Northern Health and Social Care Trust

Impact Research Centre

COVID-19 Wellbeing Survey

Time 3 Findings

Version 3: 17th June 2021

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1.1 Executive Summary

This report outlines the results of the third time point of the Northern Ireland COVID-19 Staff Wellbeing Survey that we carried out during May 10-30th 2021. In total, 2,480 health and social care staff from across Northern Ireland took part at Time 3.

The survey included four validated psychological wellbeing measures (depression, anxiety, Post–Traumatic Stress Disorder (PTSD), and insomnia). Levels of distress within the workforce were still high (depression 28%; anxiety 23%; PTSD 23%; Insomnia 26%) at Time 3. Whilst levels are still high, compared to Time 2 there was a significant reduction in the proportion of staff reporting moderate to severe symptoms of depression (down 8 % points) and post-traumatic stress (down 9 % points). On the eight indices adopted from Pre-COVID-19 staff survey, all showed relatively stable results between Times 2 & 3.

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 was made in relation to this recommentation, between Time 1 and 2, and this gain was maintained at Time 3.

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. Following this a lower portion of staff reported being worried/very worried about redeployment at Time 2. This improvement was maintained at Time 3.

Our Time 3 results show that consideration should be given to the wellbeing needs of those who were diagnosed with COVID-19 more than 12 weeks ago, as there was a tendency for these staff to report that their physical and mental health had not recovered to pre-COVID 19 diagnosis levels.

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

1. While levels of poor staff wellbeing showed significant improvement, figures remain high. We recommend the continued focus on staff support at a regional and Trust level.
2. 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 since the first time point of our survey. Our Time 3 report supports the continued importance of communication during this pandemic and evidences that progress has been maintained.
3. 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. Again, our Time 3 report evidences that progress has been maintained in this regard.
4. 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.
5. Our Time 3 results show that consideration should be given to the wellbeing needs of those who were diagnosed with COVID-19 more than 12 weeks ago. Any services being developed for staff with long term consequences of COVID-19 should include the provision of psychological interventions addressing the mental health consequences.

2.1 COVID-19 Staff Wellbeing survey

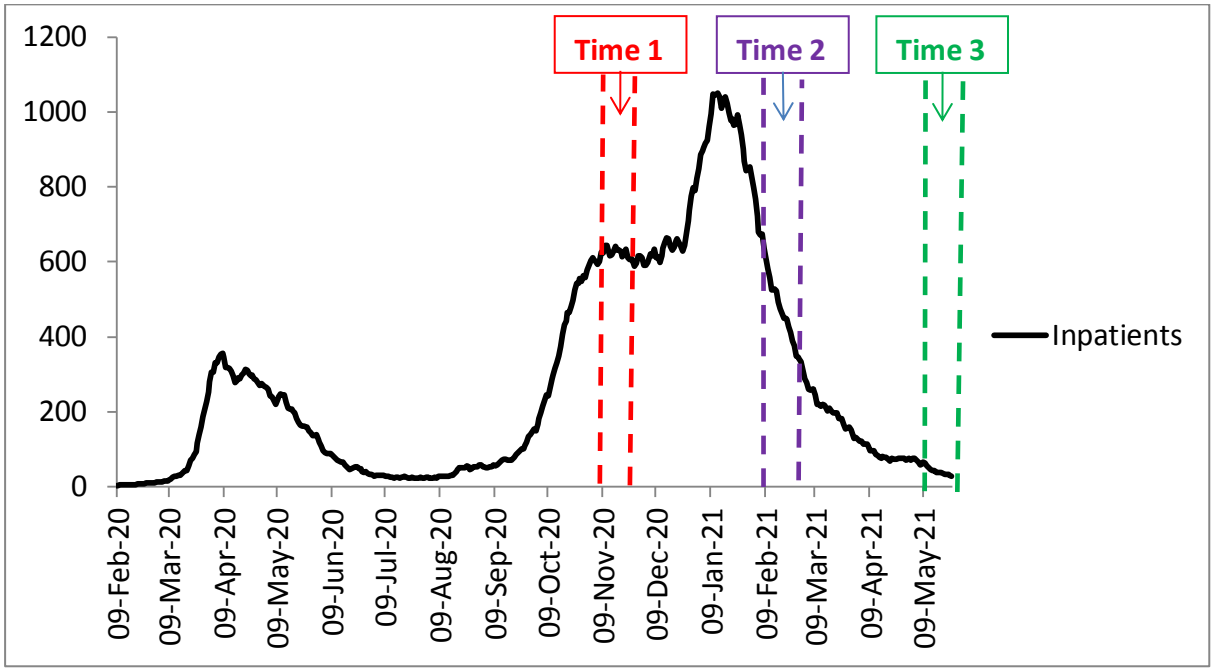
The COVID-19 Staff Wellbeing survey was carried out by Northern Health and Social Care Trust (NHSCT); Belfast Health and Social Care Trust (BHSCT), Southern Health and Social Care Trust (SHSCT), South Eastern Health and Social Care Trust (SEHSCT) and Western Health and Social Care Trust (WHSCT). The 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 third time point of the survey (May 10-30th 2021) are presented in this report.

The survey will run on one further occasion (August 2021). This will allow us to track the impact of the COVID-19 outbreak on staff over time.

Figure 1 shows that Time 1 and 2 coincided with the second and third surges of COVID-19 inpatient admissions in Northern Ireland. By contrast Time 3 took place when COVID-19 inpatient levels were much lower.

Figure 1: COVID-19 Inpatient Statistics Northern Ireland



2.2 Achieved sample and 95% confidence intervals

In total, 2,480 health and social care staff from across Northern Ireland took part in Time 3 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 +/-1.99%. For the smallest subsample analysis, that involving the 270 who had been redeployed, the precision level for a proportion of 50% was +/- 6.12% (95% Confidence intervals)

2.3. Analysis strategy

The Time 1, 2 and 3 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; Time 3 = 2,480). This report focuses on comparisons between Time 2 and 3. In Section 3.1 it is highlighted that the demographic profile of the sample was similar at Times 2 & 3, 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=616) of participants who took part at both Times 2 & 3 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 February and May 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. Differences between Time 2 and 3 are highlighted in this report for effect sizes of .15 (Cohen's d) or greater. Note; 0.2 is considered to be a small effect size.

2.4 Format of the report

Sections 3.1 – 3.10: Findings for overall sample at Time 3 are presented. In some instances both Time 1, 2 and 3 results are presented (e.g. where there is some evidence of change over time). Where trends were stable between Times 2 & 3, only Time 3 results are presented except where it was necessary to illustrate that improvements made between Times 1 & 2 were maintained.

Section 4.1: Psychological wellbeing data by organisation

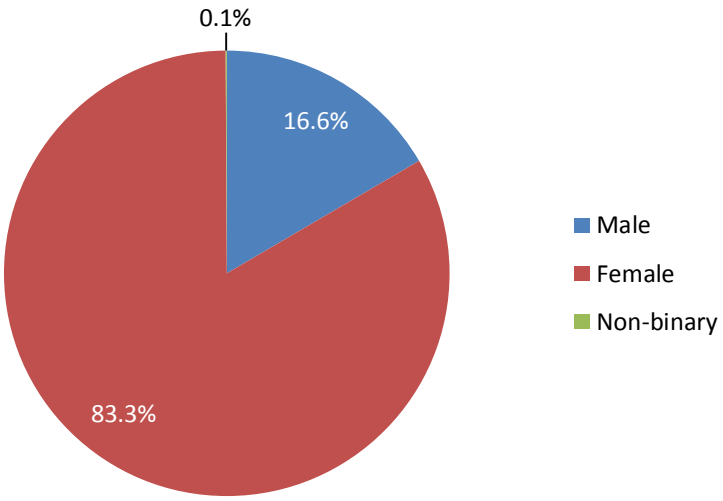
Section 5.1: Recommendations

3.1 Who took part?

Age & gender

Of the 2,480 health and social care staff that took part at Time 3, the vast majority of respondents were female (83%; Figure 2). The average age of respondent was 45 years, and the sample included individuals aged 18-76 years.

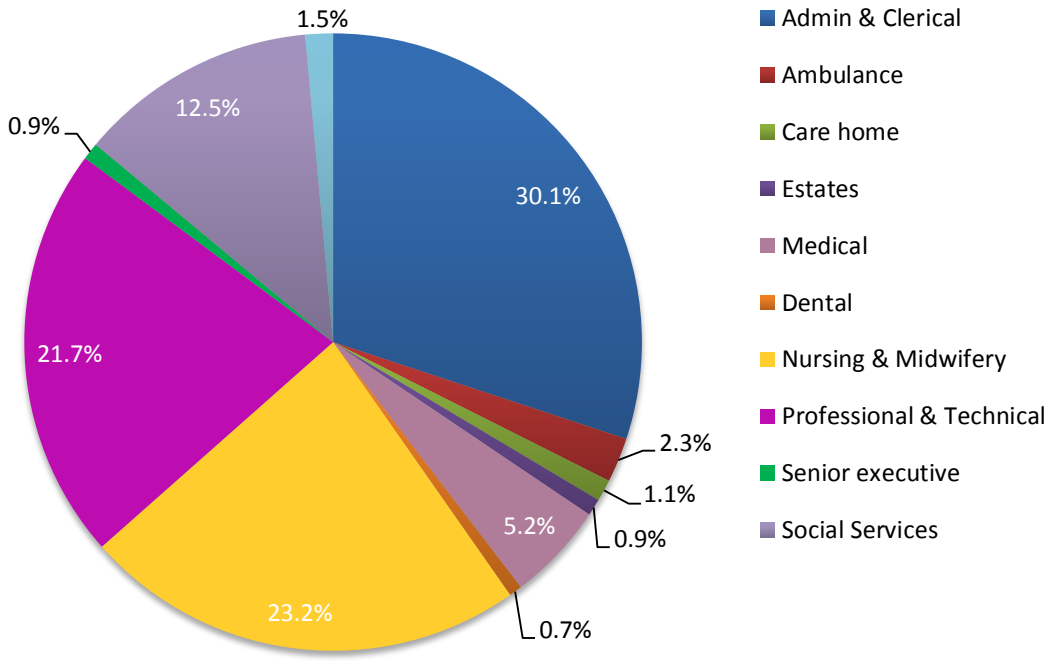
Figure 2: Gender breakdown of respondents at Time 3



Occupation

Figure 3 shows that a large proportion of the sample worked in *administrative and clerical* (30%), *nursing and midwifery* (23%), and *professional and technical* (22%) roles.

