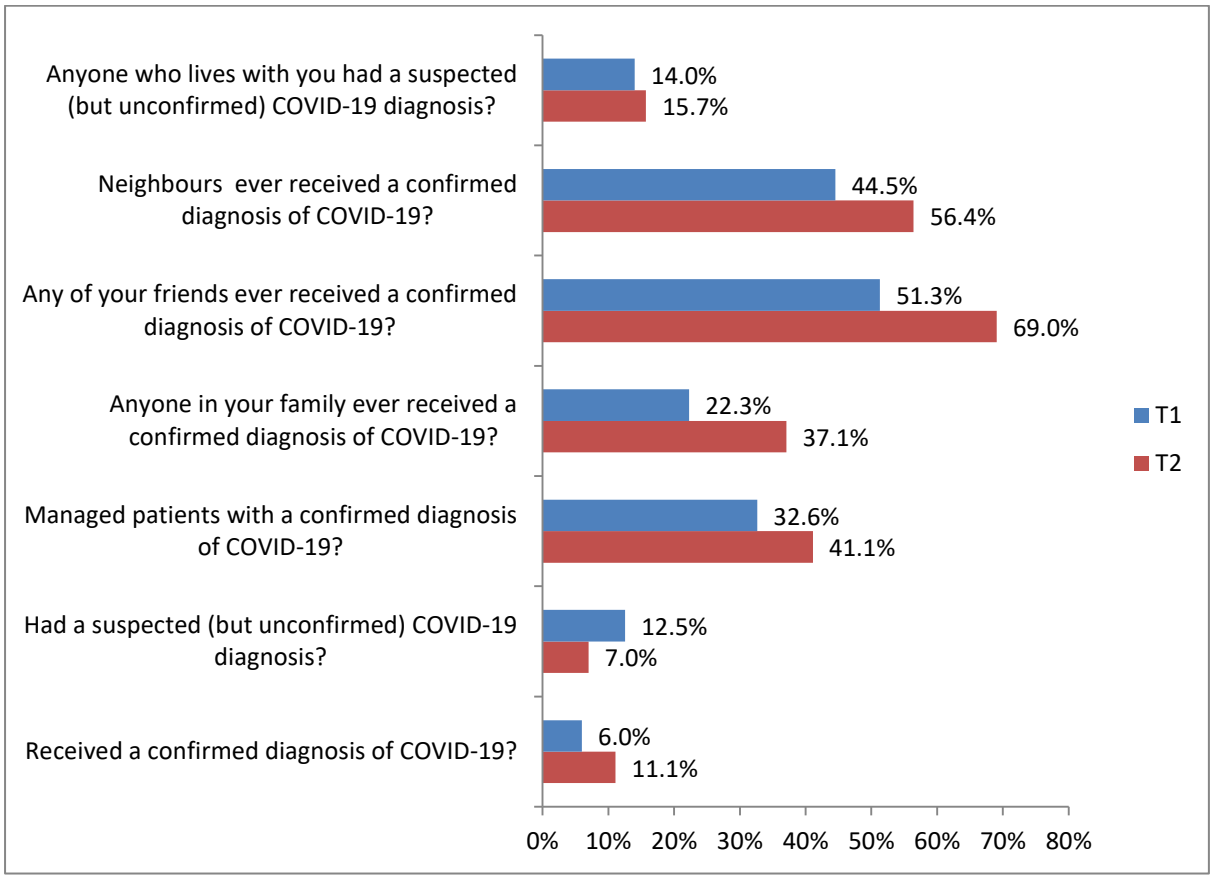
Figure 11. Experience of being redeployed at Times 1 and 2



3.4 COVID Risk Exposure

Amongst the Time 2 respondents, 11% reported having received a confirmed COVID-19 diagnosis, with fewer (7%) suspecting (no confirmation) that they had had COVID-19 (Figure 12). Four in ten respondents (41%) managed patients with confirmed COVID-19 diagnoses. Participants also commonly reported knowing friends (69%), neighbours (56%) and family members (37%) with confirmed COVID-19 diagnoses. Compared to Time 1, the proportion of people reporting yes to each aspect of COVID-19 exposure increased across all indices expect for suspected diagnoses for either the respondent (decreased) or someone they lived with (no change).

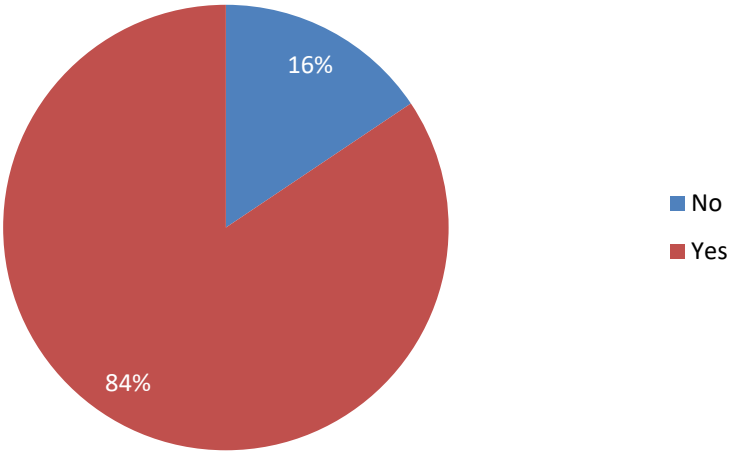
Figure 12. Exposure to COVID 19



The proportion of repondents who reported personally knowing someone who had died as a result of COVID-19 was 22% at Time 1 and 37% at Time 2.

The vast majority (84%) of respondents reported that they had received at least one COVID-19 vaccine (Figure 13).

Figure 13. Proportion of respondents who reported having been vaccinated at Time 2.



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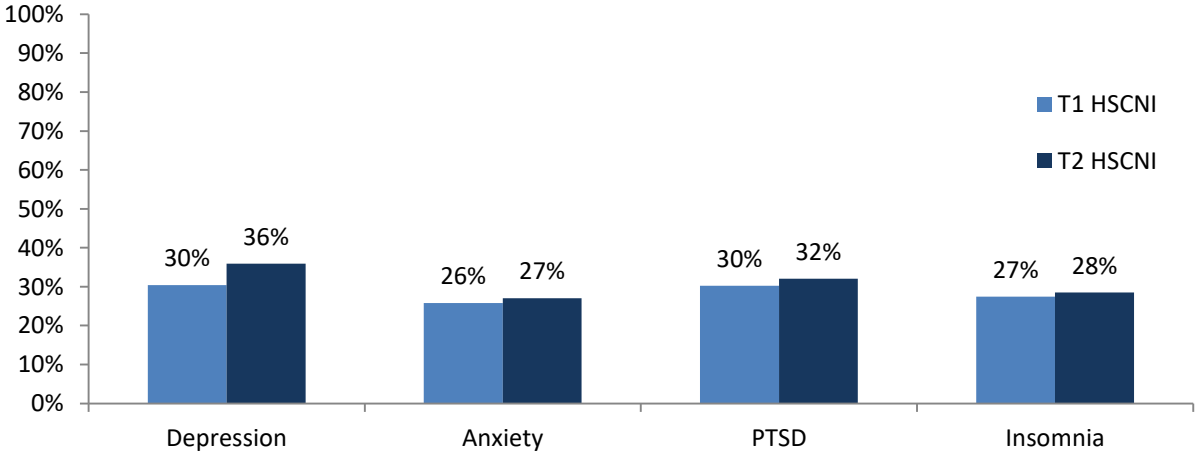
3.5 Psychological wellbeing

