Northern Health and Social Care Trust

Impact Research Centre

COVID-19 Wellbeing Survey

Time 4 Findings

Version 1: 29th September 2021

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Funding

This work was supported by the HSC Research & Development Division, Public Health Agency (grant number COM/5602/20).

1.1 Executive Summary

This report outlines the results of the Final Time point (Time 4) of the Northern Ireland COVID-19 Staff Wellbeing Survey that we carried out during August 9-29th 2021. In total, 2,119 health and social care staff from across Northern Ireland took part at Time 4.

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 30%; anxiety 24%; PTSD 28%; Insomnia 28%) at Time 4. Between Time 2 and 3 there had been 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); However, between Time 3 and 4 there was a small increase in the proportion of staff reporting moderate to severe symptoms of post-traumatic stress (up 4 % points), coinciding with the health service moving into the fourth surge On the eight indices adopted from Pre-COVID-19 staff survey, three demonstrated change between Time 3 and 4. A greater proportion of staff were considering *leaving their organisation* (up by 6% points) and a smaller proportion felt there were enough *staff in their work area* (down by 11 % points). The proportion of staff who looked forward to going to work also fell between Time 3 and 4, this is reflective of a long running downwards trend throughout the COVID-19 pandemic (down by 13 % points on pre-pandemic levels).

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. However, the Time 4 results show that satisfaction levels with communication effectiveness have started to slip back towards the levels reported at Time 1.

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 and 4.

Our Time 4 results show that most staff who worked from home felt it had improved their overall wellbeing (51%), with the remaining respondents either reporting no change (35%) or a detrimental effect to their overall wellbeing (14%). Across a wide range of wellbeing domains the vast majority staff felt that working from home had been beneficial or had no effect (e.g. work-life balance; anxiety levels; stress levels; ability to concentrate). There were, however, a small number of area where staff were more likely to report a negative than a positive impact (e.g. ability to switch off; satisfaction with social contact). Going forward most staff (84%) would like to adopt a hybrid working arrangements model (some time at home and some on health and social care premises).

Our previous reports had a number of important recommendations and nothing in this report contradicts these original recommendations. Our reports have highlighted sustained high levels of poor wellbeing and mental health. This needs a substantial response from services.

1. We recommend the continued focus on staff support at a regional and Trust level. It is vital that a regional group provides leadership in this area.
2. There is a need for large scale interventions to be resourced and implemented at a local and regional level. These interventions should be evidence-based and targeted at organisational, group and individual levels. Systemic interventions could include improving communication, the promotion of manageable workloads, compassionate leadership, and the improvement of handling redeployments.
3. Scaling up psychological interventions such as team supports and evidence-based wellbeing programmes is needed in the light of this crisis.
4. There need to be robust and strong pathways to individual psychological interventions for all staff and they should target those in particular distress.

5. Finally, while this survey has provided important insights into levels of distress over the past year we now recommend this is followed-up as the pressures of the pandemic ease, thus allowing the recovery in the staff group to be monitored.

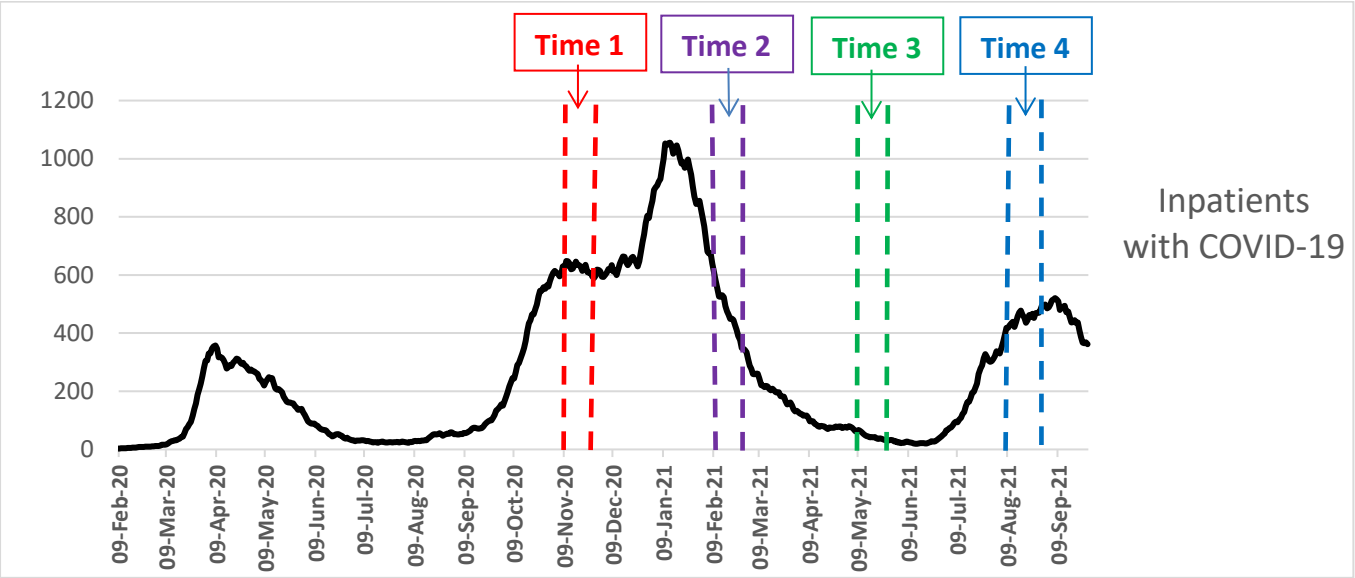
2.1 COVID-19 Staff Wellbeing survey

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 Final Time (Time 4) point of the survey (August 9-29th 2021) are presented in this report.

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. The Final Time Point, Time 4, occurred during the fourth surge of the COVID-19 pandemic.

Figure 1: COVID-19 Inpatient Statistics Northern Ireland



2.2 Achieved sample and 95% confidence intervals

In total, 2,119 health and social care staff from across Northern Ireland took part in Time 4 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 +/-2.15%. For the smallest subsample analysis, that involving the 181 who had been redeployed, the precision level for a proportion of 50% was +/- 7.51% (95% Confidence intervals)

2.3. Analysis strategy

The Time 1, 2, 3 and 4 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; Time 4 = 2,119). This report focuses on comparisons between Time 3 and 4. In Section 3.1 it is highlighted that the

demographic profile of the sample was similar at Times 3 & 4, 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=502) of participants who took part at both Times 3 & 4 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 May and August 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 3 and 4 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. For key areas of interest, (e.g. psychological wellbeing; communication, environmental needs), differences that reach statistical significance are highlighted even where the effect size is very small.

2.4 Format of the report

Sections 3.1 – 3.8: Findings for overall sample at Time 4 are presented. In some instances Time 1, 2, 3, and 4 results are presented (e.g. where there is some evidence of change over time). Where trends were stable between Time 3 & 4, only Time 4 results are presented except where it was necessary to illustrate that improvements made between Times 1 - 3 were maintained.

Section 4.1: Psychological wellbeing data by organisation

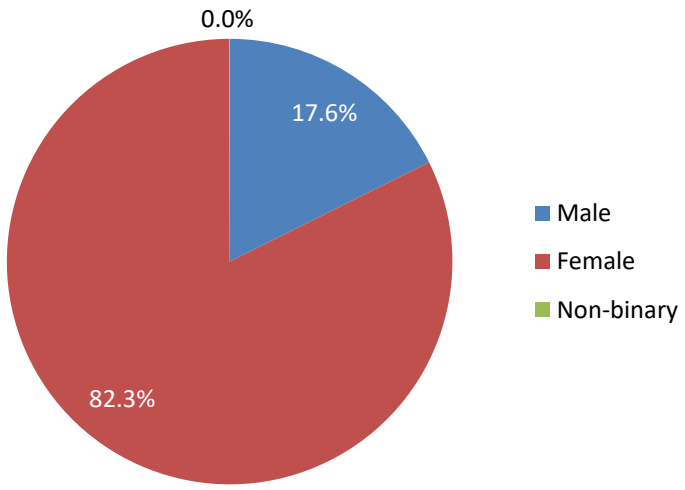
Section 5.1: Recommendations

3.1 Who took part?

Age & gender

Of the 2,119 health and social care staff that took part at Time 4, the vast majority of respondents were female (82%; Figure 2). The average age of respondent was 45 years, and the sample included individuals aged 18-76 years.

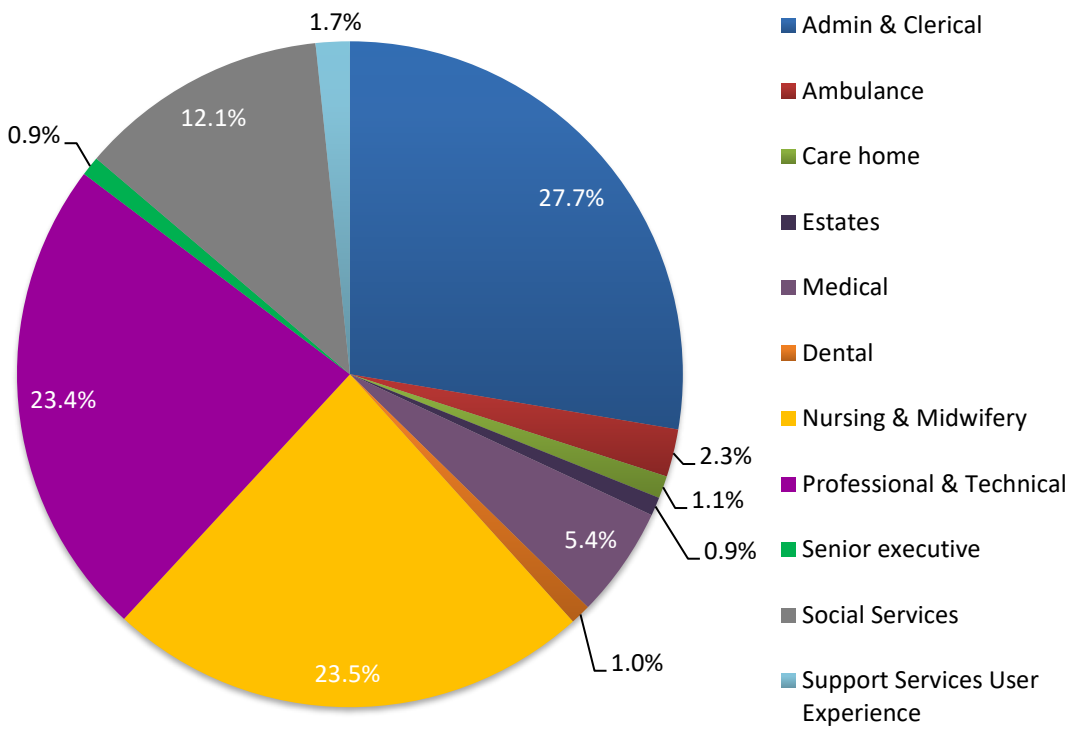
Figure 2: Gender breakdown of respondents at Time 4



Occupation

Figure 3 shows that a large proportion of the sample worked in *administrative and clerical* (28%), *nursing and midwifery* (24%), and *professional and technical* (23%) roles.