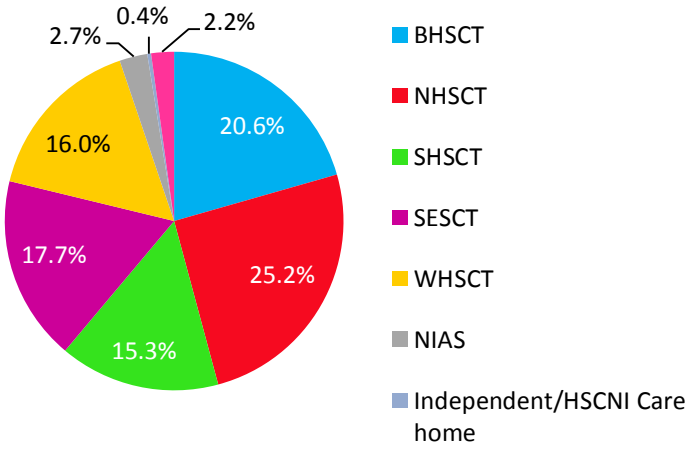
Figure 3: Occupation breakdown of respondents at Time 3



HSCNI Trust/Organisation

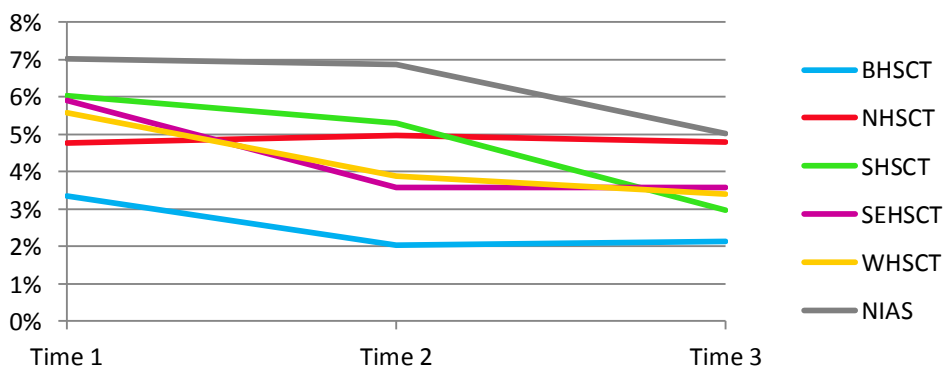
The HSCNI Trust/Organisation that the respondents reported belonging to is shown in Figure 4. Of the 2,480 participants, the numbers of staff who took part in each Trust at Time 2 are as follows: SHSCT (n=380); NHSCT (n=626); BHSCT (n=510); WHSCT (n=397); SEHSCT (n=438); NIAS (n=66).

Figure 4: HSCNI Trust/Organisation of respondents at Time 3



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 3, NIAS had the highest response rate (5.0%), followed by NHSCT (4.8%), WHSCT (3.4%), SEHSCT (3.6%), SHSCT (3.0%), and BHSCT (2.1%). Compared to Time 2, the response rates for most trusts were similar at Time 3 (Figure 5). A drop in response rate of 1.8 % points for NIAS and 2.3 % points for SHSCT was seen between Times 2 and 3. Detailed descriptives by HSCNI Trust/organisation are presented in Section 4.

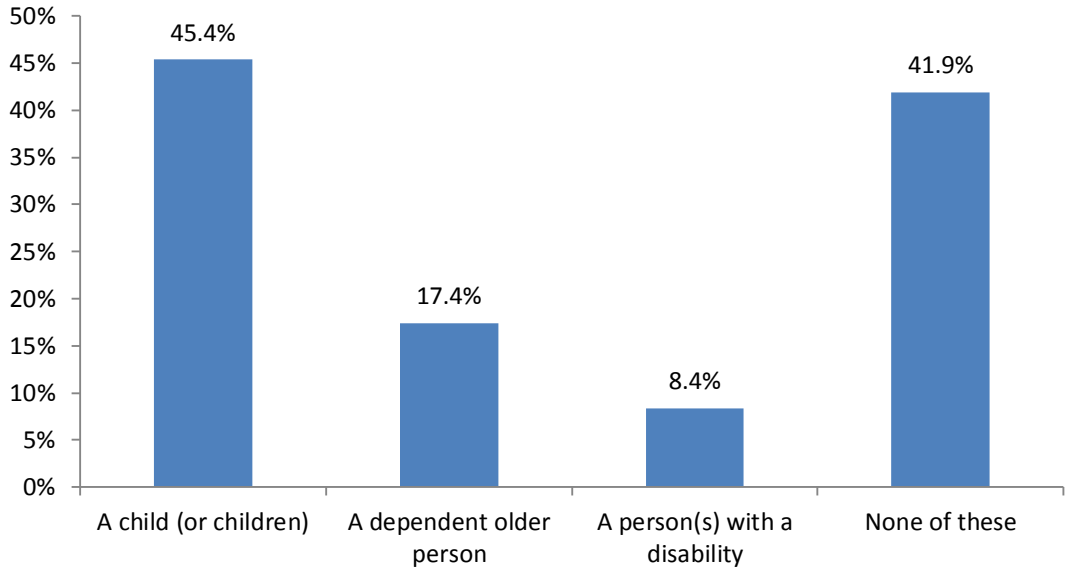
Figure 5: HSCNI Trust/Organisation of respondents at Time 3



Dependants

The majority of respondents (58%) identified at least one dependant that they had caring responsibilities for (Figure 6).

Figure 6. Caring responsibilities of respondents at Time 3



Profile of the sample over time

The Time 1 - 3 samples had broadly 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 the six trusts followed different patterns over time.

3.2. Looking after Dependants during the COVID-19 outbreak

Amongst Health and Social Care (HSC) staff with children who took part at Time 3 (n = 1,125), 47% reported that it was challenging or very challenging to provide home schooling in the three months prior to the survey (before May 2021; Time 3), a reduction of 8 % points compared to the three months prior to February 2021 (Time 2)

Figure 7. Proportion of respondents who found it difficult to home school prior to Time points 1, 2 & 3

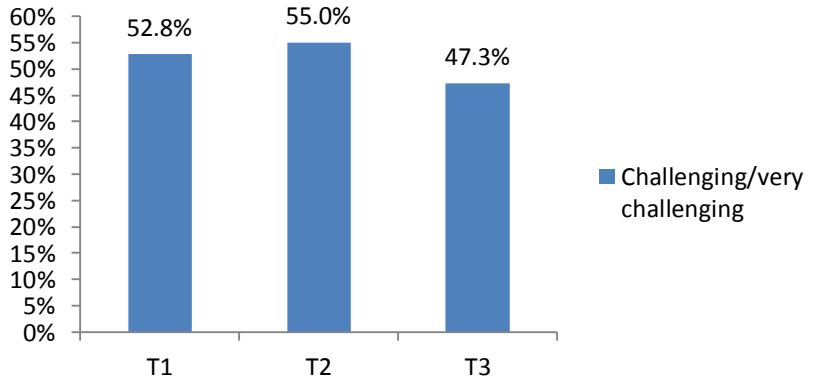
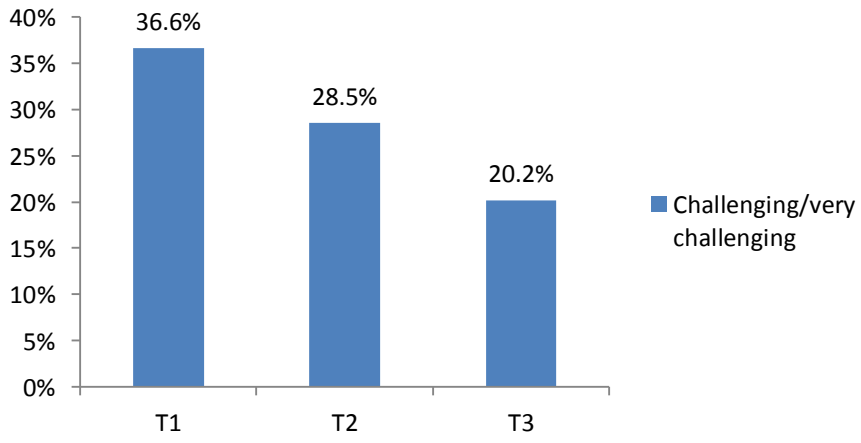


Figure 8 shows for HSC staff with children, the proportion who found it challenging or very challenging to arrange childcare declined from November 2020 (Time 1; 37%) though to May 2021 (Time 3; 20%).