Prevalence of moderate to severe psychological wellbeing difficulties

The survey included four validated psychological wellbeing measures (depression, anxiety, PTSD, and insomnia). Figure 14 shows the proportion of staff who self-reported symptoms in the moderate to severe range on these measures at Times 1 & 2. The time comparisons suggest that the overall level of moderate to severe psychological wellbeing difficulties remained high between November 2020 and February 2021, with a slight increase in the proportion reporting moderate to severe depression.

Consistent with Time 1 analyses, communication emerged as the strongest predictor of staff wellbeing in the Time 2 statistical models. Vaccination uptake, a new variable introduced at Time 2, did not demonstrate a signifcant relationship with staff wellbeing.

Figure 14. Proportion of sample self-reporting moderate to severe psychological wellbeing symptoms

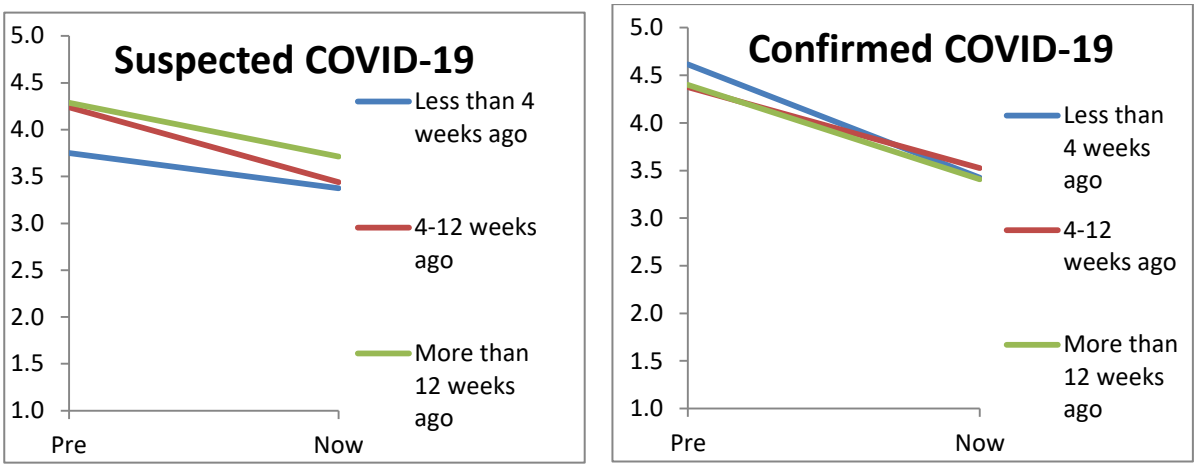


3.6. Long COVID

At Time 2, those who reported a confirmed or suspected COVID-19 diagnosis were asked to rate their physical health before symptom onset and at the time of survey completion. They rated their health on a 5 point scale (1 = very poor, 2 = poor, 3=acceptable, 4 = good, 5 very good). Average scores are presented on Figure 15 broken down by whether the participants symptoms started less than 4 weeks ago, 4-12 weeks ago, or more than 12 weeks ago. According to NICE guidelines (18th December 2020) the length of time COVID-19 symptoms have been present for can be designated as follows: *Acute COVID-19* – up to four weeks; *Ongoing symptomatic COVID-19* – 4-12 weeks; *Post-COVID-19 syndrome* – more than 12 weeks and not explained by an alternative diagnosis. 'Long COVID' includes both *Ongoing symptomatic COVID-19 and Post-COVID-19 syndrome*.

For suspected COVID-19 cases deteriorations in physical health were reported for those whose symptoms started less than 4 weeks ago (down 0.38), 4-12 weeks ago (down 0.80), or more than 12 weeks ago (down 0.58). For those with confirmed COVID-19 diagnoses physical health worsened to a greater extent for all three time categories: less than 4 weeks ago (down 1.19), 4-12 weeks ago (down 0.85), or more than 12 weeks ago (down 0.99). Of note, for confirmed COVID-19 diagnoses who had experienced symptoms 12 weeks or more ago, the average reduction represented the equivalent of going from having good/very good health (4.4 score) to acceptable/good health (3.4 score).

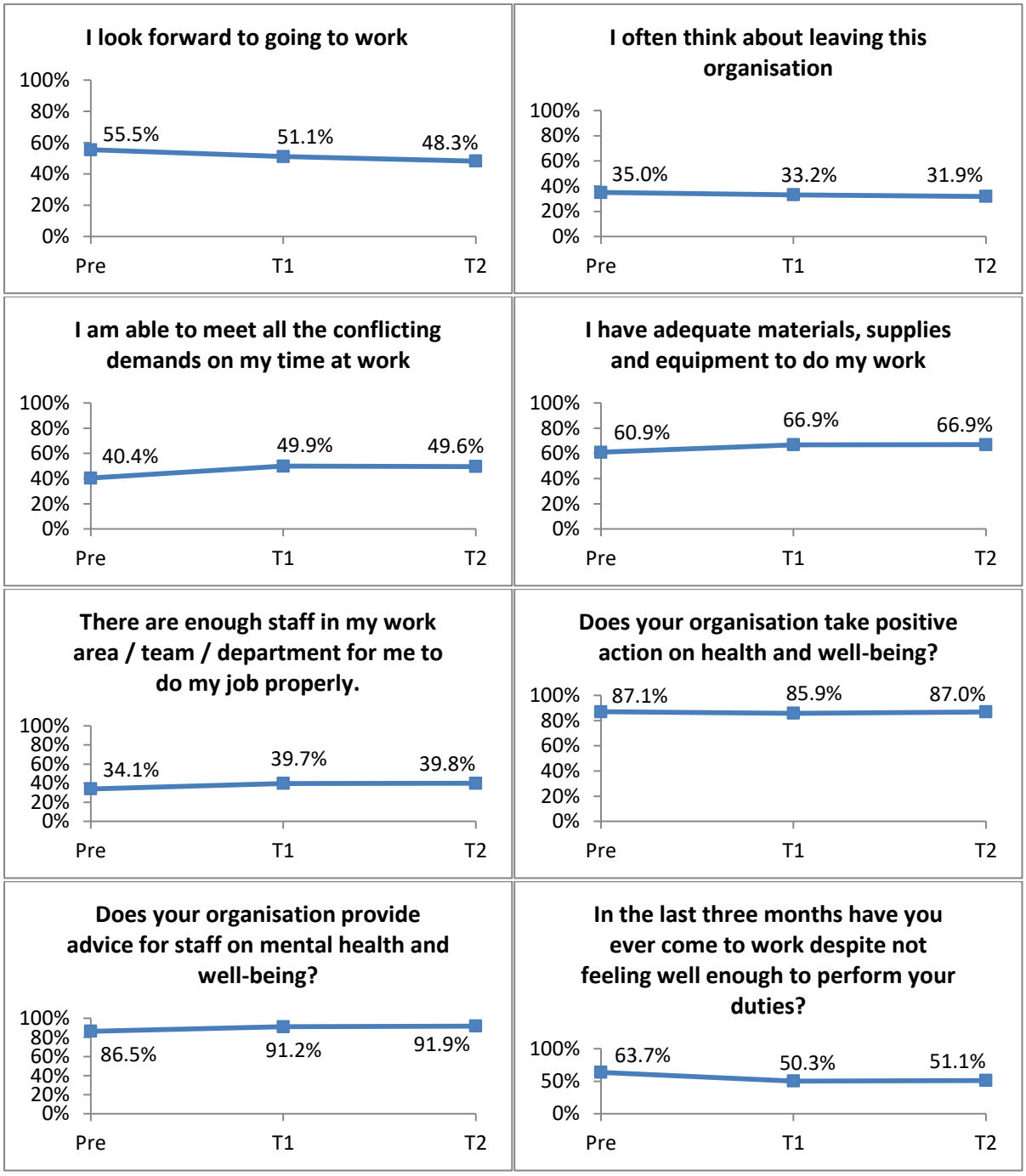
Figure 15: Average physical health scores for individuals with suspected or confirmed COVID-19 diagnoses (before diagnosis vs now)