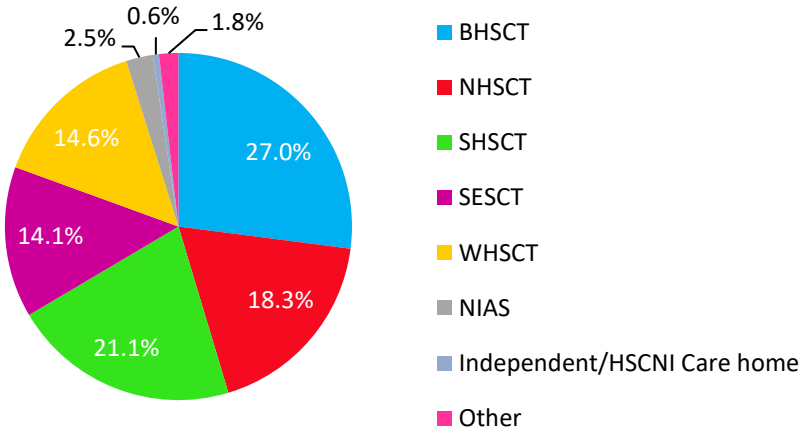
Figure 3: Occupation breakdown of respondents at Time 4



HSCNI Trust/Organisation

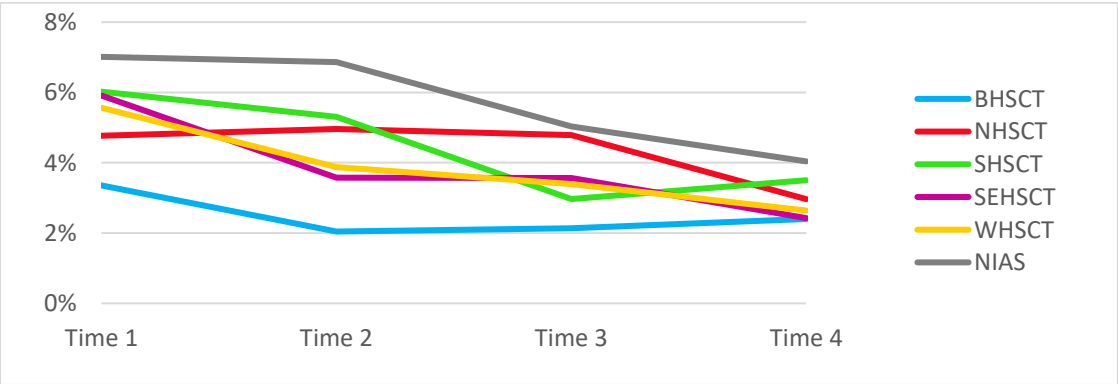
The HSCNI Trust/Organisation that the respondents reported belonging to is shown in Figure 4. Of the 2,119 participants, the numbers of staff who took part in each Trust at Time 4 are as follows: BHSCT (n=573); SHSCT (n=448); NHSCT (n=388); WHSCT (n=309); SEHSCT (n=298); NIAS (n=53).

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



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 4, NIAS had the highest response rate (4.0%), followed by SHSCT (3.5%), NHSCT (3.0%), SEHSCT (2.4%), WHSCT (2.6%), and BHSCT (2.4%). Compared to Time 3, the response rates for most trusts were lower at Time 4 (Figure 5; down by 0.8-1.8 % points). Although small increases were evident for BHSCT and SHSCT (up by 0.3-0.5 % points) Detailed descriptives by HSCNI Trust/organisation are presented in Section 4.

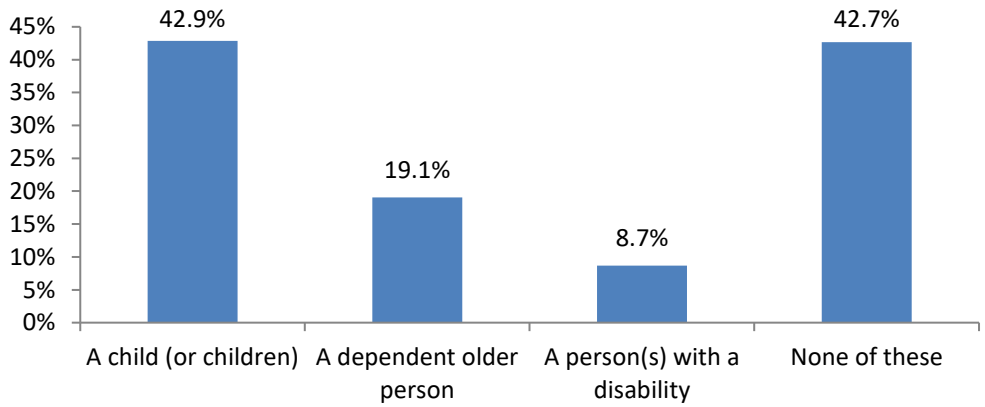
Figure 5: HSCNI Trust/Organisation of respondents at Time 4



Dependants

The majority of respondents (57%) identified at least one dependant that they had caring responsibilities for (Figure 6).

Figure 6. Caring responsibilities of respondents at Time 4



Profile of the sample over time

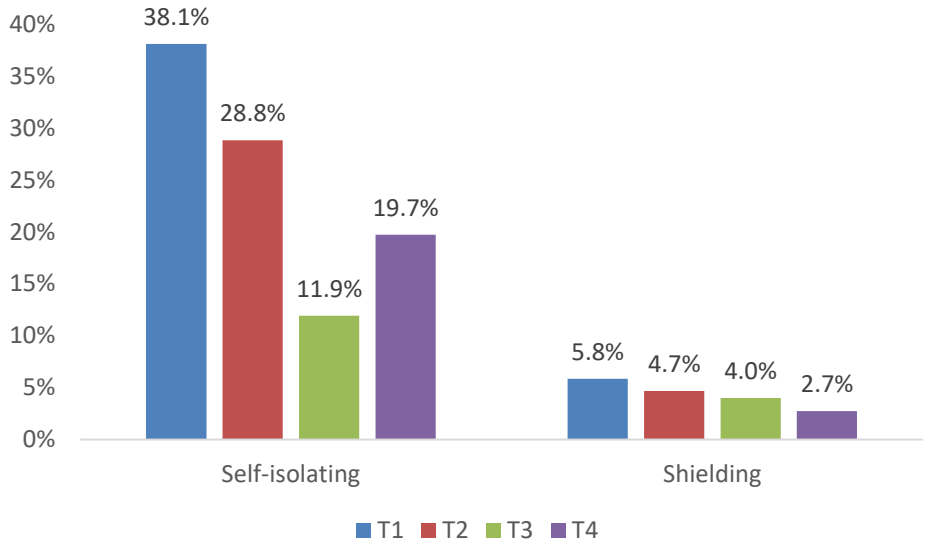
The Time 1 - 4 samples had broadly similar characteristics across the following demographics: gender, age, occupation, banding, education level, dependants, and marital status. The only exception was HSCNI/organisation – the response rates for the six trusts followed different patterns over time.

3.2 Changes in work patterns

The Time 4 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 4 they had worked from home, self-isolated, shielded, or considered a redeployment opportunity; 48% of staff reported having worked from home and 15% reported being asked to consider a redeployment opportunity at some stage during this period.

Compared with May 2021, at the August 2021 time point a lower proportion of staff had been shielding and a higher proportion reported self-isolating (Times 1 to 4; Figure 7).

Figure 7. Working arrangements during the COVID-19 outbreak at Times 1 - 4.



Redeployment

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 8). 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%) and Time 4 (39%).

Figure 8. Views on redeployment at Times 1 – 4

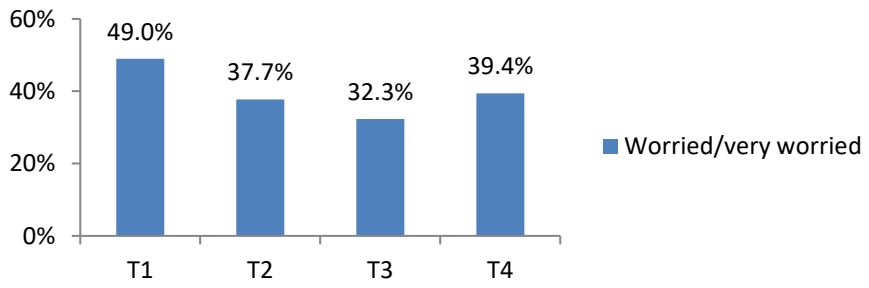
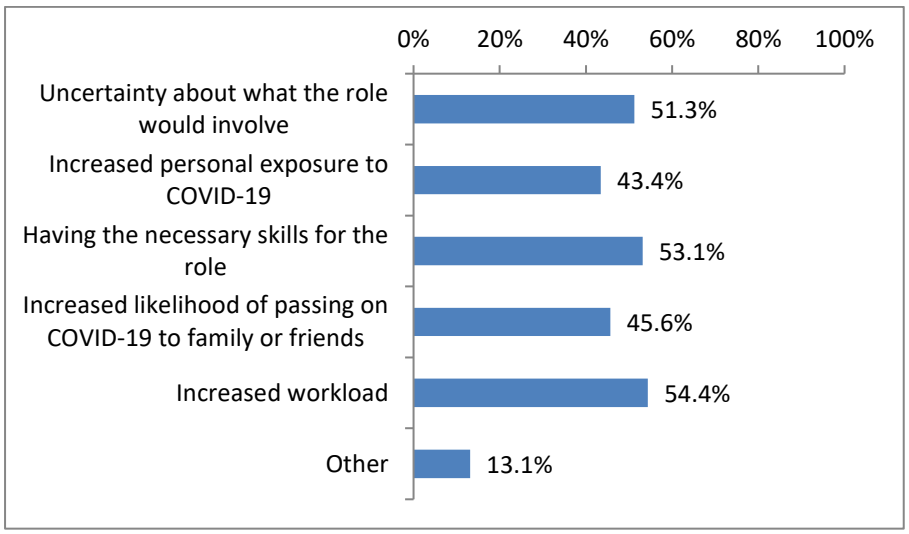