Figure 8. Proportion of respondents who found it difficult to arrange childcare prior to Time points 1, 2 & 3

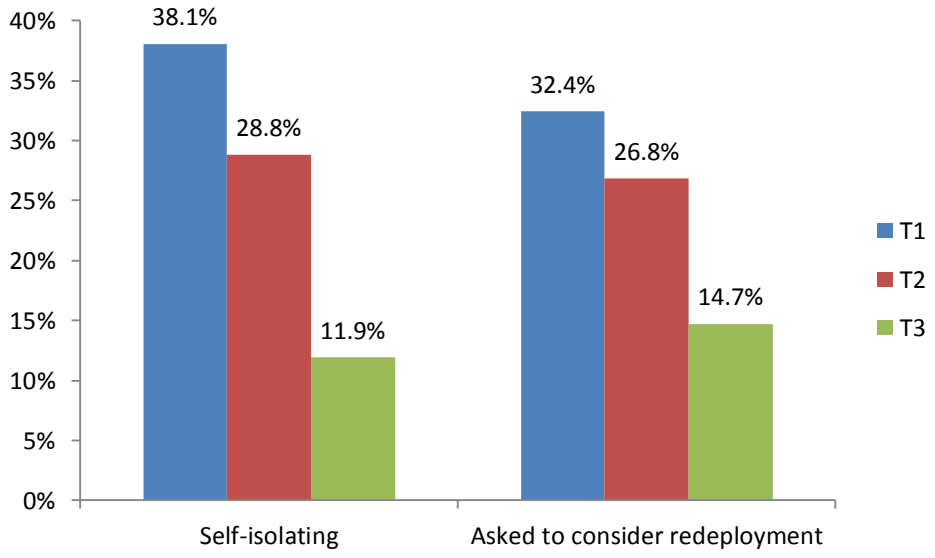


3.3 Changes in work patterns

The Time 3 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 3 they had worked from home, self-isolated, shielded, or considered a redeployment opportunity; 53% of staff reported having worked from home and 4% reported shielding at some stage during this period.

The proportion of people who had to self-isolate or consider a redeployment opportunity declined throughout November 2020 – May 2021 (Times 1 to 3; Figure 9).

Figure 9. Working arrangements during the COVID-19 outbreak at Times 1 - 3.



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 10). 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%), and this reduction was maintained at Time 3 (32%).

Figure 10. Views on redeployment at Times 1 - 3

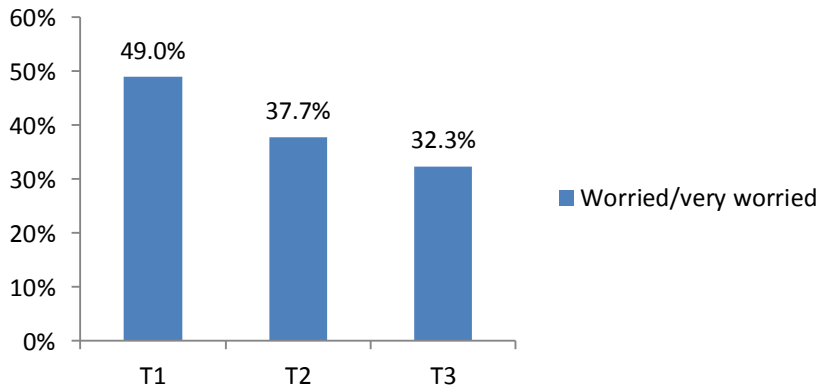
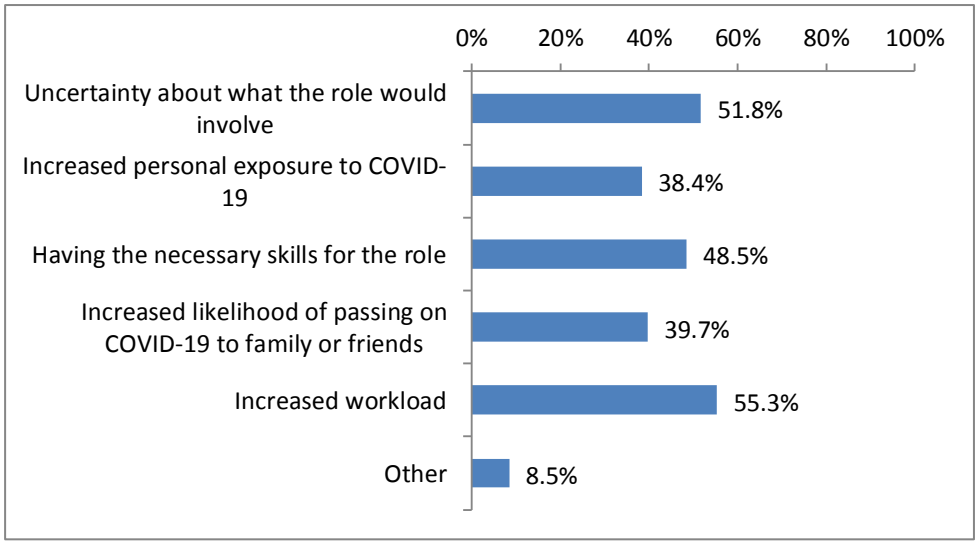


Figure 11 shows that redeployment concerned staff in many ways at Time 3 including uncertainty about what the role would involve (52%), increased personal exposure to COVID-19 (38%), having the necessary skills for the role (48%), increased likelihood of passing on COVID-19 to family or friends (40%), and increased workload (55%).

Figure 11. Concerns about redeployment at Time 3

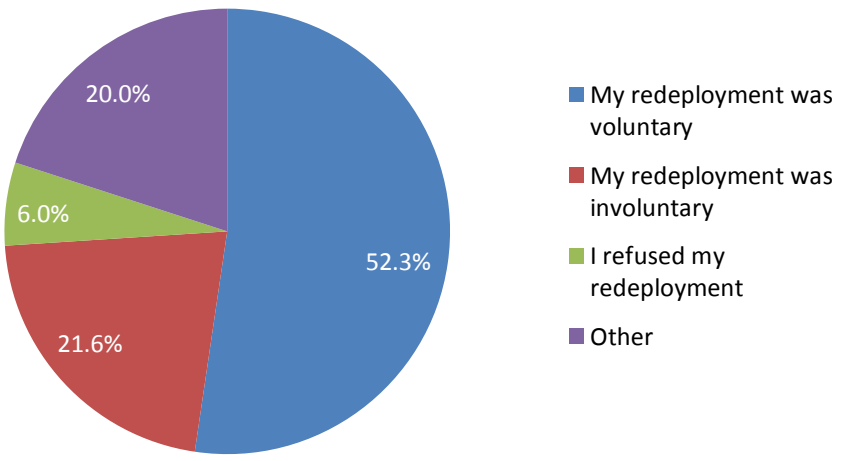


At Time 3 participants who had been asked to consider a redeployment opportunity in the last three months were asked where that request came from. Most reported receiving the request from their line manager/supervisor (61%); however, requests via email from their organisation (27%) or from their senior management (49%) were also very common (Figure 12).

Figure 12. Who asked the participant to consider a redeployment opportunity at Time 3

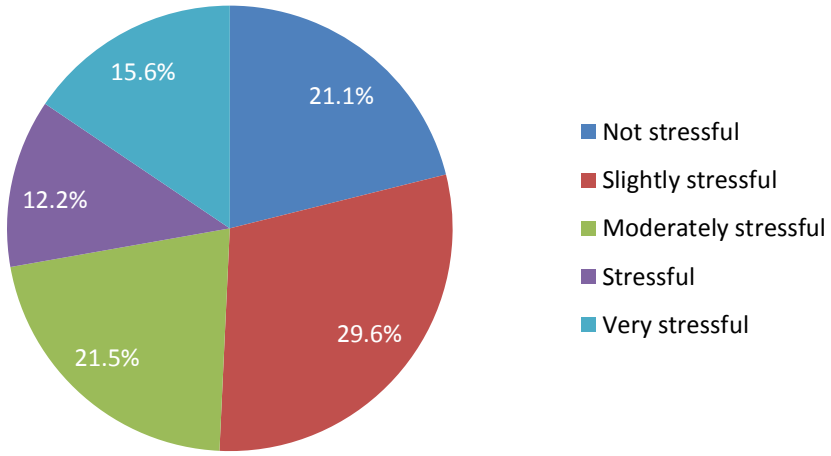
The majority of staff asked to consider a redeployment opportunity in the last three months ended up in that role either on a voluntary or involuntary basis at Time 3 (74%; Figure 13).

Figure 13: Outcome of redeployment request at Time 3



For those who were redeployed in the three months before Time 3 (n=270), high levels of stress during their redeployment were reported by 28% of staff.