3.7 Pre-post COVID-19 comparisons

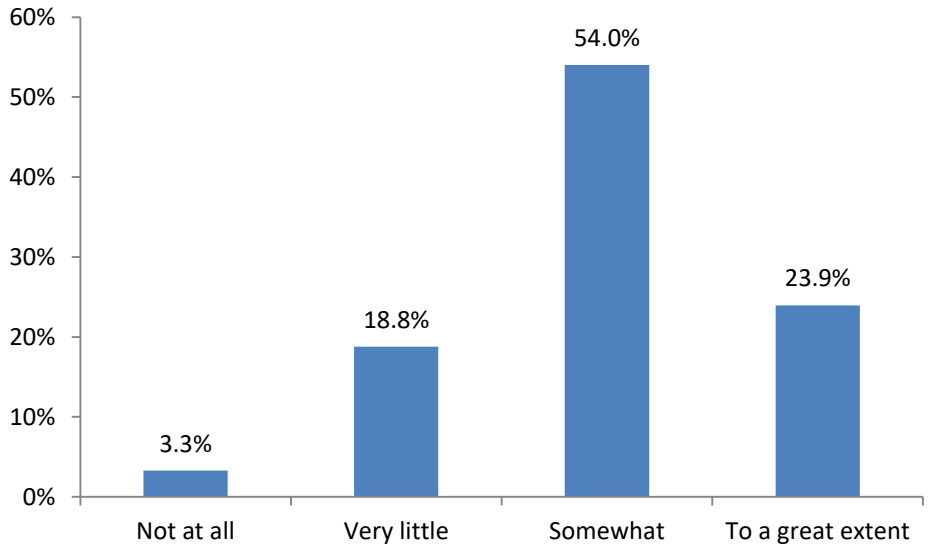
Eight questions from the 2019 HSCNI staff survey were included in the COVID-19 Wellbeing survey to allow pre-post COVID-19 comparisons on things like job satisfaction, access to resources, and how HSCNI deals with staff health and wellbeing (Figure 16). From Time 1 to Time 2 the proportion of people who 'look forward to going to work' dropped by 3 percentage points. However, for the other questions the results were stable between Time 1 and 2.

Figure 16. Pre and post COVID-19 survey comparisions



Participants were asked ‘how much has your psychological wellbeing been affected by your experience of the COVID-19 pandemic?’ (Figure 17). Over three quarters (78%) felt that their wellbeing had been affected somewhat/to a great extent at Time 2.

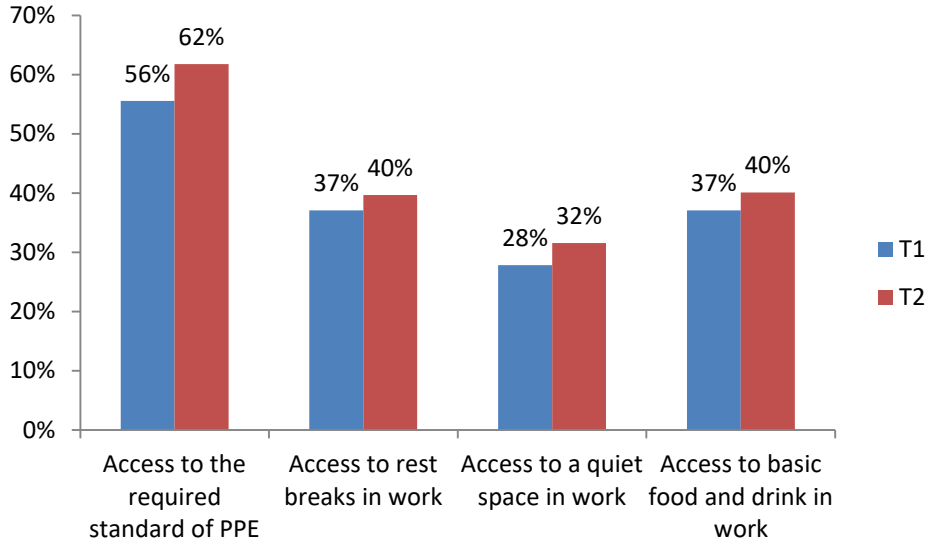
Figure 17. Effect of COVID-19 pandemic on psychological wellbeing at Time 2



3.8 Environmental needs

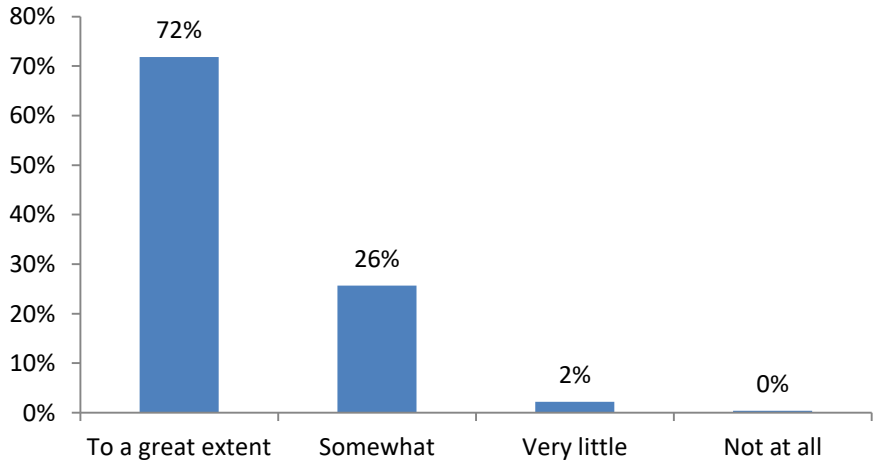
HSC staff felt that access to the required standard of PPE, rest breaks in work, a quiet space in work, and basic food and drink in work improved between November 2020 and February 2021 (Figure 18).