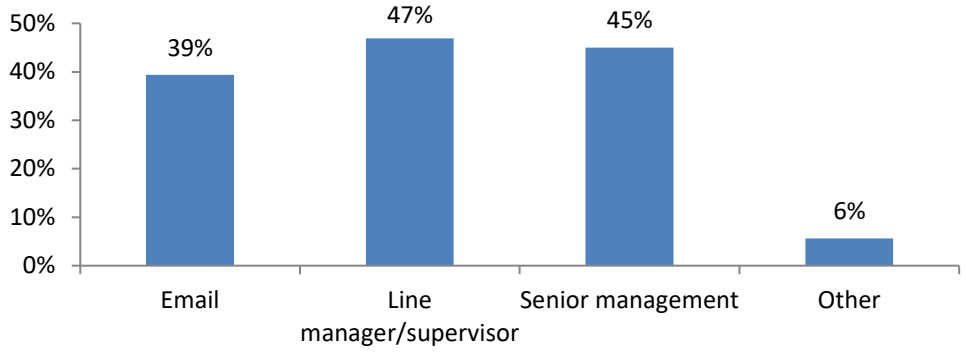
Figure 9 shows that redeployment concerned staff in many ways at Time 4 including uncertainty about what the role would involve (51%), increased personal exposure to COVID-19 (43%), having the necessary skills for the role (53%), increased likelihood of passing on COVID-19 to family or friends (46%), and increased workload (54%).

Figure 9. Concerns about redeployment at Time 4



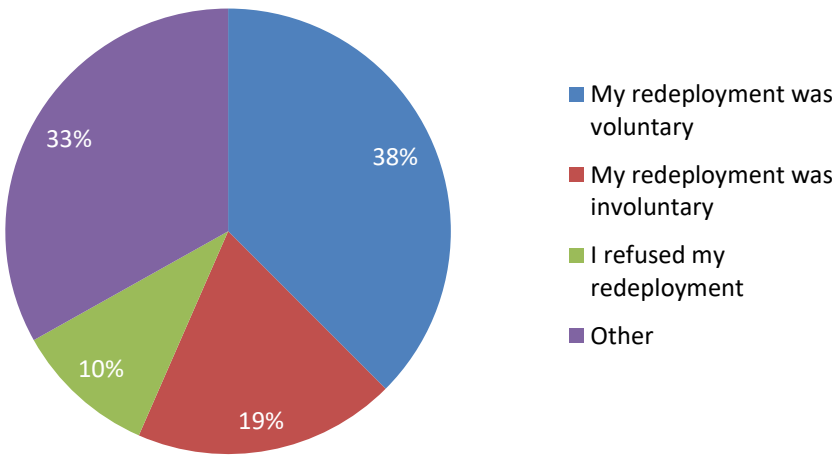
At Time 4 participants who had been asked to consider a redeployment opportunity in the last three months were asked where that request came from (Figure 10). Many reported receiving the request from their line manager/supervisor (47%), senior management (45%) or via an email from their organisation (39%).

Figure 10. Who asked the participant to consider a redeployment opportunity at Time 4



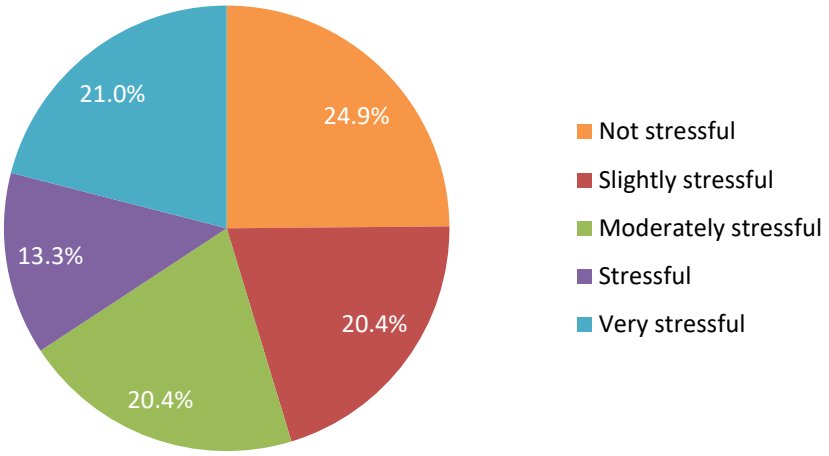
The majority of staff asked to consider a redeployment opportunity in the last three months ended up in that role either on a voluntary or involuntary basis at Time 4 (57%; Figure 11).

Figure 11: Outcome of redeployment request at Time 4



For those who were redeployed in the three months before Time 4 (n=181), high levels of stress during their redeployment were reported by 34% of staff (Figure 12).

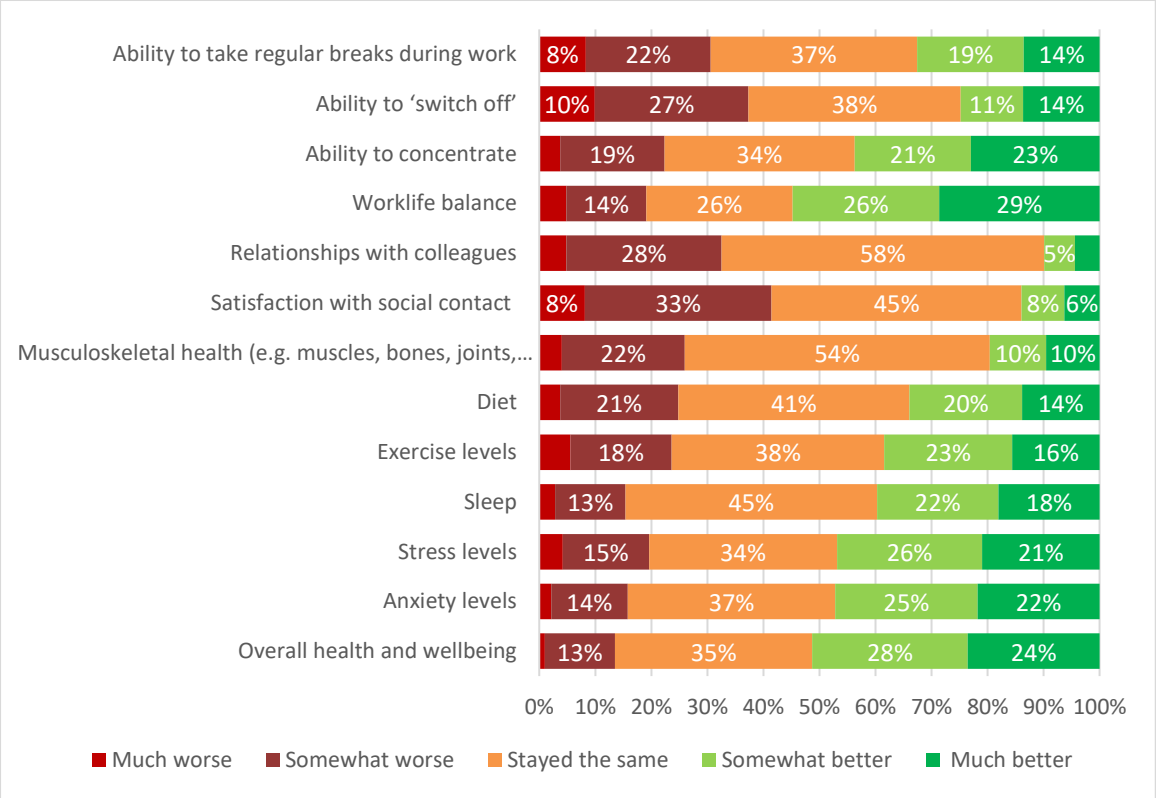
Figure 12. Experience of being redeployed at Time 4



Working from home

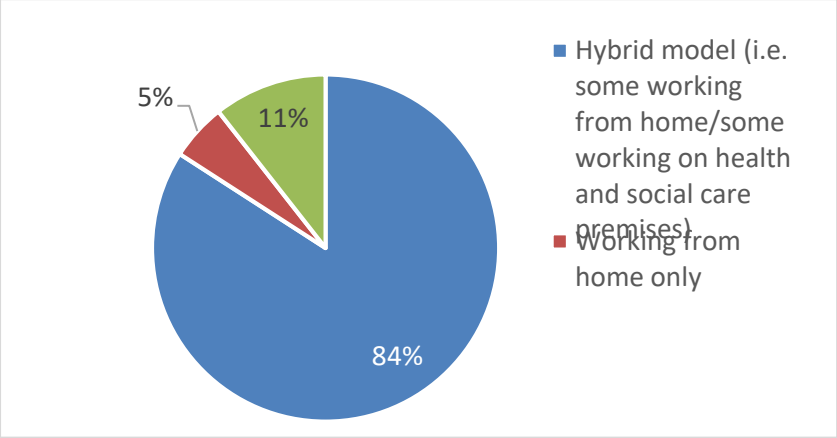
Staff who reported working from home to some extent in the three months prior Time 4 (n=1020) were asked to compare their working from home experience to their experience in their job role when they were working on health and social care premises (Figure 13). The areas of wellbeing examined were drawn from the key areas identified as being affected by working from home in the Working from Home Policy Paper published by the Royal Society for Public Health (February, 2021). Across a wide range of wellbeing areas many staff felt that working from home had no impact on them (26% - 58%). For some wellbeing areas more than a third of staff reported that working from home made their wellbeing somewhat or much better: overall health and wellbeing (51%); anxiety levels (47%); stress levels (47%); sleep (40%); exercise levels (38%); diet (34%); work-life balance (55%); ability to concentrate (44%); and ability to take regular breaks during work (33%). In a small number of areas, more than a third of respondents felt that working from home resulted in somewhat or much worse wellbeing: relationships with colleagues (33%); ability to 'switch off' (37%); and satisfaction with social contact (41%).