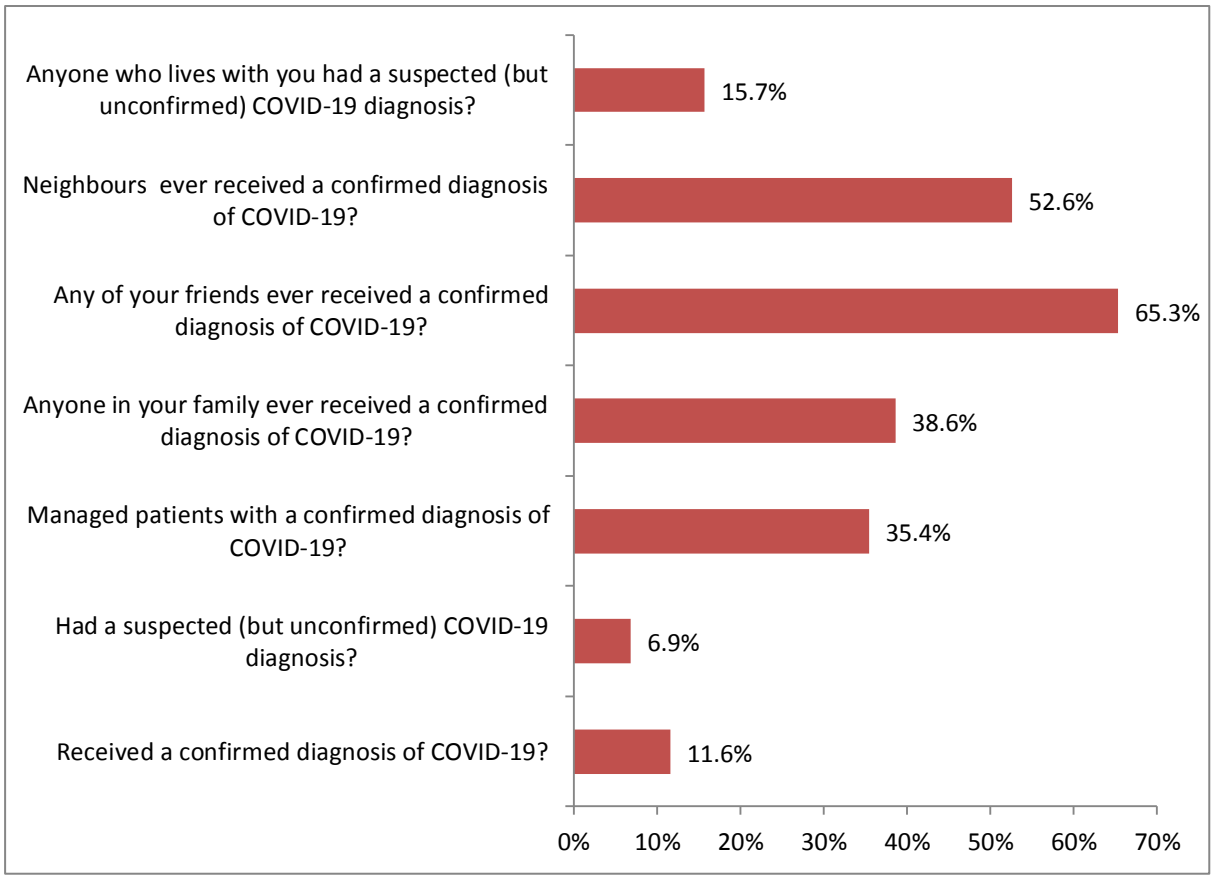
Figure 14. Experience of being redeployed at Time 3



3.4 COVID Risk Exposure

Amongst the Time 3 respondents, 12% reported having received a confirmed COVID-19 diagnosis, with fewer (7%) suspecting (no confirmation) that they had had COVID-19 (Figure 15). Over a third of respondents (35%) managed patients with confirmed COVID-19 diagnoses. Participants also commonly reported knowing friends (65%), neighbours (53%) and family members (39%) with confirmed COVID-19 diagnoses.

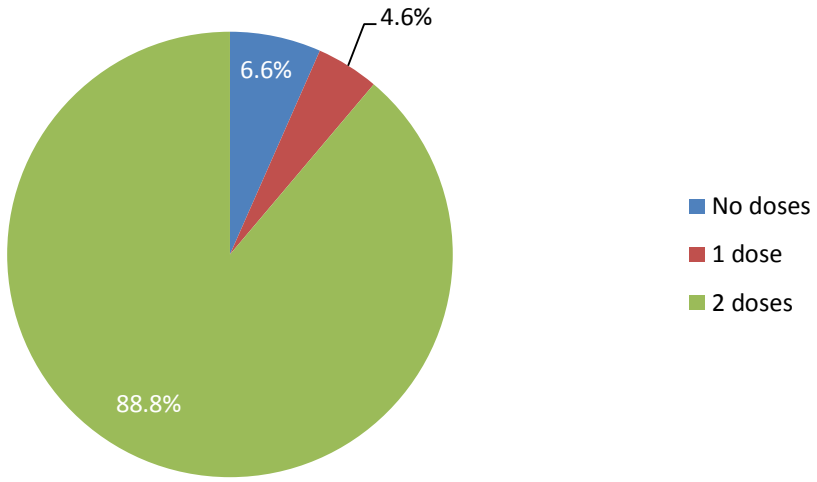
Figure 15. Exposure to COVID 19 at Time 3



The proportion of repondents who reported personally knowing someone who had died as a result of COVID-19 was 33% at Time 3.

The vast majority (89%) of respondents reported that they had received two doses of a COVID-19 vaccine as of May 2021 (Figure 16).

Figure 16. Proportion of respondents who reported having been vaccinated at Time 3.



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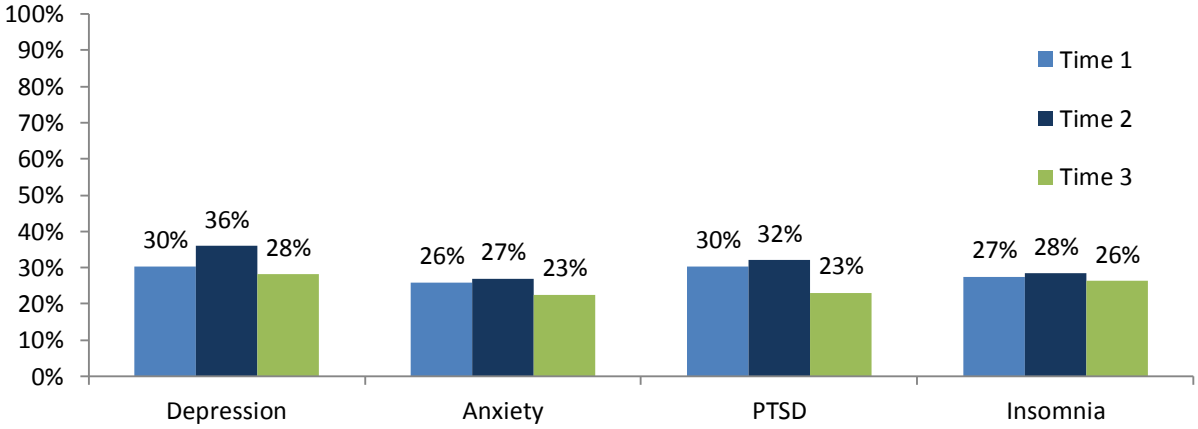
3.5 Psychological wellbeing

Prevalence of moderate to severe psychological wellbeing difficulties

The survey included four validated psychological wellbeing measures (depression, anxiety, PTSD, and insomnia). Figure 17 shows the proportion of staff who self-reported symptoms in the moderate to severe range on these measures at Times 1 - 3. Previous comparisons of Time 1 & 2, suggested that the overall level of moderate to severe psychological wellbeing difficulties remained high between November 2020 and February 2021, with very little change occuring. Comparisons between Time 2 and 3, revealed a significant reduction in the proportion of staff self-reporting moderate to severe symptoms of both depression and post-traumatic stress.

Figure 17. Proportion of sample self-reporting moderate to severe psychological wellbeing symptoms at Times 1-3

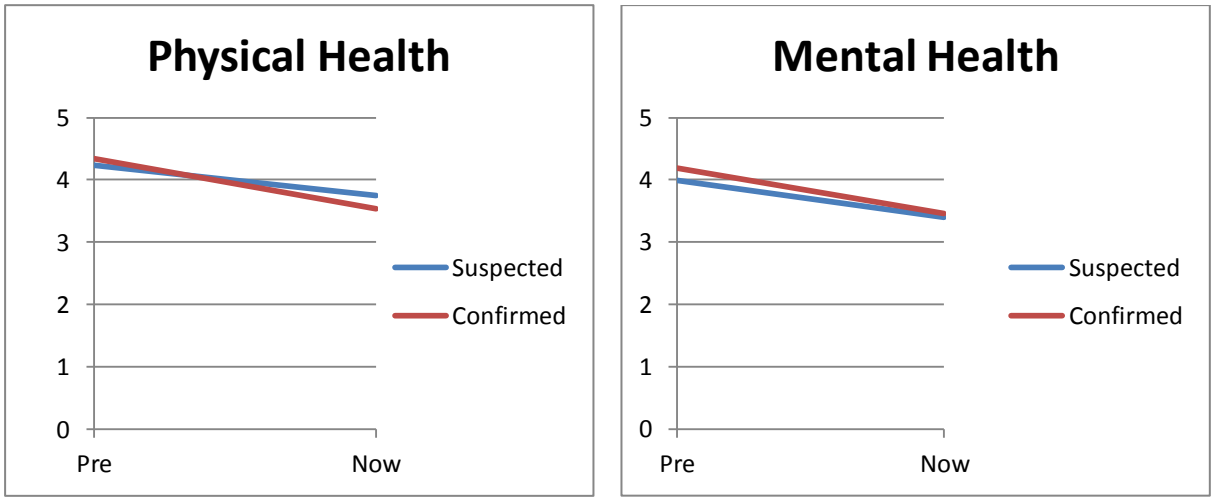


3.6. Long COVID

At Time 3, those who reported a confirmed or suspected COVID-19 diagnosis were asked to rate their physical and mental 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 18 broken down for participants whose symptoms started 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 those with *suspected* COVID-19 diagnoses commencing more than 12 weeks ago, deteriorations in both physical health (down .49) and mental health (down .60) were reported. These reductions were greater for those with *confirmed* COVID-19 diagnoses occuring more than 12 weeks ago for both physical health (down .81) and mental health (.73).