Figure 18. Access to basic needs during at Time 1 & 2 (% good/very good)



At Time 2 staff were asked to what extent have health and social care staff been following government and HSCNI guidance on Infection Prevention & Control and use of Personal Protective Equipment (e.g. use of face coverings, social distancing); the majority of respondents (72%) felt that health and social care staff had been following the guidelines to a great extent.

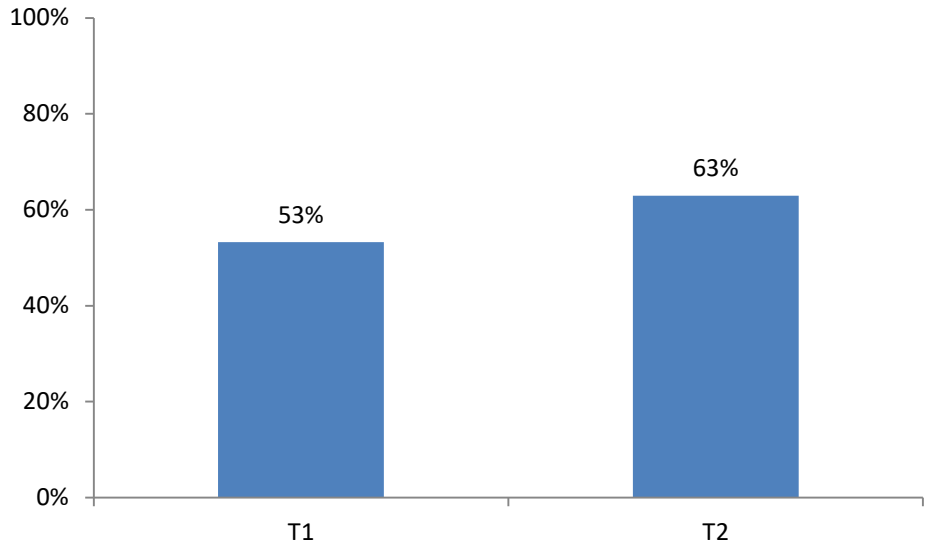
Figure 19: Perceived staff adherence to guidelines at Time 2



3.9 Communication

Staff were asked how effective communication from their organisation on COVID-19 related matters had been in the months prior to Times 1 & 2 (Figure 20). Of note, communication was highlighted as being the strongest predictor of psychological wellbeing amongst health and social care staff in at Times 1 & 2. At Time 1 around half of respondents (53%) felt that communication from their organisation had been effective or very effective; this proportion rose to 63% at Time 2

Figure 20. Communication effectiveness in relation to COVID-19 related matters from respondents organisation at Time 1 and 2.