Figure 13: Impact of working from home on wellbeing at Time 4



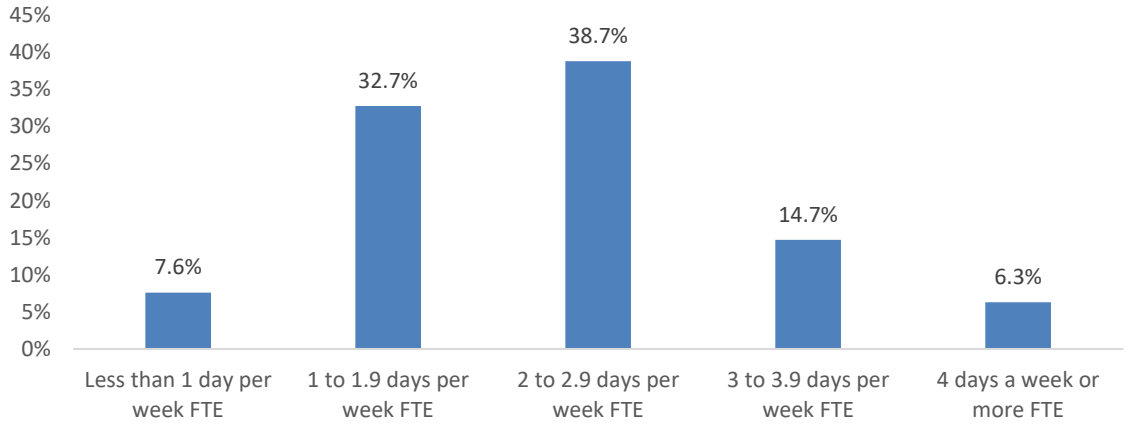
Time 4 respondents who had worked from home were asked what would be their preference in terms of working arrangements after the COVID-19 restrictions are fully lifted. The overwhelming majority (84%) expressed a preference for a hybrid model involving some time working from home and some on health and social care premises (Figure 14).

Figure 14: Preferred working arrangements following the removal of all COVID-19 restrictions (Time 4).



Amongst those who expressed an interest in a hybrid model going forward, staff differed with regards to how much time they would like to spend working from home. More than seven in ten (71%) of those with an interest in a hybrid model would prefer 1 - 2.9 days per week FTE working from home (Figure 15).

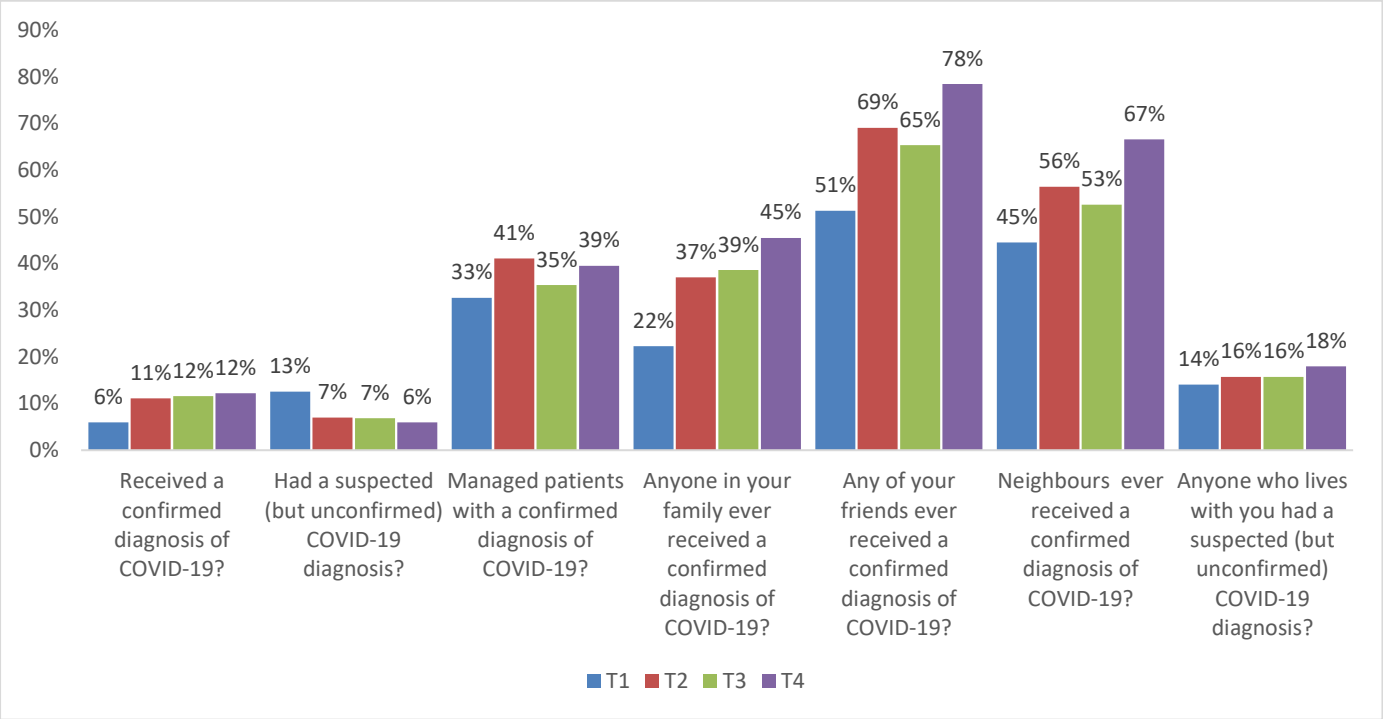
Figure 15: Preferred FTE days spent working from home amongst those in favour of a hybrid model (Time 4).



3.3 COVID Risk Exposure

Amongst the Time 4 respondents, 12% reported having received a confirmed COVID-19 diagnosis, with fewer (6%) suspecting (no confirmation) that they had had COVID-19 (Figure 16). Nearly four in ten respondents (39%) managed patients with confirmed COVID-19 diagnoses. Participants also commonly reported knowing friends (78%), neighbours (67%) and family members (45%) with confirmed COVID-19 diagnoses. The findings show a trend towards increased likelihood of exposure to COVID-19 over time, with the proportion of respondents having a confirmed case of COVID-19 or knowing a family member, friend or neighbour with a confirmed COVID-19 diagnosis increasing between May and August 2021.

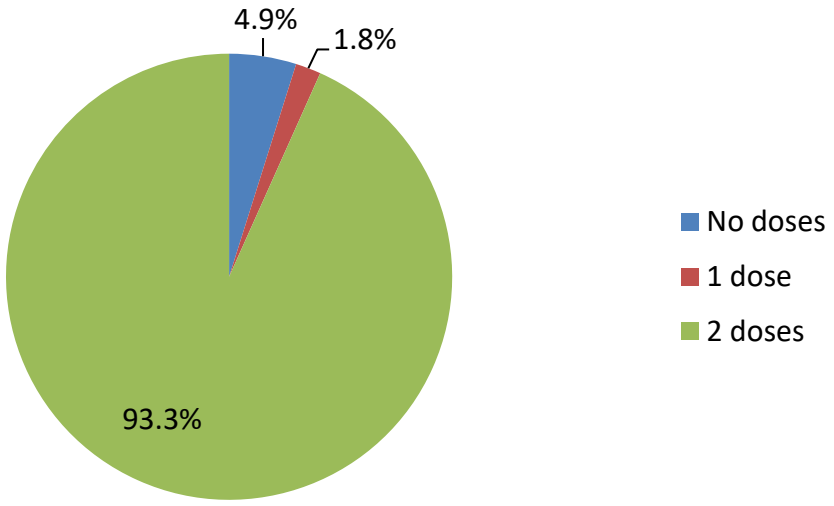
Figure 16. Exposure to COVID 19 at Time 1-4



The proportion of repondents who reported personally knowing someone who had died as a result of COVID-19 was 34% at Time 4.

The vast majority (93%) of respondents reported that they had received two doses of a COVID-19 vaccine as of August 2021 (Figure 17).

Figure 17. Proportion of respondents who reported having been vaccinated at Time 4.



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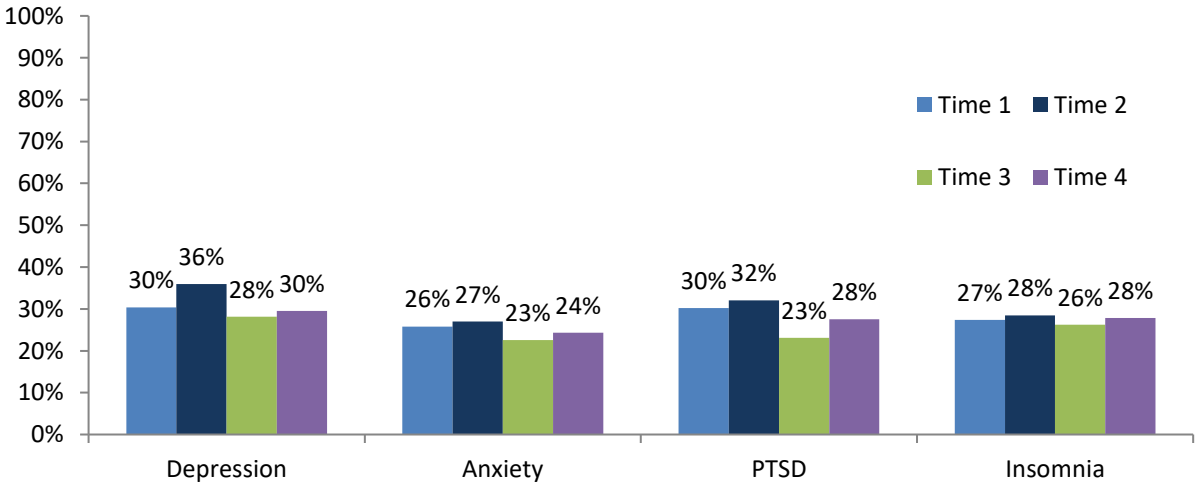
3.4 Psychological wellbeing

Prevalence of moderate to severe psychological wellbeing difficulties

The survey included four validated psychological wellbeing measures (depression, anxiety, PTSD, and insomnia). Figure 18 shows the proportion of staff who self-reported symptoms in the moderate to severe range on these measures at Times 1 - 4. Previous comparisons of Time 1 & 2, suggested that the overall level of moderate to severe psychological welbeing 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. Between May and August 2021 (Time 3 and 4), levels of moderate to severe symptoms remained stable across the wellbeing measures, except for post-tramatic stress which showed a small increase (23% to 28%) albeit not back to the levels of November 2020.