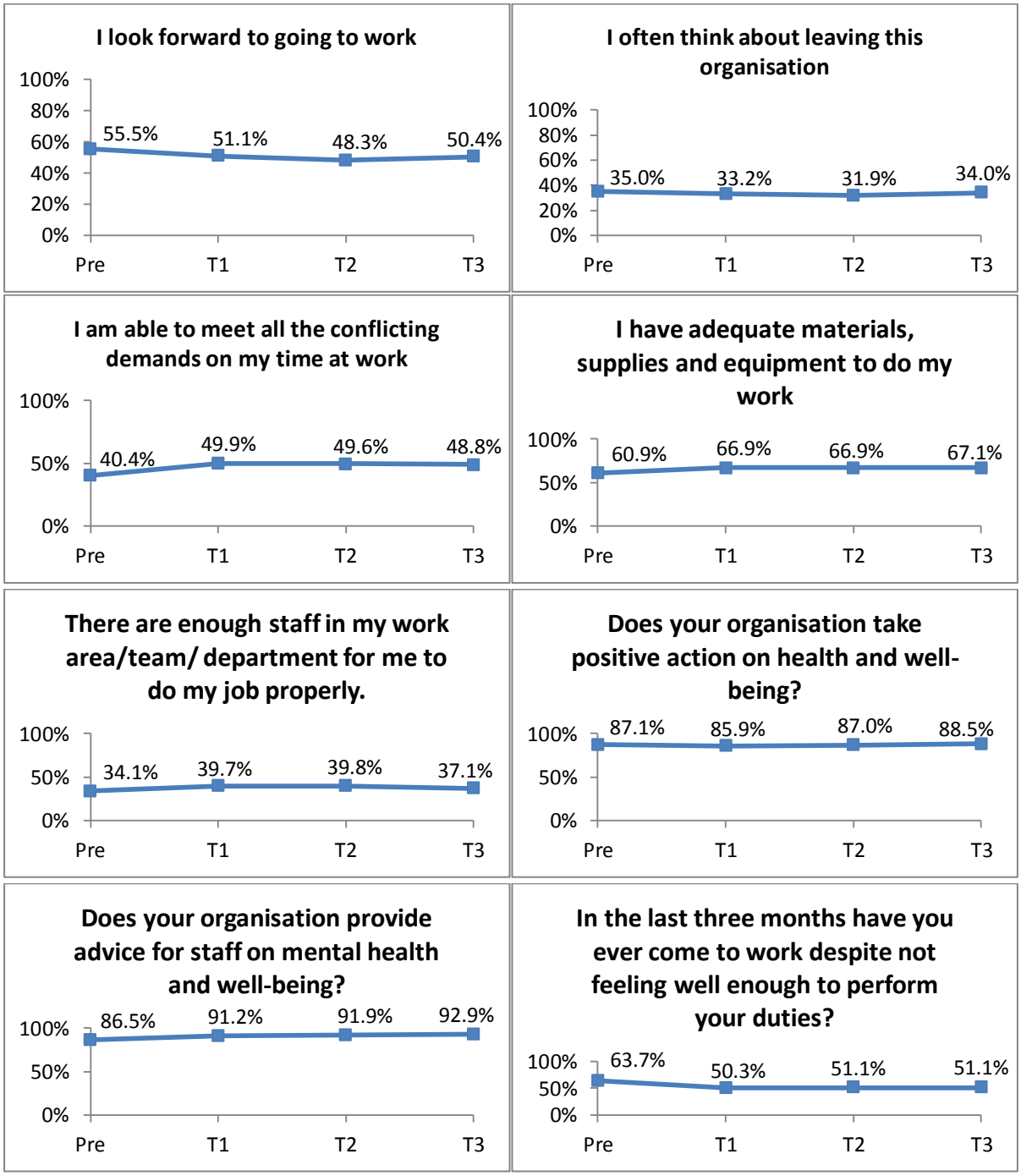
Figure 18: Average physical health scores for individuals with suspected or confirmed COVID-19 diagnoses (before diagnosis vs now)



3.7 Pre-post COVID-19 comparisons

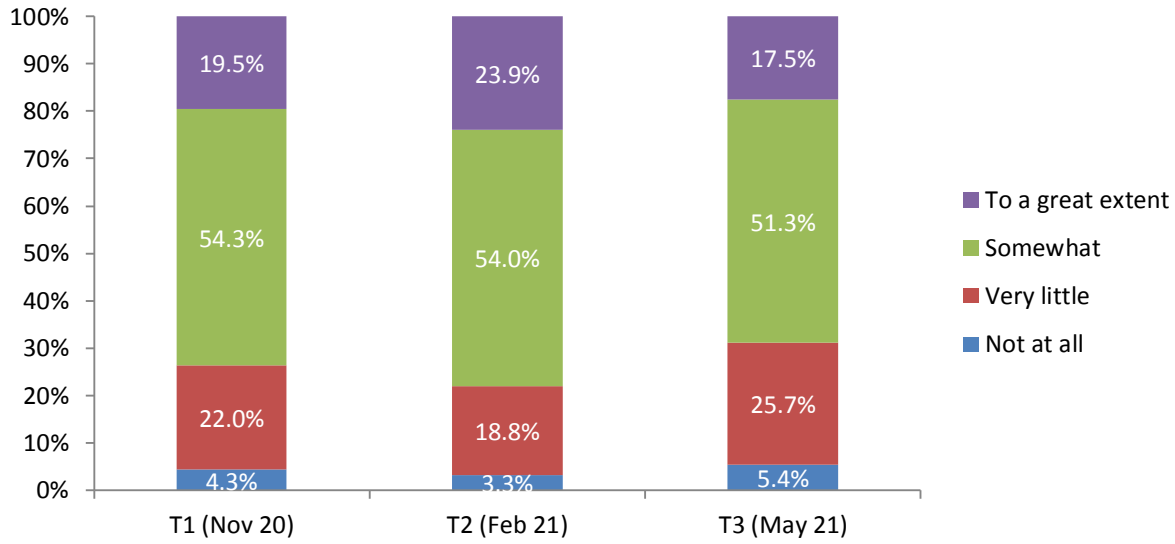
Eight questions from the 2019 HSCNI staff survey were included in the COVID-19 Wellbeing survey to allow pre-post COVID-19 comparisons on things like job satisfaction, access to resources, and how HSCNI deals with staff health and wellbeing (Figure 19). From Time 2 to Time 3 there was very little change in the level of agreement to the eight statements presented.

Figure 19. 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 20). Over three quarters (78%) felt that their wellbeing had been affected somewhat/to a great extent at Time 2. This proportion was lower after the 3rd surge of the COVID-19 pandemic had passed (69%; Time 3).

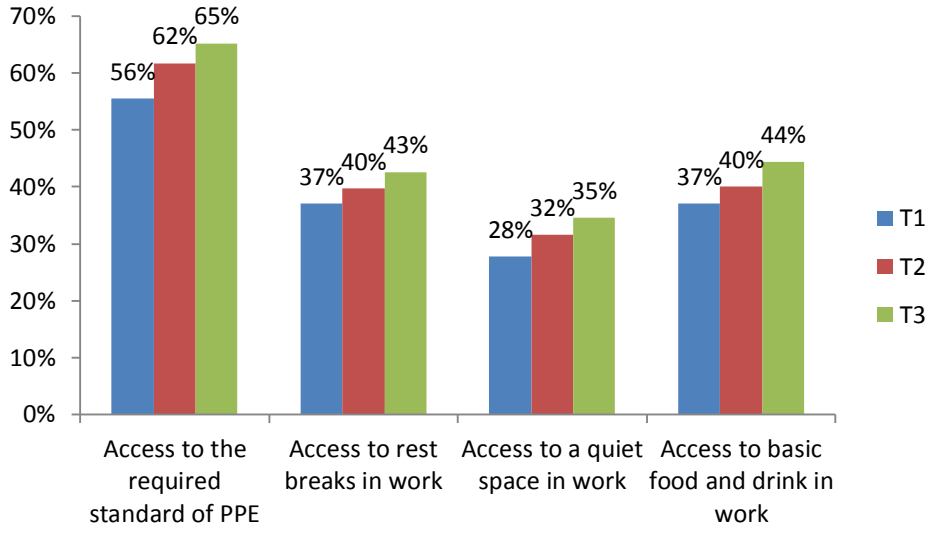
Figure 20. Effect of COVID-19 pandemic on psychological wellbeing at Time 1-3



3.8 Environmental needs

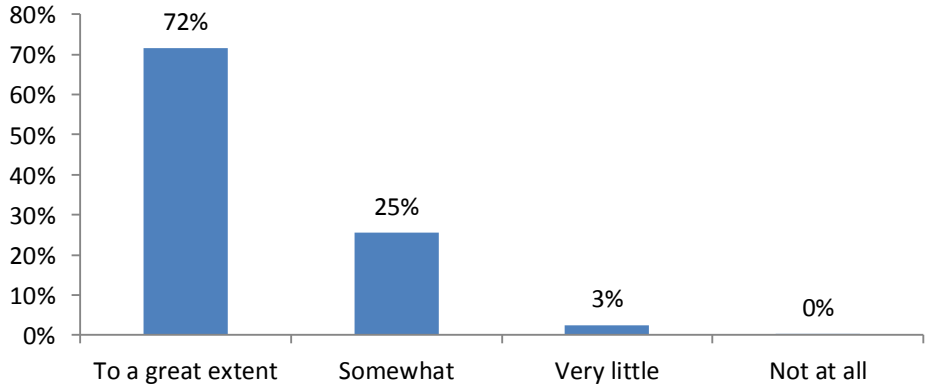
HSC staff felt that access to the required standard of PPE, rest breaks in work, a quiet space in work, and basic food and drink in work improved between November 2020 and February 2021 (Figure 21). The improved levels of access to these basic needs were maintained at Time 3 (May 2021).

Figure 21. Access to basic needs during at Time 1 & 2 (% good/very good)



At Time 3 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 22).