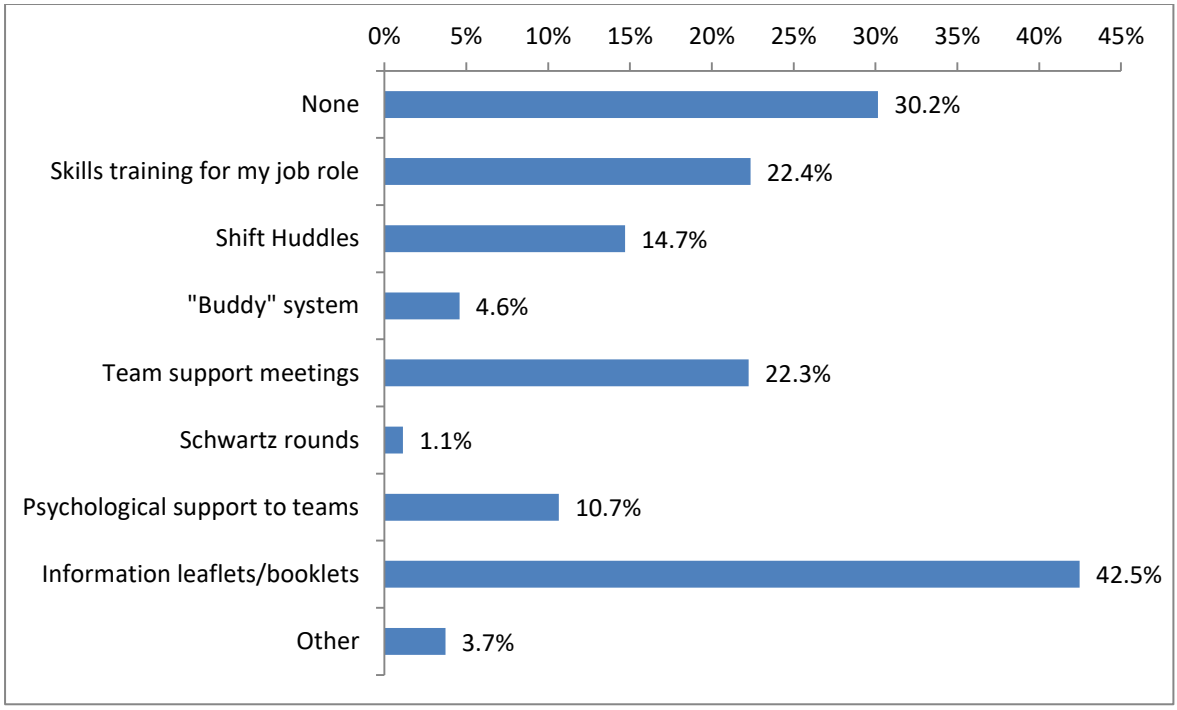


3.10 Support

Team supports

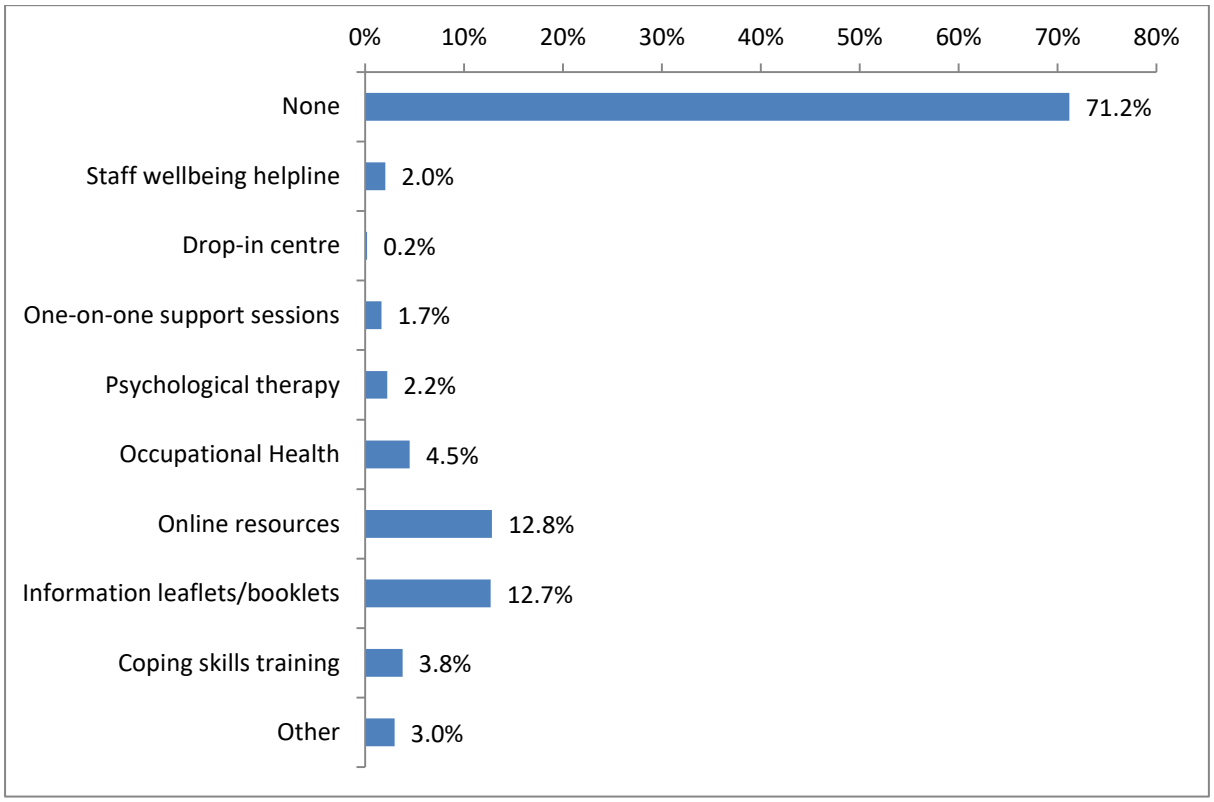
The participants were asked which team supports were made available within their service during the three months before Time 2 (Figure 21). The most common types of team supports used were Information sheets/booklets (43%), skills training for their role (22%) and team support meetings (23%).

Figure 21. Team supports available within respondent's service during the COVID-19 pandemic (Time 2)



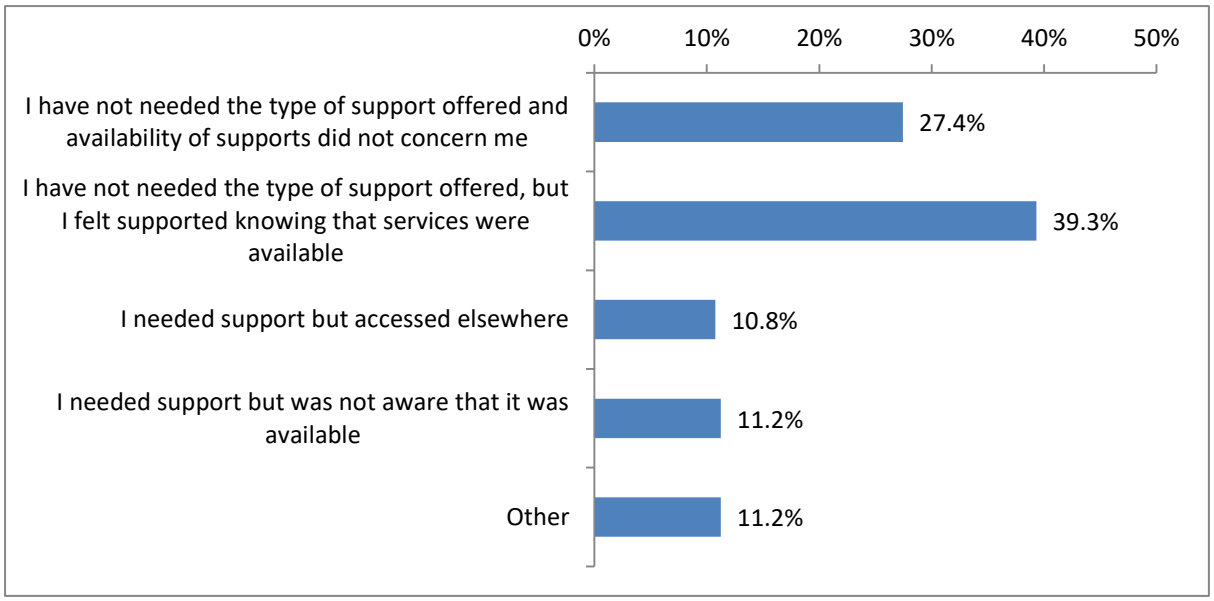
The particpants were then asked if they used any staff wellbeing supports during the 3 months before Time 2 (Figure 22). At Time 2, a slightly higher proportion (71%) said they had used none of the supports offered, compared to Time 1 (68%). For those who did use some form of support, online resources and information leaflets/booklets where the most common types of support used at Time 2

Figure 22. Staff wellbeing supports used during the COVID-19 pandemic



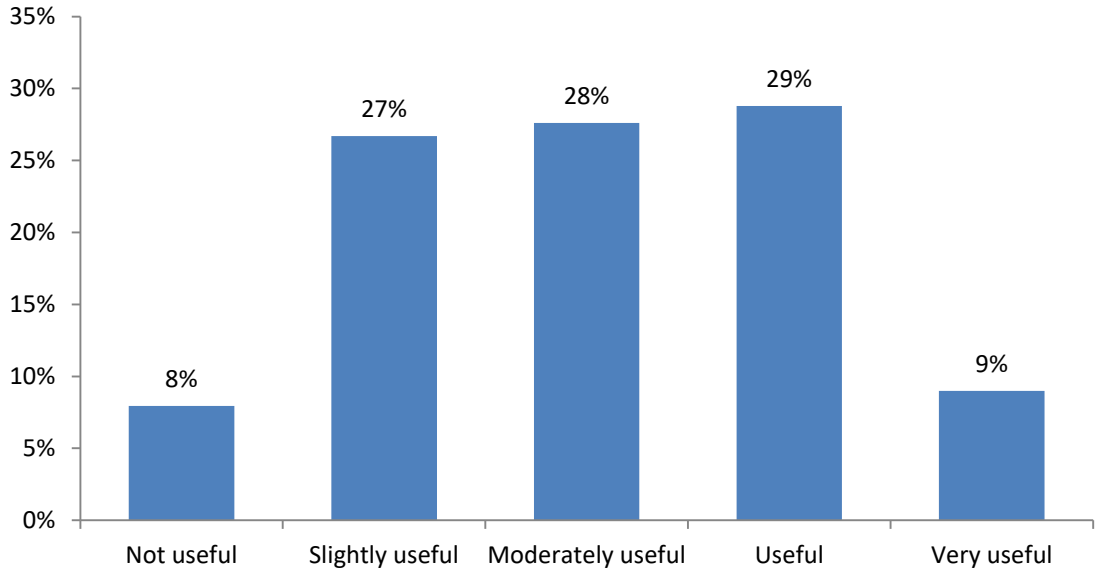
Those who ticked ‘none’ were asked why they did not use any supports in the three months before Time 2 (Figure 23). Most participants reported not needing support or being able to get support elsewhere when needed. It is interesting to note that 39% did not need any support but felt reassured just by knowing that support was available. However, it is concerning that some respondents did say they needed support but were not aware that it was available (11%).