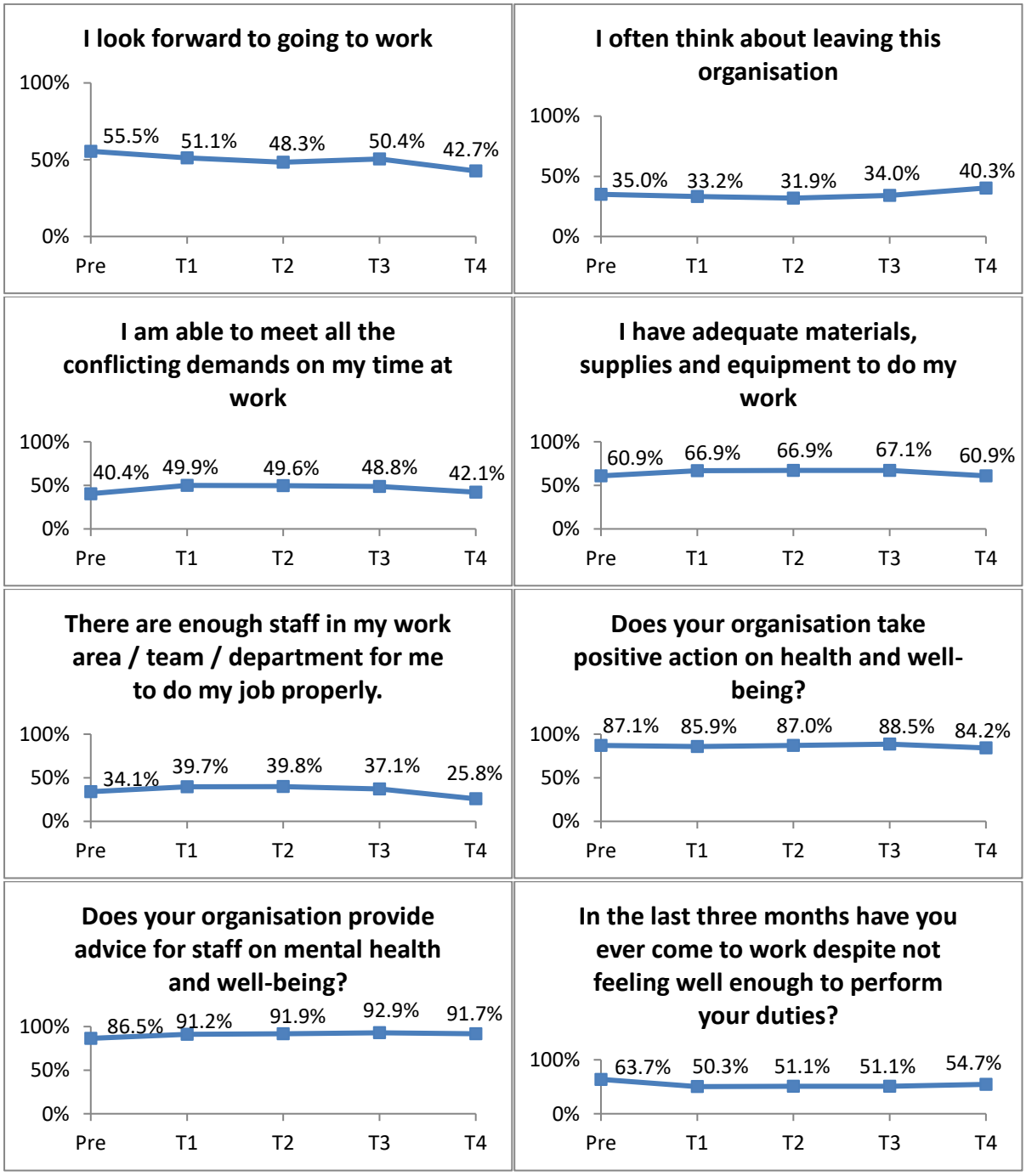
Figure 18. Proportion of sample self-reporting moderate to severe psychological wellbeing symptoms at Times 1-4



3.5 Pre-post COVID-19 comparisons

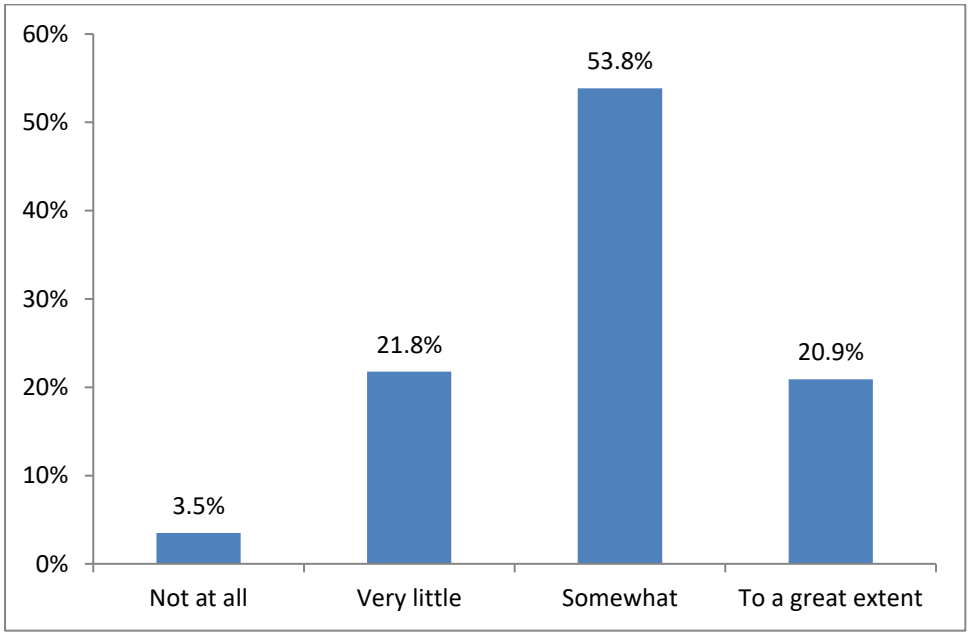
Eight questions from the 2019 HSCNI staff survey were included in the COVID-19 Wellbeing survey to allow pre-post COVID-19 comparisons on things like job satisfaction, access to resources, and how HSCNI deals with staff health and wellbeing (Figure 19). There has been a gradual decline in the proportion of staff who look forward to going to work. More recently, the proportion of staff considering leaving their organisation or thinking their area is understaffed has increased.

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). Three quarters (75%) felt that their wellbeing had been affected somewhat/to a great extent at Time 4.

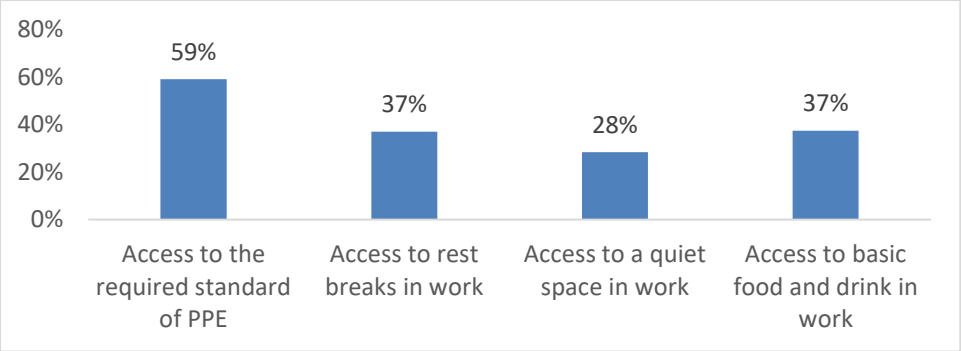
Figure 20. Effect of COVID-19 pandemic on psychological wellbeing at Times 4



3.6 Environmental needs

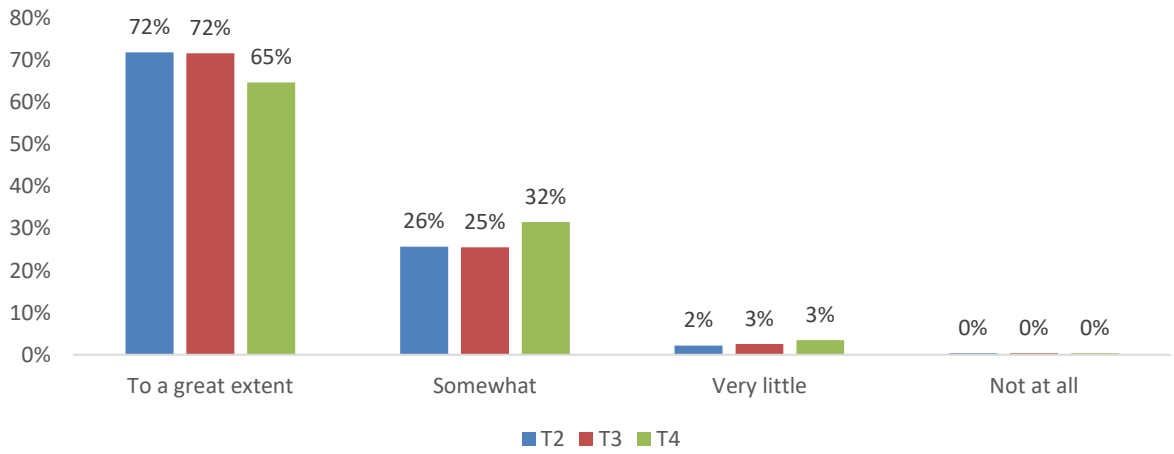
Figure 21 shows the proportion of staff who felt that access to the required standard of PPE, rest breaks in work, a quiet space in work, and basic food and drink in work was good or very good at Time 4 (Figure 21). These proportions are similar to Time 3, although there was a small drop in the proportion of staff rating access to the required standard of PPE as good/very good (65% to 59%)

Figure 21. Access to basic needs during at Time 4 (% good/very good)



From Time 2-4 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 at Times 2 and 3; however, by Time 4 this had dropped to 65% (Figure 22).

