Northern Health and Social Care Trust

Impact Research Centre

COVID-19 Wellbeing Survey

Time One Findings

Version 1: 21st December 2020

Research team

Dr Ciaran Shannon (Northern Health and Social Care Trust), Principal Investigator

Dr Julie-Ann Jordan (Northern Health and Social Care Trust)

Dr Kevin Dyer (Northern Health and Social Care Trust)

Trust Leads

Dr Dympna Browne (Belfast Health and Social Care Trust)

Dr Emma Carroll (Northern Health and Social Care Trust)

Jarlath Kearney (Northern Ireland Ambulance Service)

Dr Jenny Maguire (South Eastern Health and Social Care Trust)

Dr Keith Kerrigan (Northern Health and Social Care Trust)

Dr Sinead Hannan (Southern Health and Social Care Trust)

Dr Thomas McCarthy (Western Health and Social Care Trust)

Advisory group members

Prof Ciaran Mulholland (Northern Health and Social Care Trust; Queen's University Belfast)

Prof Mark Tully (Ulster University)

Frances Johnston (Northern Health and Social Care Trust)

Pauline Shepherd (Independent Health and Care Providers)

Ann Marie McStocker (Northern Ireland Ambulance Service)

Lynn McGookin (Staff representative)

Simon Hilditch (Staff representative)

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1.1 Executive Summary

This report outlines the results of the first time point of the Northern Ireland COVID-19 Staff Wellbeing Survey that we carried out during November 9-22nd 2020. Time point one of the survey took place during the 2nd surge of the COVID-19 pandemic in Northern Ireland, when there was considerable excess strain on the health service. In total, 3,834 health and social care staff from across Northern Ireland took part at Time 1.

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 30%; anxiety 26%; PTSD 30%; Insomnia 27%). The prevalance of moderate to severe anxiety and depression was higher amongst the HSCNI staff in the present survey, than that reported in the general population in the UK during the pandemic.

For all four measures of psychological wellbeing the perceived effectiveness of communication by their organisation on COVID-19 related matters was the strongest predictor of wellbeing; specifically, more effective communication was associated with lower self-reported levels of depression, anxiety, PTSD, and insomnia. For most of the psychological wellbeing measures, those who managed COVID-19 patients, had higher exposure to COVID-19, had at least one COVID-19 risk factor, and had been asked to consider a redeployment opportunity had worse psychlogical wellbeing.

More than two thirds of participants (68%) said they had used none of the supports offered during the pandemic. For those who did use some form of support, online resources and information leaflets/booklets where the most common types of support used. Most participants reported not needing support or being able to get support elsewhere when needed. However, 36% of those not using supports felt reassured just by knowing that it was available.

Amongst those who had used some form of support (n=1178), 38% found it useful or very useful. After using the supports, many were likely or very likely to say they would use them again (44%) or recommend them to a friend or a work colleague (50%).

The report has a number of recommendations:

1. The high levels of distress within the staff group further highlight the importance of a regional coordinated approach to staff wellbeing and supports. We recommend the continued working of the regional staff support group.

2. The report highlights the importance of clear, frequent and transparent communication throughout all levels in HSC organisations (our biggest predictor of distress). Organisations need to pay particular attention to this aspect of dealing with their workforce during this pandemic.

3. Staff clearly value the range of supports implemented (information, helplines etc) and it is clear that continued provision of a broad range of supports is needed throughout all organisations involved in the survey. It is clear that 2020 has been a difficult year for all HSC staff and robust methods of staff support are much needed.

4. However, it is also clear that we need to innovate in reaching more staff in need. High levels of distress with low levels of uptake of formal support mechanisms does suggest services need to adapt in order to reach staff in need.

5. Our report has clear implications for redeployment:

    a. Very clear communication about expectations and workload of new role in any communication.

    b. Reassurance it does not increase personal or family risk (current prioritisation of the vaccine is likely to be of considerable help here).

    c. It is important that any redeployment is appropriate and that staff have the necessary training and skills to carry out any new roles.