Figure 23. Reasons for not using supports during the COVID-19 pandemic at Time 2



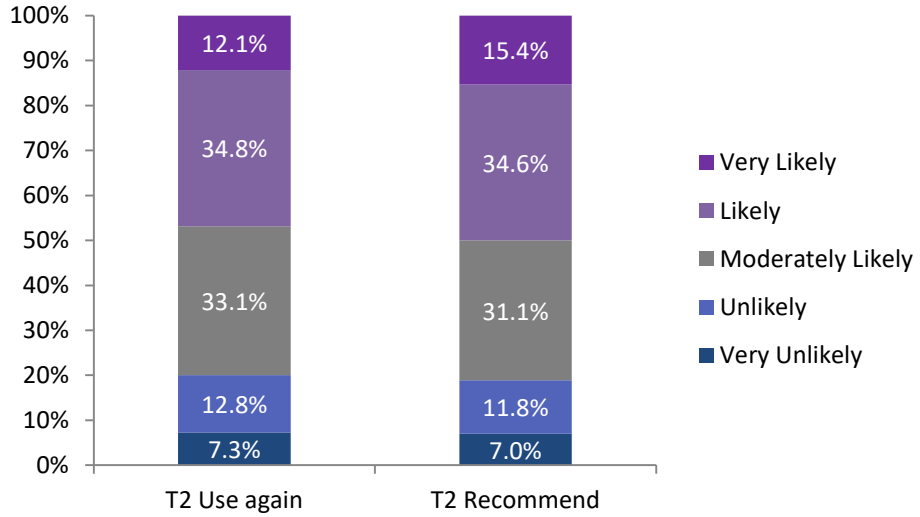
Amongst those who had used some form of support at Time 2 (n=768), 38% found it useful or very useful (Figure 24).

Figure 24. Usefulness of support used at Time 2.



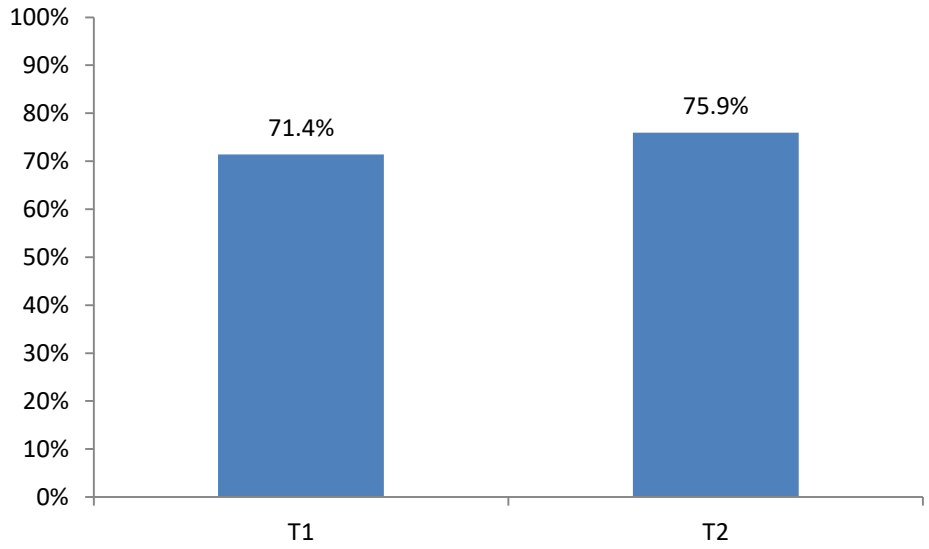
After using the supports (Time 2), many were likely or very likely to say they would use them again (47%) or recommend them to a friend or a work colleague (50%; Figure 25).

Figure 25: Likelihood of using supports again or recommending them at Time 2



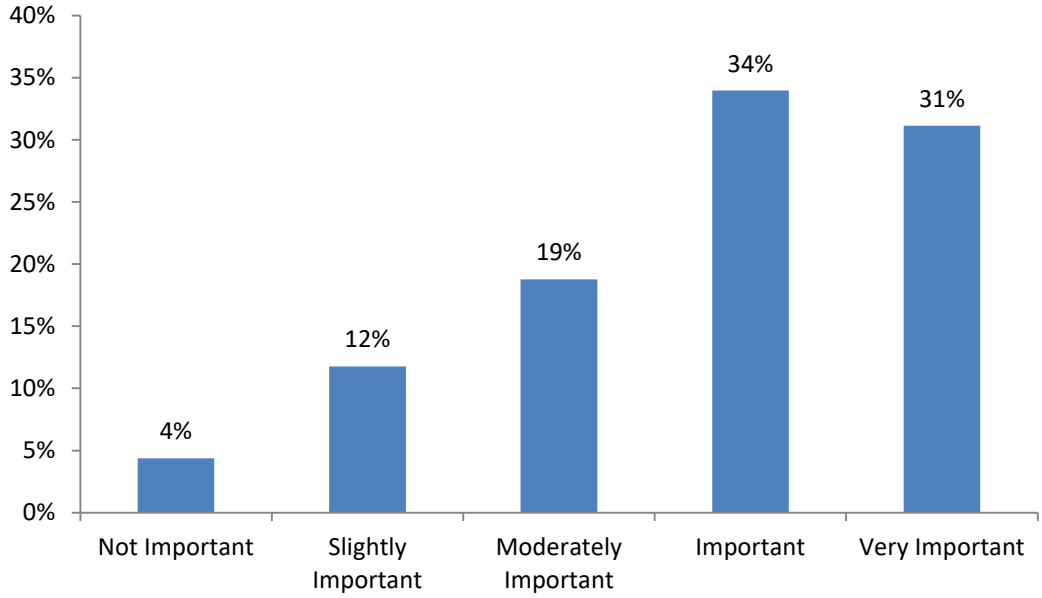
The majority (71%) of health and social care staff were somewhat or greatly aware of the staff wellbeing supports available to them within their organisation (Figure 26) at Time 1, and this proportion in increased further at Time 2 to 76%.