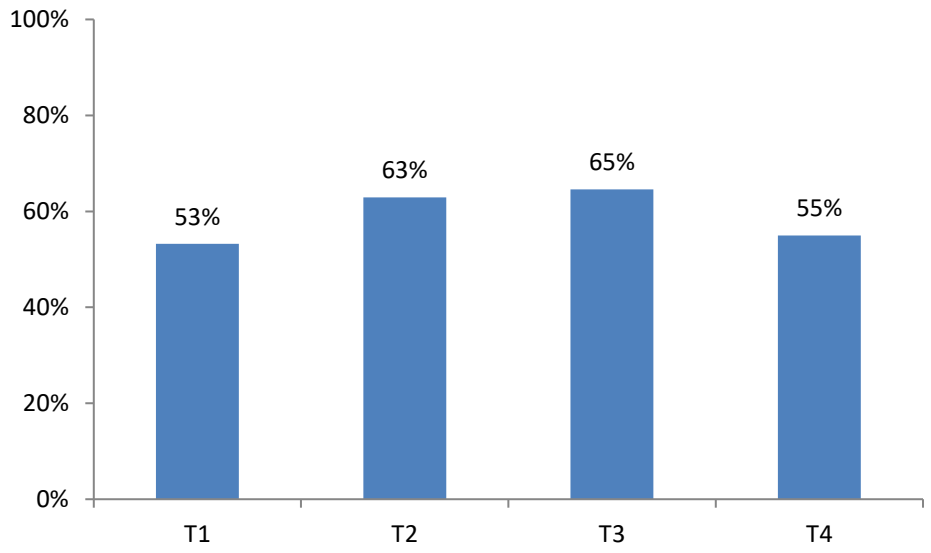
Figure 22: Perceived staff adherence to guidelines at Times 2-4



3.7 Communication

Staff were asked how effective communication from their organisation on COVID-19 related matters had been in the months prior to Times 1- 4 (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. However, satisfaction levels with communication effectiveness have started to slip back to those reported at Time 1 (Time 4 = 55%).

Figure 23. Communication effectiveness in relation to COVID-19 related matters from respondents organisation at Times 1 - 4.

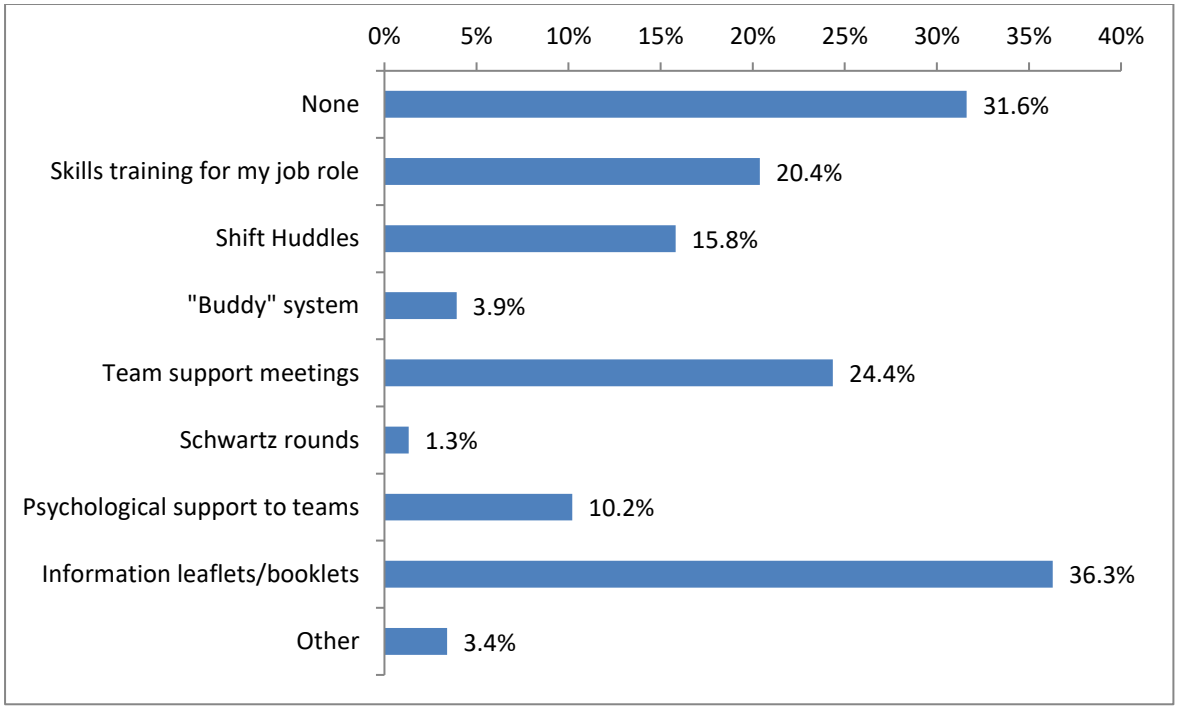


3.8 Support

Team supports

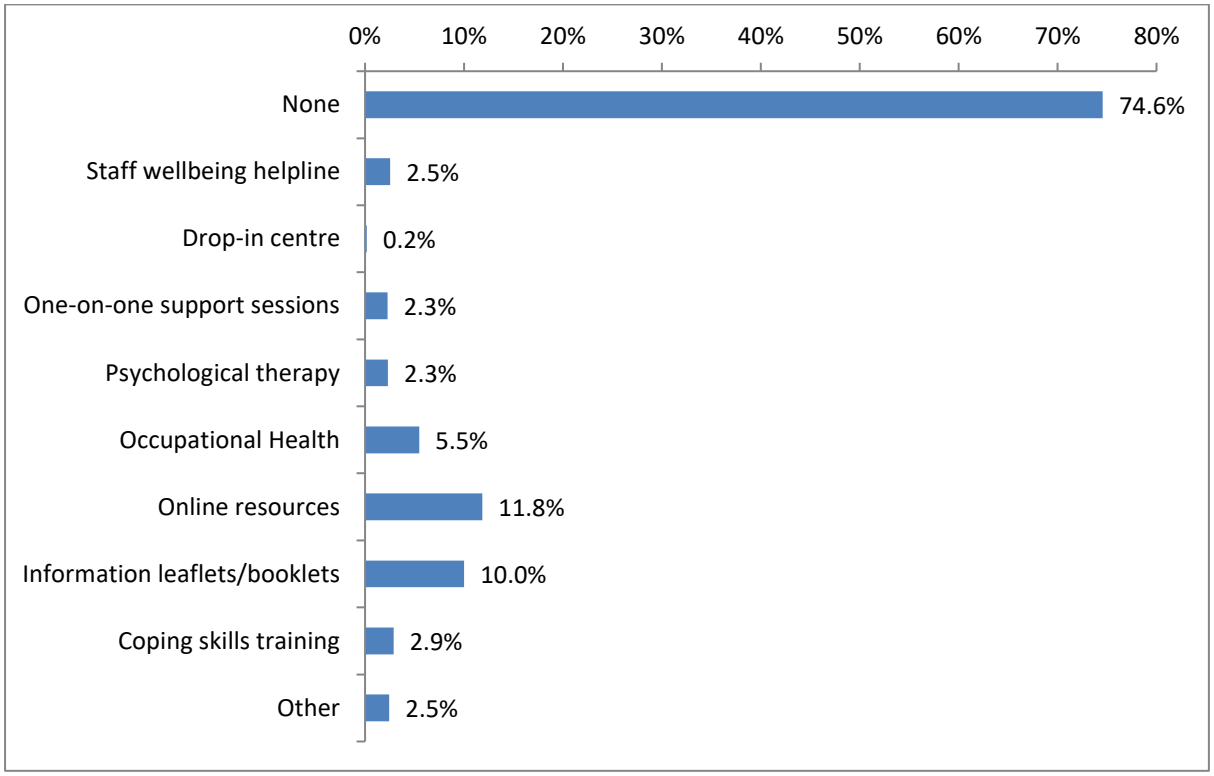
The participants were asked which team supports were made available within their service during the three months before Time 4 (Figure 24). The most common types of team supports used were Information sheets/booklets (36%), team support meetings (24%), and skills training for their role (20%).

Figure 24. Team supports available within respondent's service during the COVID-19 pandemic (Time 4)



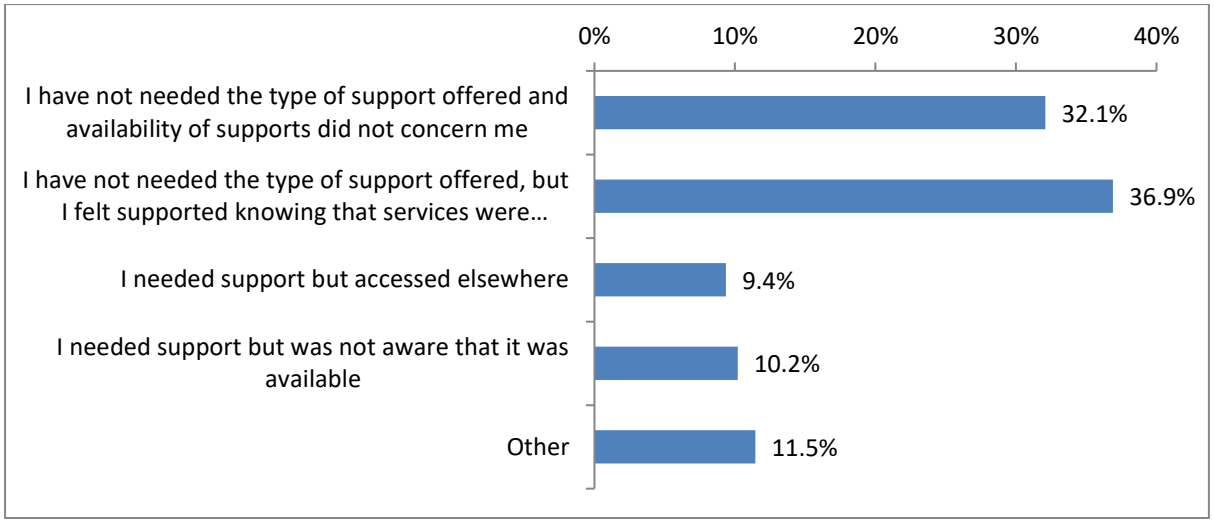
The participants were then asked if they used any staff wellbeing supports during the 3 months before Time 4 (Figure 25). At Time 4, around three quarters (75%) said they had used none of the supports offered. The most common types of supports used were online resources (12%) and information leaflets /booklets (10%). Compared to Time 3, the proportion of staff using coping skills training dropped at Time 4 from 4.3% to 2.9%.