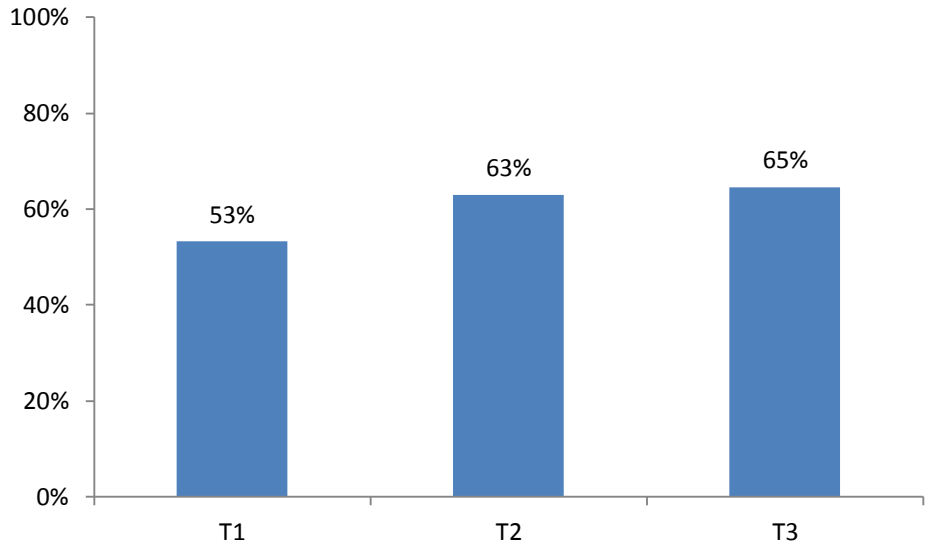
Figure 22: Perceived staff adherence to guidelines at Time 3



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 & 3 (Figure 23). 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. The improvement in communication effectiveness was maintained at Time 3.

Figure 23. Communication effectiveness in relation to COVID-19 related matters from respondents organisation at Times 1 - 3.

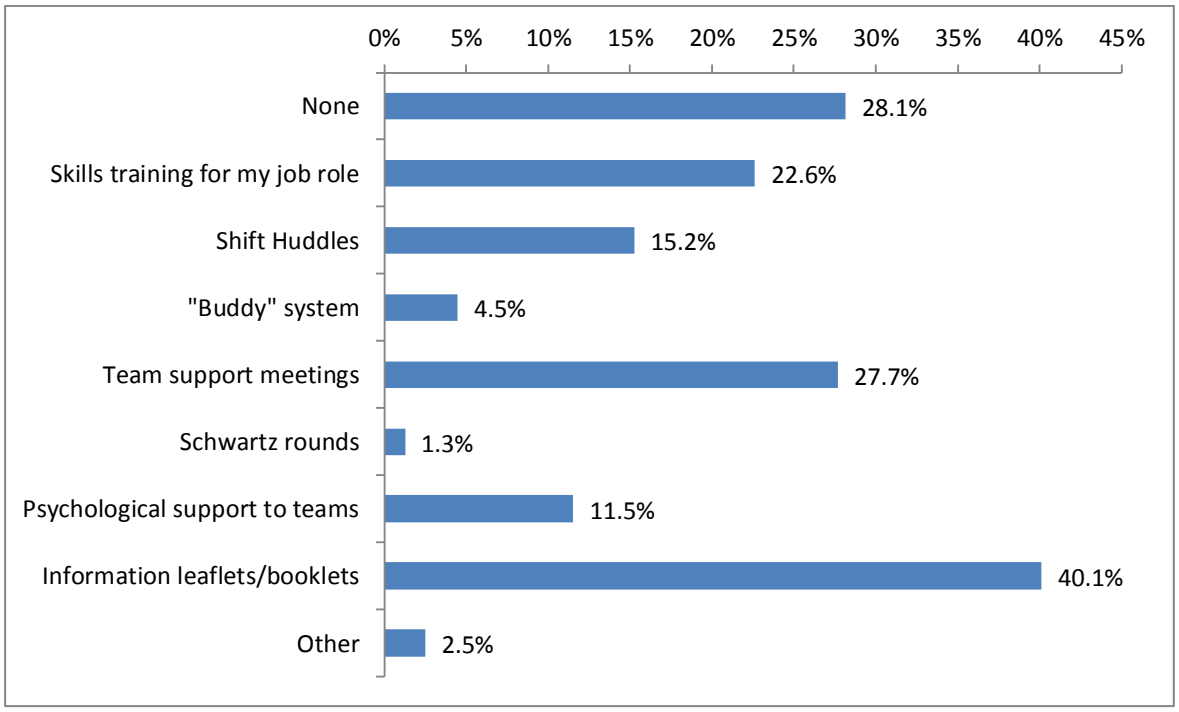


3.10 Support

Team supports

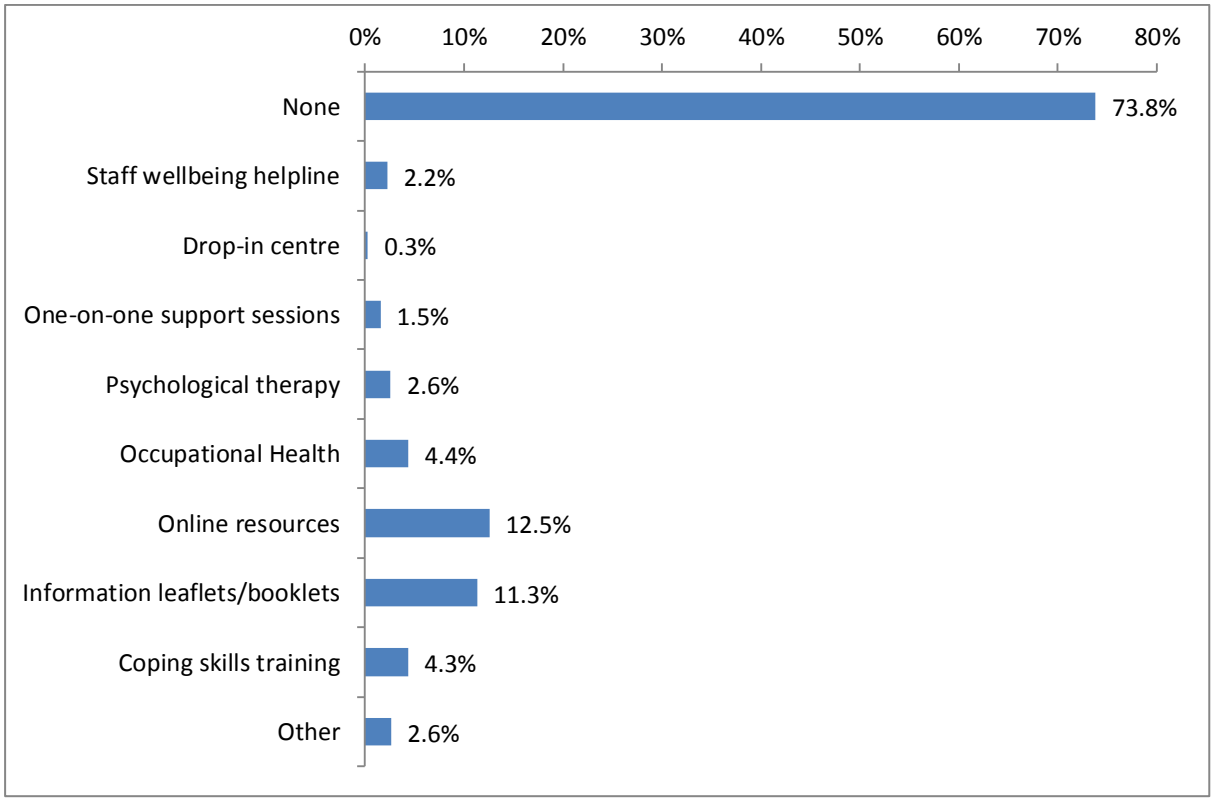
The participants were asked which team supports were made available within their service during the three months before Time 3 (Figure 24). The most common types of team supports used were Information sheets/booklets (40%), team support meetings (28%), and skills training for their role (23%).

Figure 24. Team supports available within respondent's service during the COVID-19 pandemic (Time 3)



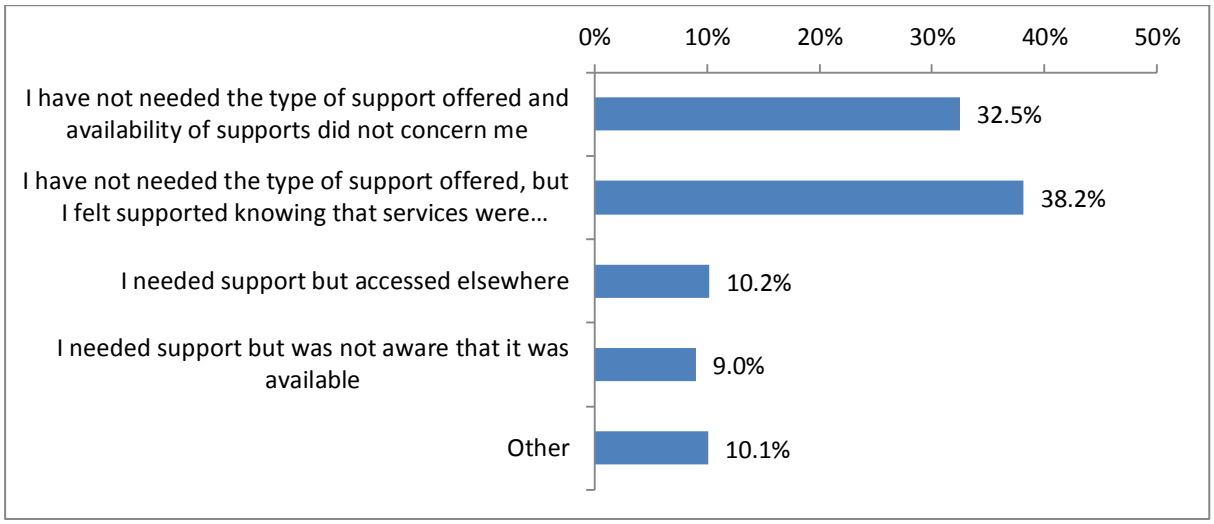
The particpants were then asked if they used any staff wellbeing supports during the 3 months before Time 3 (Figure 25). At Time 3, around three quarters (74%) said they had used none of the supports offered. The most common types of supports used were online resources (13%) and information leaflets /booklets (11%).