Figure 26: Awareness of staff wellbeing support available within their Trust at Times 1 & 2



Having staff wellbeing support available within their organisation was important or very important for 65% of staff at Time 2 (Figure 27).

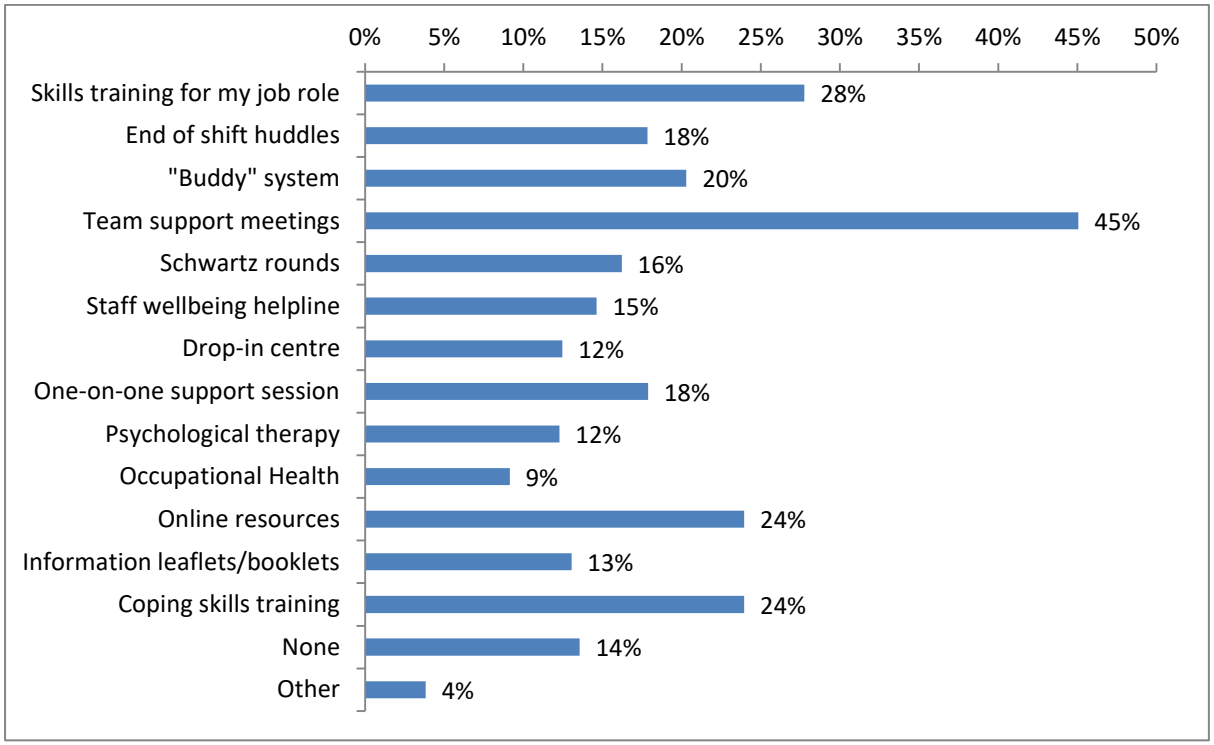
Figure 27: Perceived importance of support at Time 2



Future support

To help the health and social care organisations to plan future health and wellbeing provision for HSCNI staff, the survey participants were asked what support would they find most useful in managing their wellbeing in the coming weeks (Figure 28). Small reductions in demand for 'Buddy' system (T1 = 23%; T2 = 20%) and the Staff Wellbeing Helpline (T1 = 18%; T2 = 15%) were seen over time.

Figure 28. Future support needs at Time 2



4.1. Psychological wellbeing by organisation

The proportion of staff with moderate to severe self-reported depression, anxiety, PTSD, and insomnia a Time 2 is shown by organisation in Figures 29-32. In the absence of statistical data (e.g. confidence intervals, statistical tests including covariates) comparisons between levels of psychological wellbeing issues should not be drawn between trusts.

Figure 29: Proportion of HSCNI staff with moderate to severe self-reported depression at Time 2

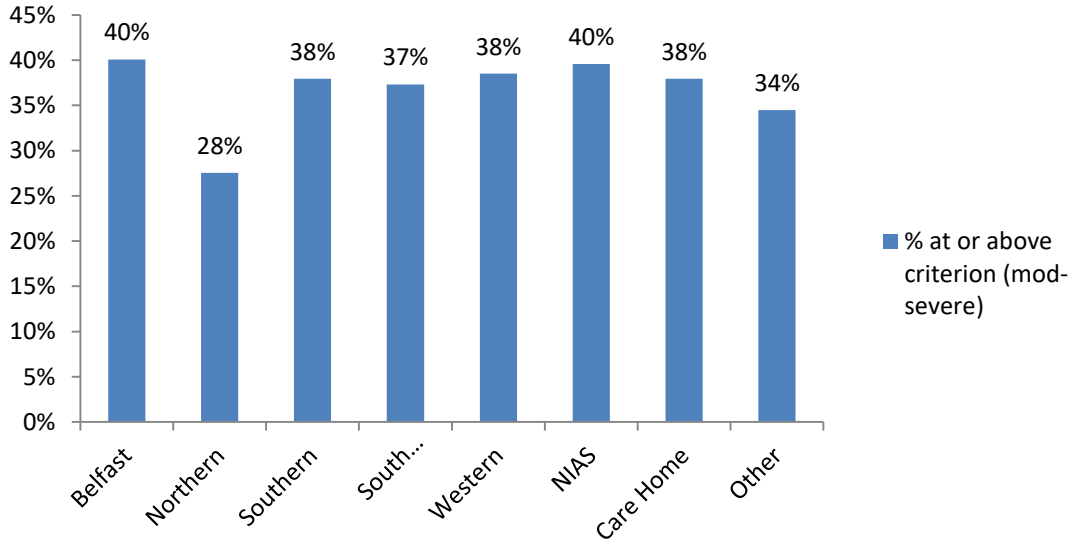


Figure 30: Proportion of HSCNI staff with moderate to severe self-reported anxiety at Time 2