Figure 25. Staff wellbeing suports used during the COVID-19 pandemic (Time 4)



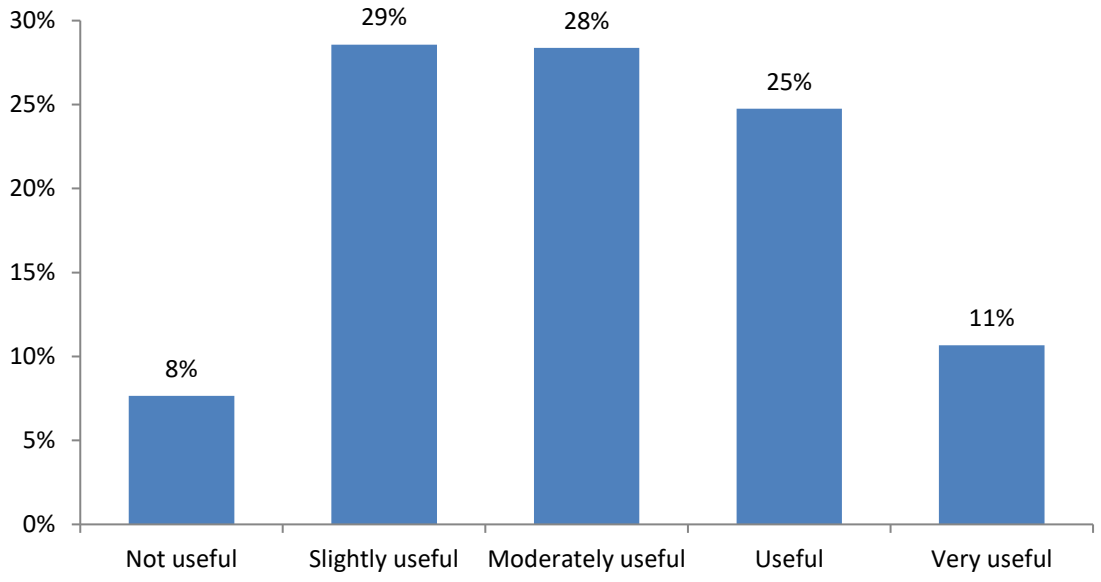
Those who ticked ‘none’ were asked why they did not use any supports in the three months before Time 4 (Figure 26; n=1580). Reassuringly, 37% stated they did not need any support but felt supported just by knowing that services were available. Around a third, told us they had not needed the support offered and that availability of supports did not concern them. One in ten said they had needed support but were not aware that it was available (10%).

Figure 26. Reasons for not using supports during the COVID-19 pandemic at Time 4



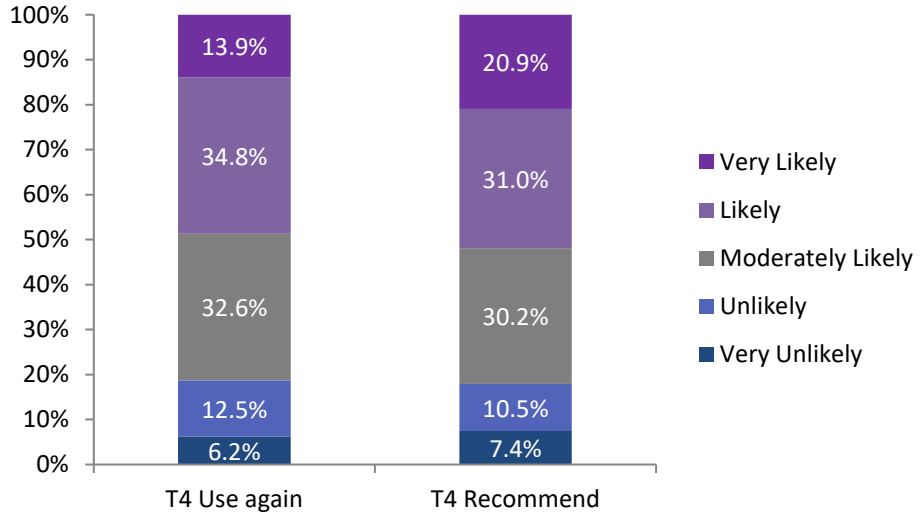
Amongst those who had used some form of support at Time 4 (n = 497; excluding those who only ticked ‘other’), 35% found it useful or very useful (Figure 27).

Figure 27. Usefulness of support used at Time 4.



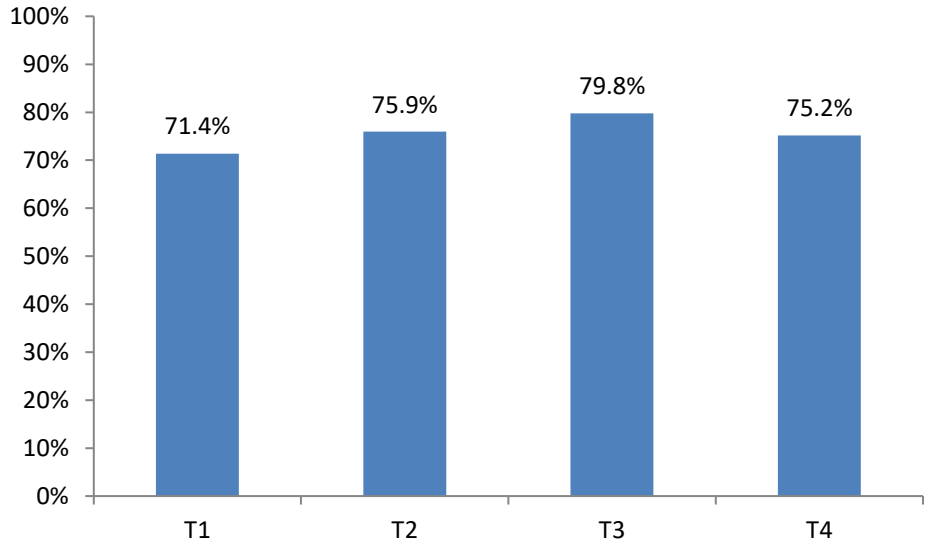
After using the supports (Time 4), many were likely or very likely to say they would use them again (49%) or recommend them to a friend or a work colleague (52%; Figure 28).

Figure 28: Likelihood of using supports again or recommending them at Time 4



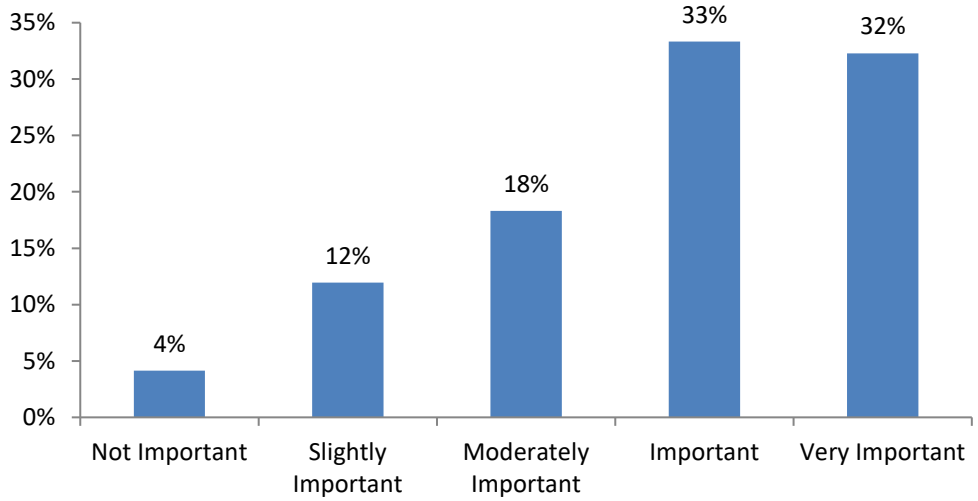
The majority (71%) of health and social care staff were somewhat or greatly aware of the staff wellbeing supports available to them within their organisation (Figure 29) at Time 1, and this proportion increased further at Time 2 to 76%. The improvement in awareness levels was maintained at Time 3 (80%) and Time 4 (75%).

Figure 29: Awareness of staff wellbeing support available within their Trust at Times 1-4



Having staff wellbeing support available within their organisation was important or very important for 66% of staff at Time 4 (Figure 30).

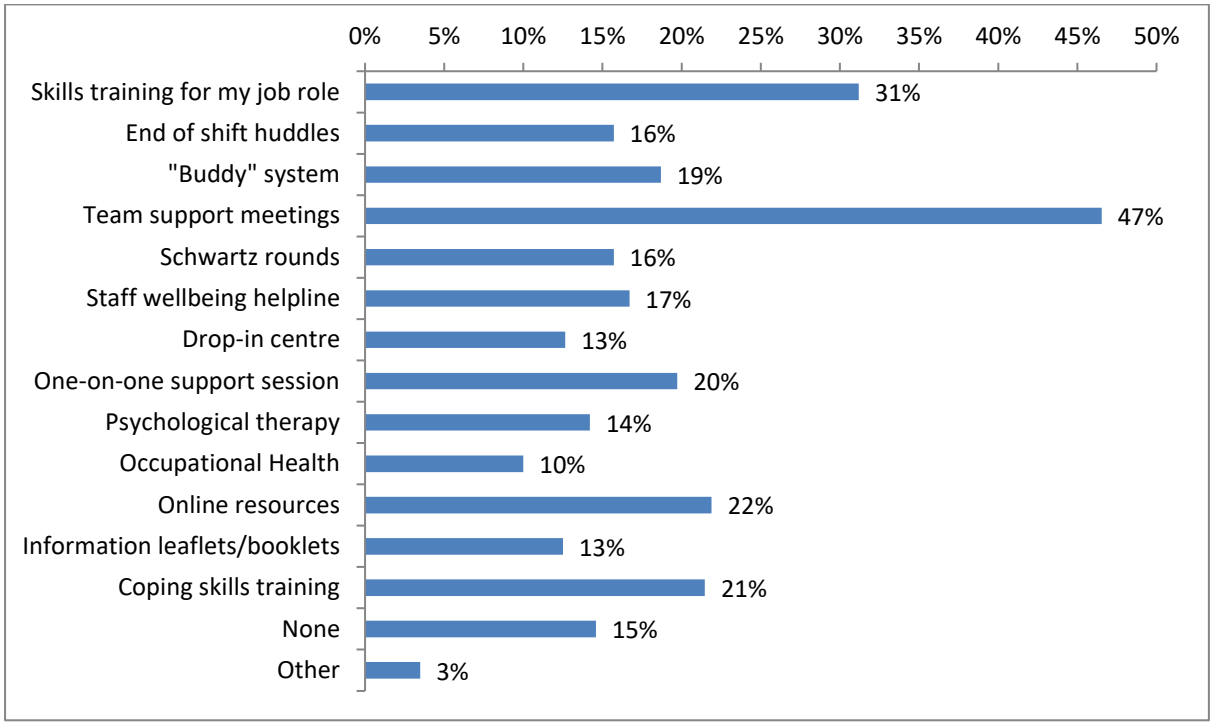
Figure 30: Perceived importance of support at Time 4