Figure 25. Staff wellbeing supports used during the COVID-19 pandemic (Time 3)



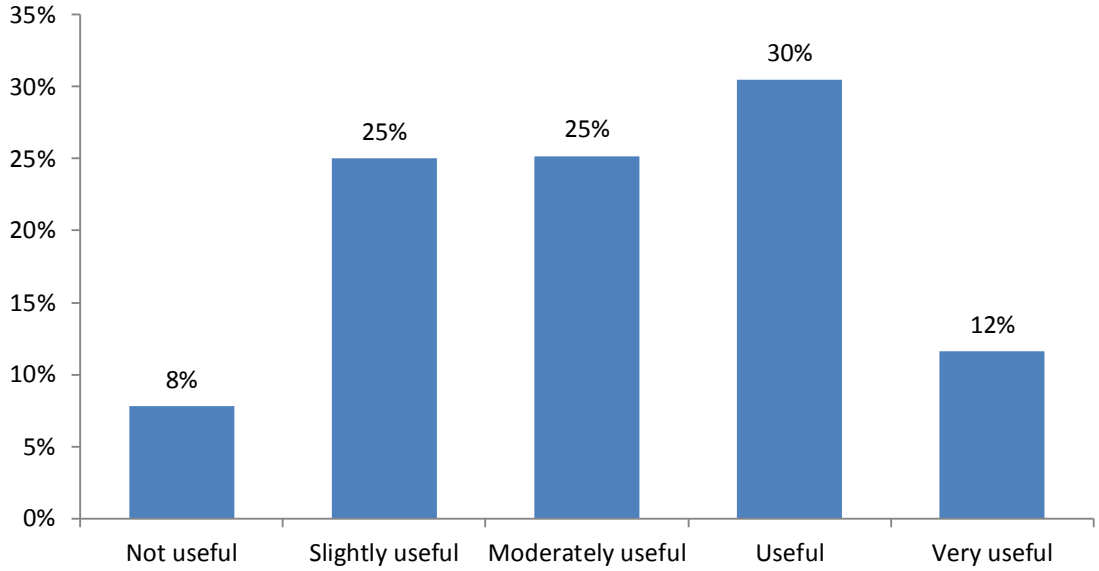
Those who ticked 'none' were asked why they did not use any supports in the three months before Time 3 (Figure 26; n=604 – this excludes those who only ticked 'other'). Reassuringly, 38% stated they did not need any support but felt supported just by knowing that services were available. Around a third, told us they had not needed the support offered and that availability of supports did not concern them. Fewer than one in ten said they had needed support but were not aware that it was available (9%).

Figure 26. Reasons for not using supports during the COVID-19 pandemic at Time 3



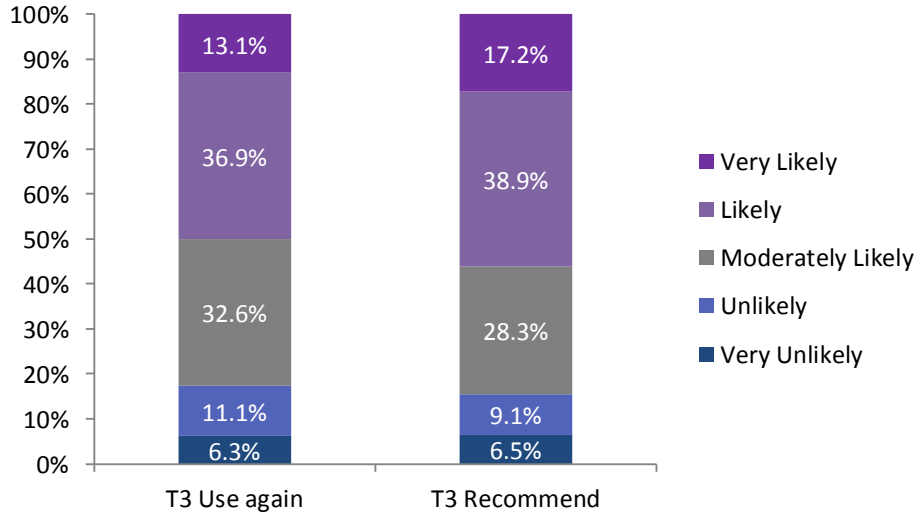
Amongst those who had used some form of support at Time 3, 42% found it useful or very useful (Figure 27).

Figure 27. Usefulness of support used at Time 3.



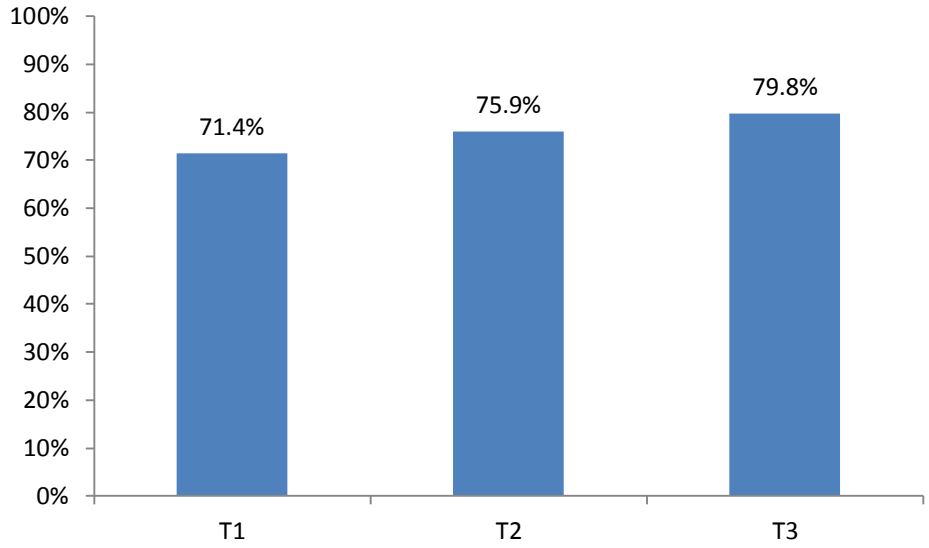
After using the supports (Time 3), many were likely or very likely to say they would use them again (50%) or recommend them to a friend or a work colleague (56%; Figure 28).

Figure 28: Likelihood of using supports again or recommending them at Time 3



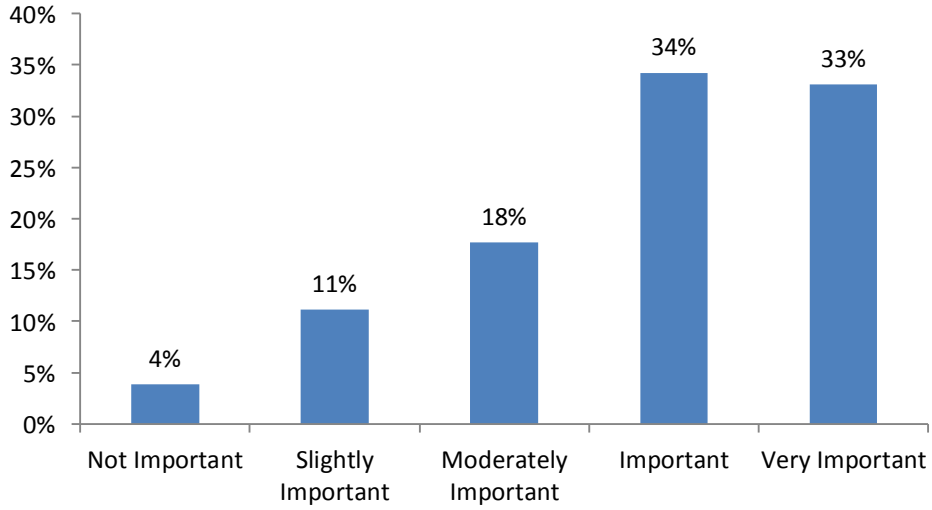
The majority (71%) of health and social care staff were somewhat or greatly aware of the staff wellbeing supports available to them within their organisation (Figure 29) at Time 1, and this proportion increased further at Time 2 to 76%. The improvement in awareness levels was maintained at Time 3 (80%).

Figure 29: 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 67% of staff at Time 3 (Figure 30).

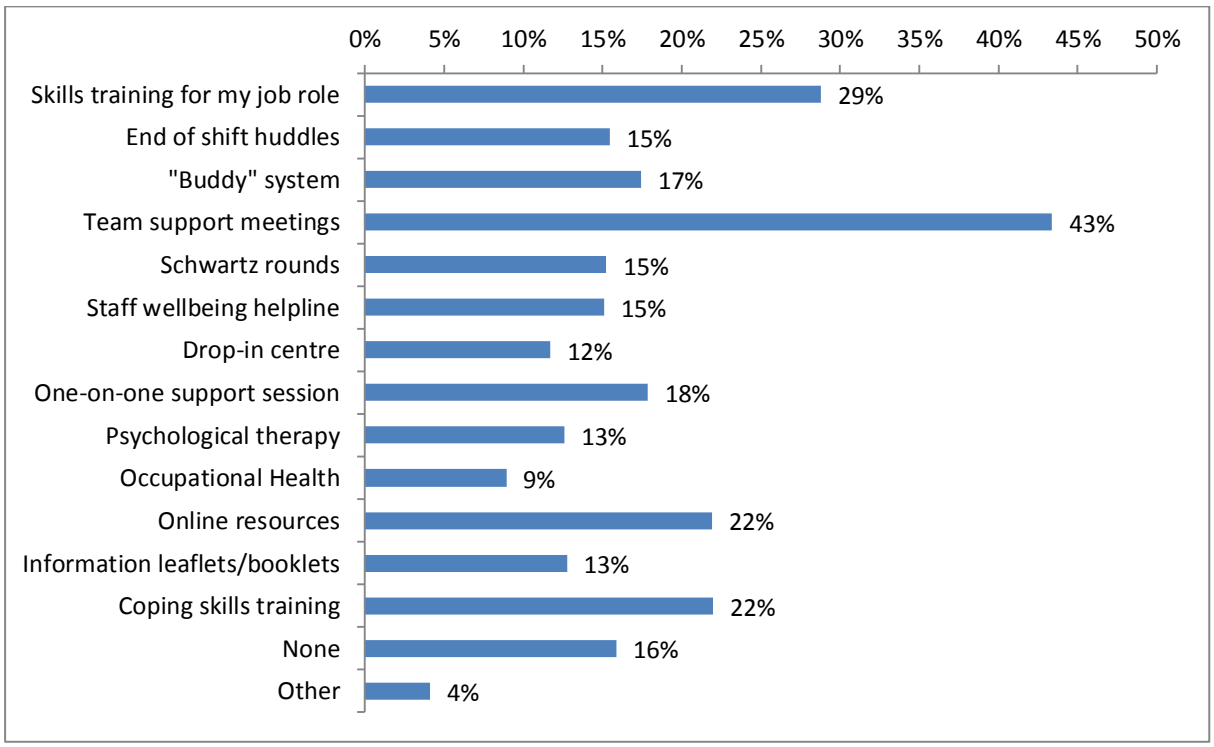
Figure 30: Perceived importance of support at Time 3



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 31).