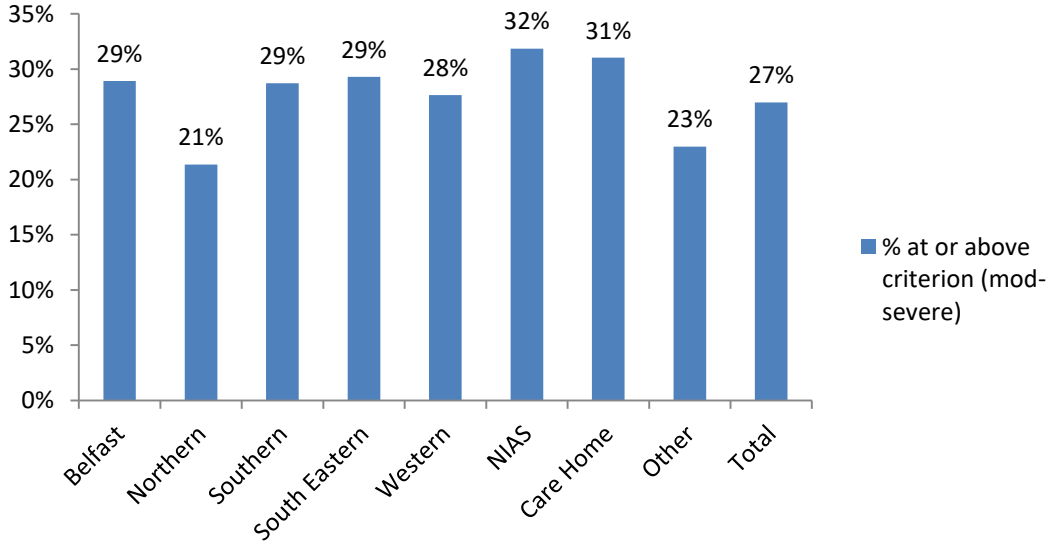


Figure 31: Proportion of HSCNI staff with moderate to severe self-reported PTSD at Time 2

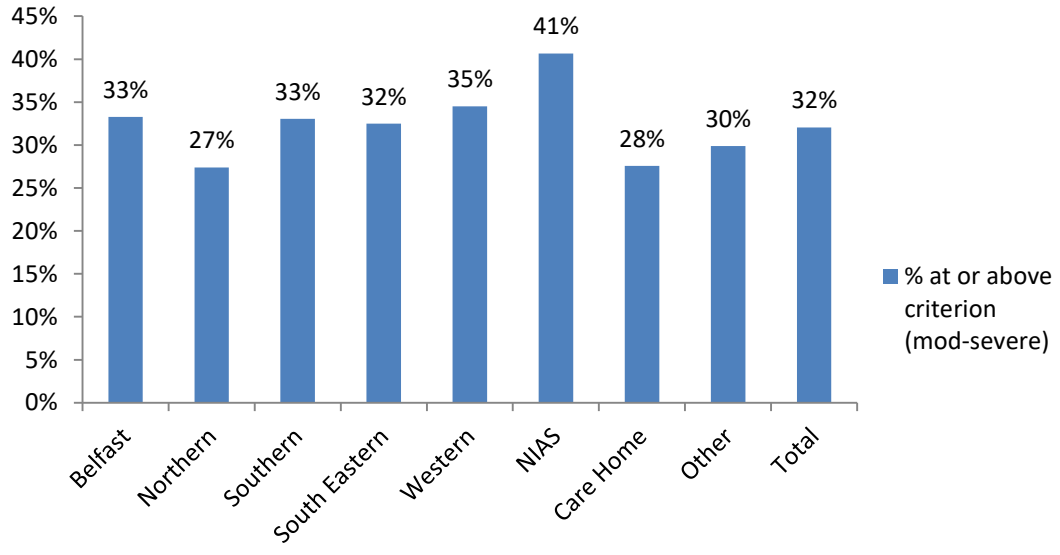
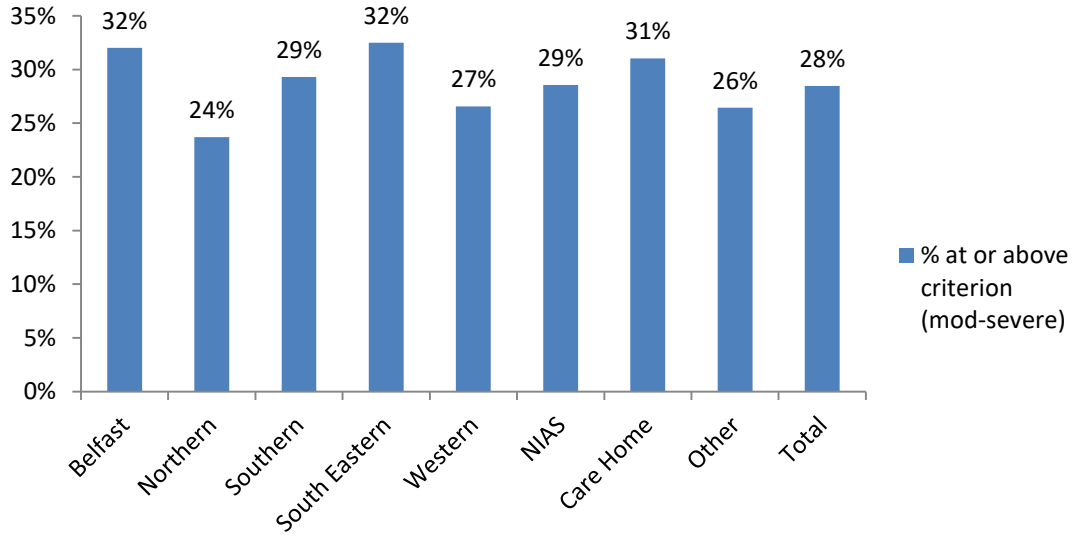


Figure 32: Proportion of HSCNI staff with moderate to severe self-reported insomnia at Time 2



5.1 Recommendations

Our Time 1 report had a number of important recommendations and nothing in this report contradicts these original recommendations. To reiterate in the light our new data:

1. There are continued high levels of distress within the staff group and recovery may be prolonged in this respect. We recommend the continued working of the regional staff support group.
2. The fact that there has been no “vaccine bounce’ in terms of mental health and wellbeing is important. The majority of our sample had at least one dose of the vaccine but this did not impact on mental health and wellbeing measures. Organisations can’t rely on vaccination as a wellbeing strategy – multiple innovative approaches are needed.
3. Our previous report highlighted the importance of clear, frequent and transparent communication. We note that many of the organisations involved in this study have made great strides in this respect. Our Time 2 report supports the continued importance of communicating during this pandemic.
4. It is clear many organisations involved in the study have improved the manner in which redeployment is discussed and executed (e.g. clear communication, appropriate redeployment, necessary training and mitigation of risk by providing appropriate PPE and vaccination). Anxiety regarding redeployment has reduced but needs to be handled appropriately and sensitively by organisations.
5. Some staff are using and valuing the range of supports on offer. However, it is also clear that we need to continue to innovate in reaching more staff in need. Staff have given clear opinions regarding the range of future supports they think they need and this should inform future provision.
6. The physical consequences of having COVID-19 have emerged in this time point as a significant issue for some staff. It would seem important for occupational health departments in organisations to be aware of these issues and develop appropriate responses. We will continue to monitor its possible effects on mental health in the coming survey time points.

Our Vision

To deliver excellent integrated services in partnership with our community

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