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 4



4.1. Psychological wellbeing by organisation

The proportion of staff with moderate to severe self-reported depression, anxiety, PTSD, and insomnia a Time 4 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 4

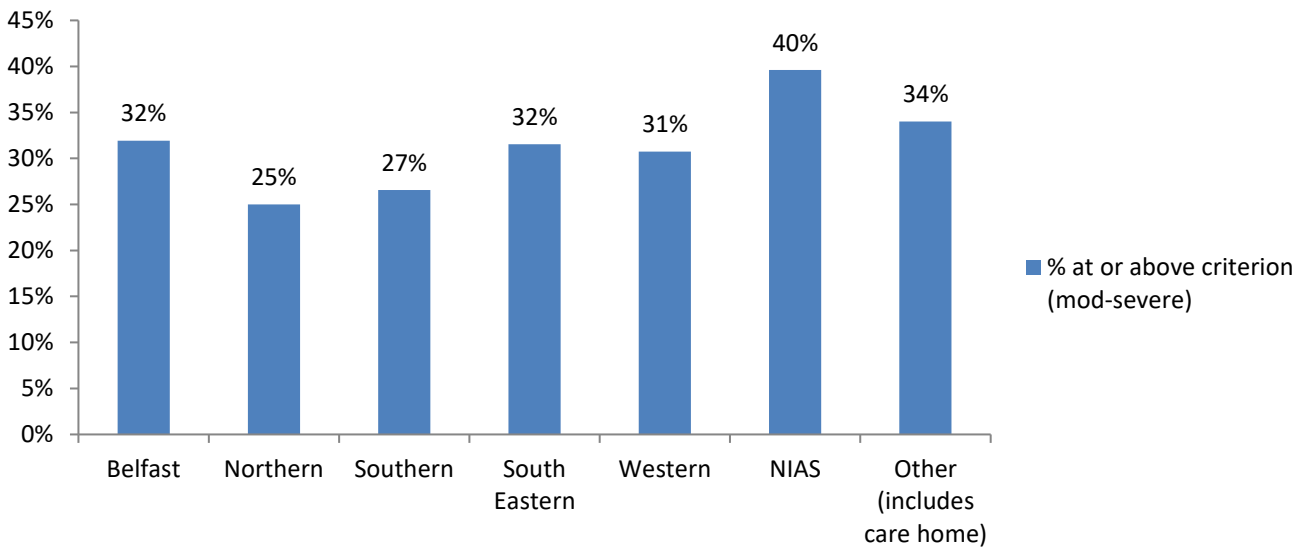


Figure 33: Proportion of HSCNI staff with moderate to severe self-reported anxiety at Time 4

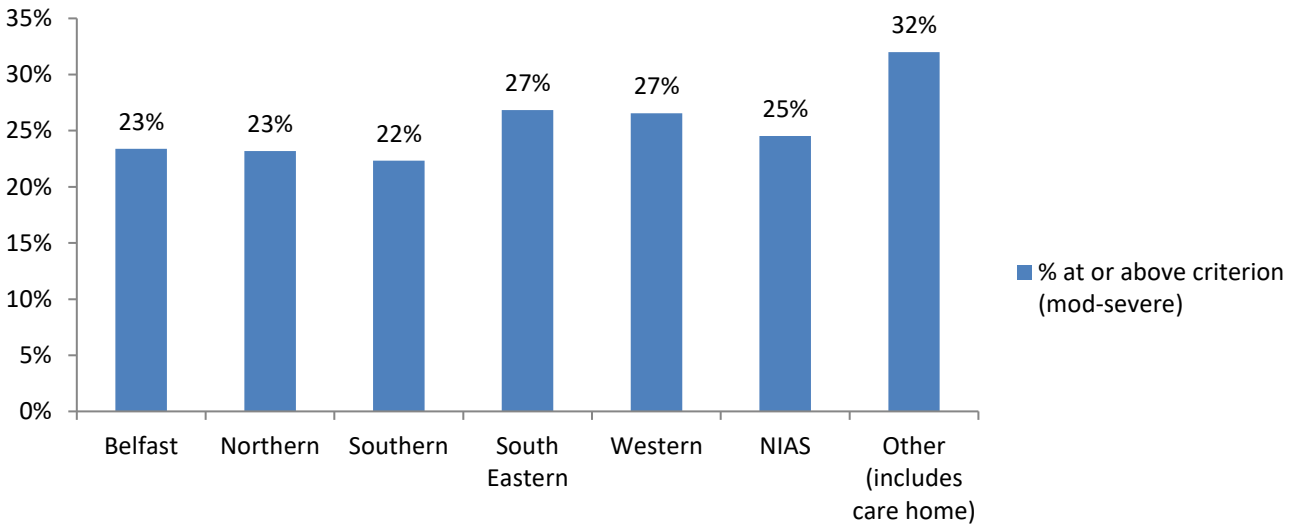


Figure 34: Proportion of HSCNI staff with moderate to severe self-reported PTSD at Time 4

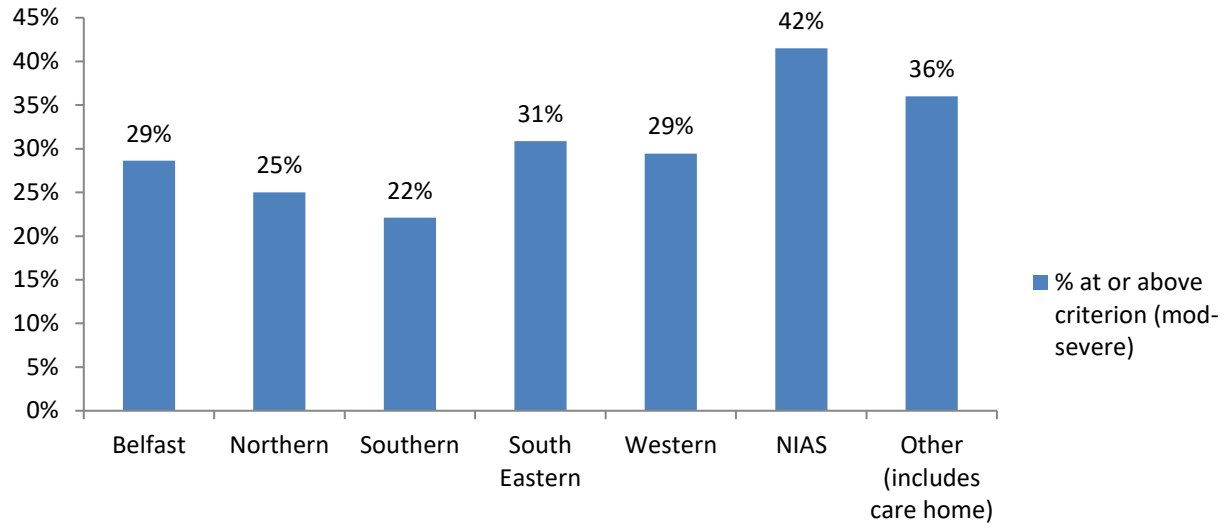
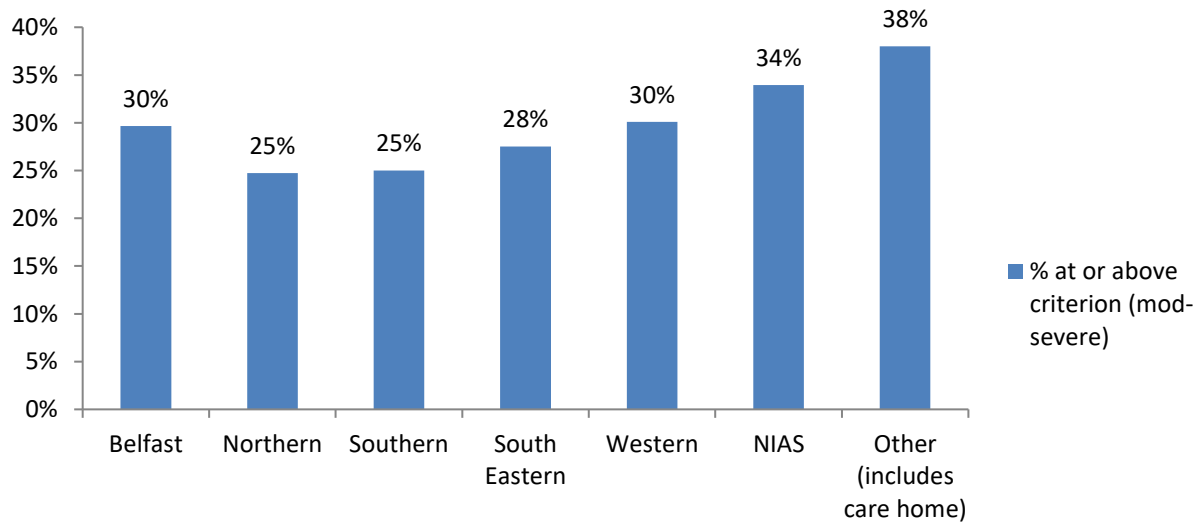


Figure 35: Proportion of HSCNI staff with moderate to severe self-reported insomnia at Time 4



5.1 Recommendations

Our previous reports had a number of important recommendations and nothing in this report contradicts these original recommendations. Our reports have highlighted sustained high levels of poor wellbeing and mental health. This needs a substantial response from services.

1. We recommend the continued focus on staff support at a regional and Trust level. It is vital that a regional group provides leadership in this area.
2. There is a need for large scale interventions to be resourced and implemented at a local and regional level. These interventions should be evidence-based and targeted at organisational, group and individual levels. Systemic interventions could include improving communication, the promotion of manageable workloads, compassionate leadership, and the improvement of handling redeployments.
3. Scaling up psychological interventions such as team supports and evidence-based wellbeing programmes is needed in the light of this crisis.
4. There need to be robust and strong pathways to individual psychological interventions for all staff and they should target those in particular distress.
5. Finally, while this survey has provided important insights into levels of distress over the past year we now recommend this is followed-up as the pressures of the pandemic ease, thus allowing the recovery in the staff group to be monitored.

Our Vision

To deliver excellent integrated services in partnership with our community

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