Figure 31. Future support needs at Time 3



4.1. Psychological wellbeing by organisation

The proportion of staff with moderate to severe self-reported depression, anxiety, PTSD, and insomnia a Time 3 is shown by organisation in Figures 32-35. 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 32: Proportion of HSCNI staff with moderate to severe self-reported depression at Time 3

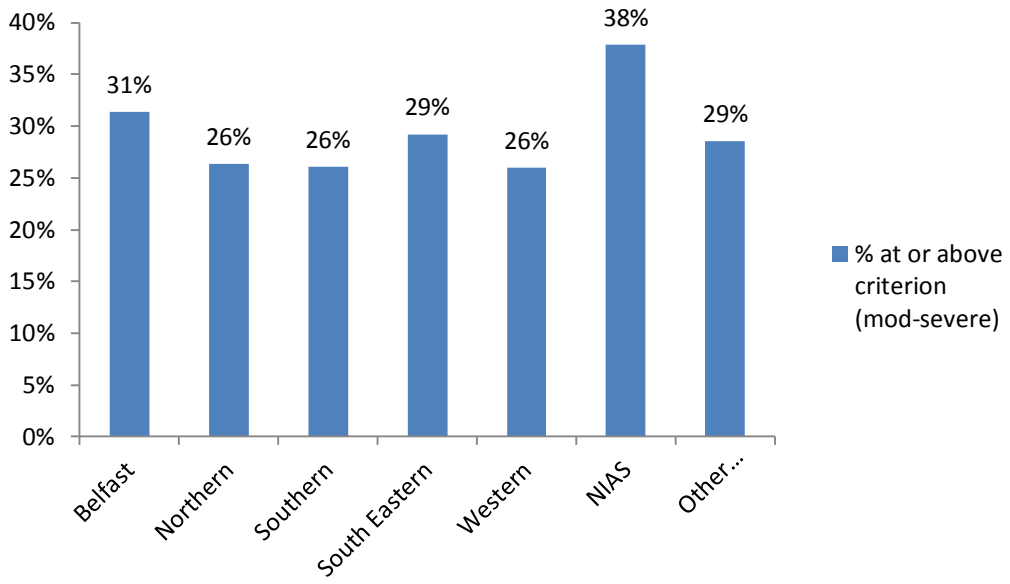


Figure 33: Proportion of HSCNI staff with moderate to severe self-reported anxiety at Time 3

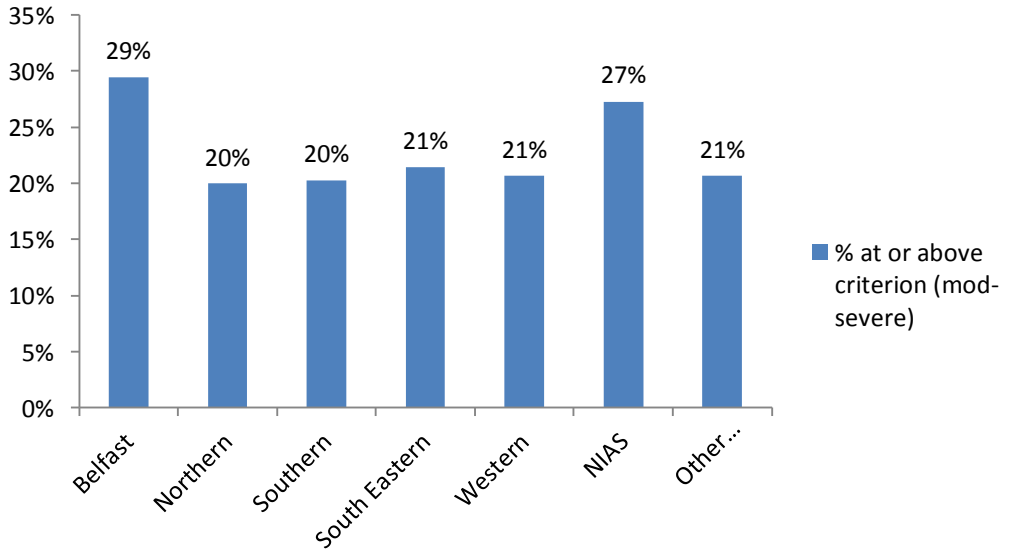


Figure 34: Proportion of HSCNI staff with moderate to severe self-reported PTSD at Time 3

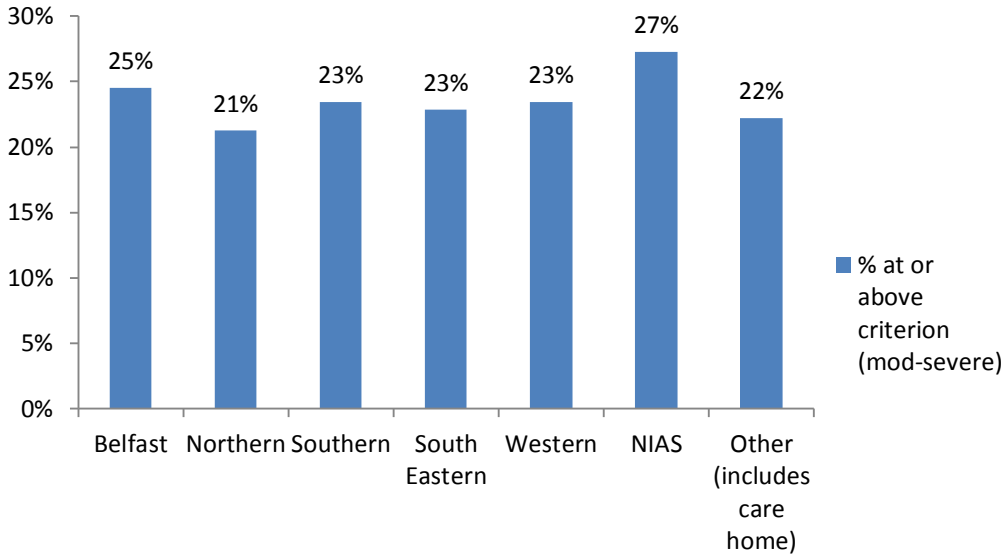
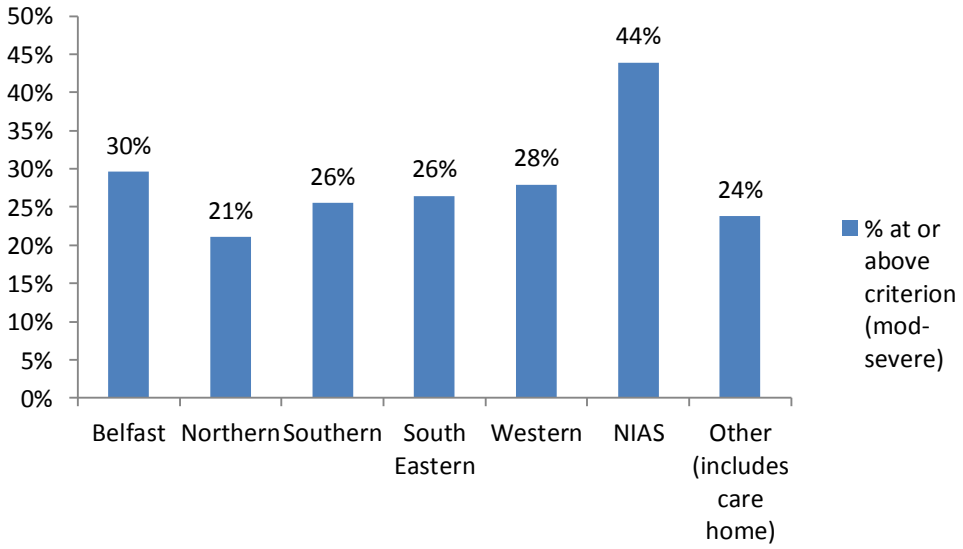


Figure 35: Proportion of HSCNI staff with moderate to severe self-reported insomnia at Time 3



5.1 Recommendations

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

1. While levels of poor staff wellbeing showed significant improvement figures remain high. We recommend the continued focus on staff support at a regional and Trust level.
2. 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 since the first time point of our survey. Our Time 3 report supports the continued importance of communicating during this pandemic and evidences that progress has been maintained.
3. 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. Again our Time 3 report evidences that progress has been maintained in this regard.
4. 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.
5. Our Time 3 results show that consideration should be given to the wellbeing needs of those who were diagnosed with COVID-19 more than 12 weeks ago. Any services being developed for staff with long term consequences of COVID-19 should include the provision of psychological interventions addressing the mental health consequences.

Our Vision

To deliver excellent integrated services in partnership with our community

If you would like to give feedback on any of our services please contact:
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