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 first time point of the survey (November 9-22nd 2020) are presented in this report. Time point one of the survey took place during the 2nd surge of the COVID-19 pandemic in Northern Ireland, when there was considerable excess strain on the health service. Indeed, as Figure 1 shows (NISRA, 2020), the survey coincided with the 2nd peak of COVID-19 related deaths, with 96 and 100 deaths being recorded in the weeks ending 13/11/20 and 20/11/20. The first time point of the survey also coincided with the second peak in hospital admissions (Figure 2; NISRA, 2020).

The survey will also run on a further three occasions which will occur after HSCNI staff have had an opportunity to get vaccinated against COVID-19 (February, May, and August 2021) This will allow us to track the impact of the COVID-19 outbreak on staff over time.

Figure 1. Weekly COVID-19 deaths in Northern Ireland (NISRA, 2020)

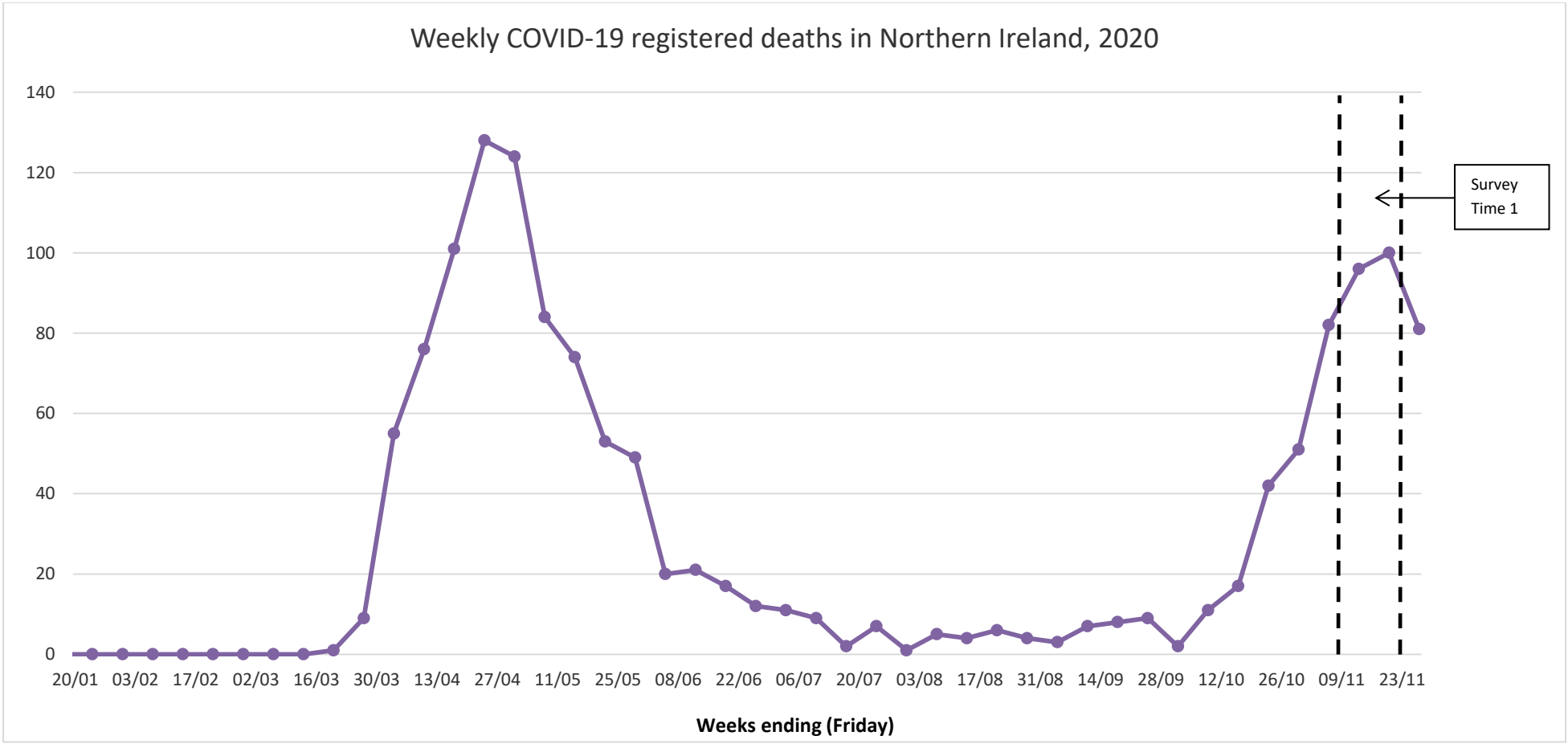
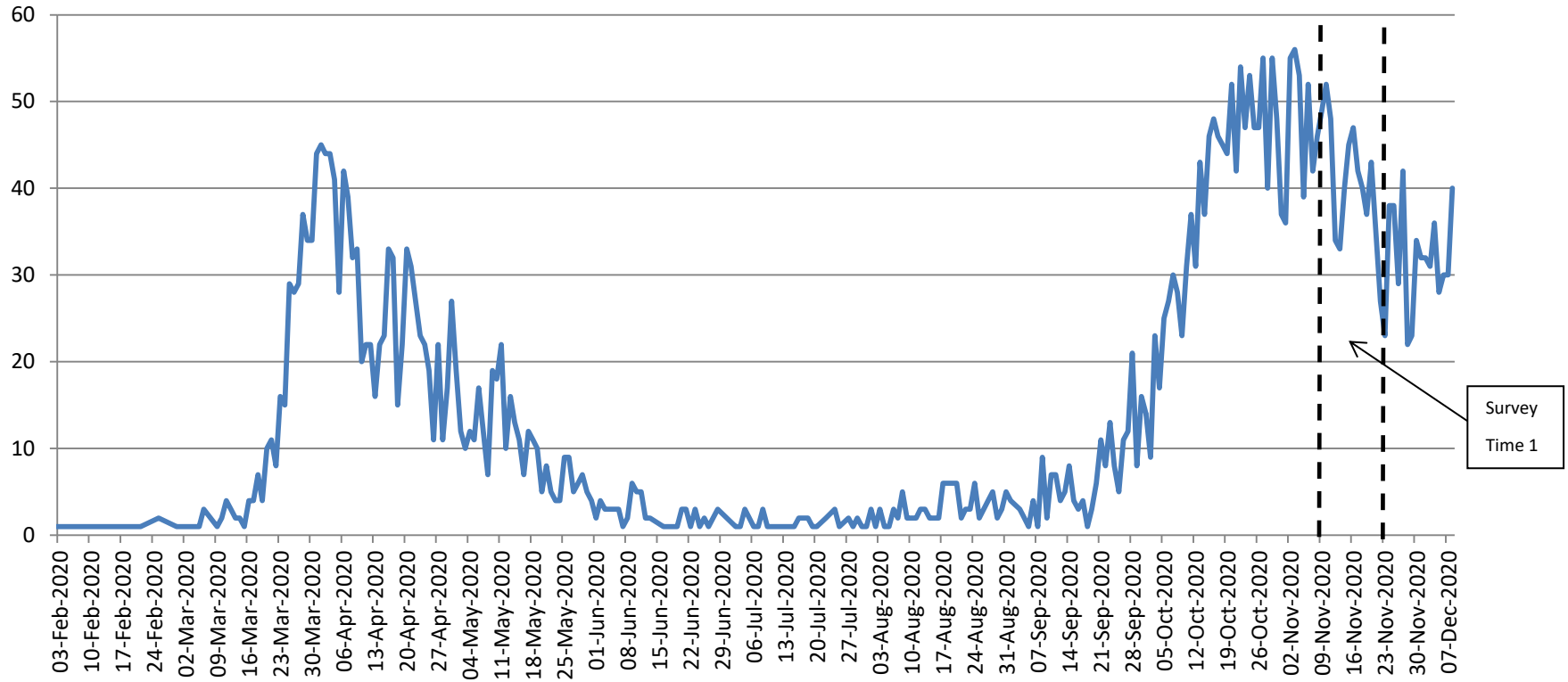


Figure 2. Daily COVID-19 hospital admissions in Northern Ireland (NISRA, 2020)



2.2 Achieved sample and 95% confidence intervals

In total, 3,834 health and social care staff from across Northern Ireland took part in Time 1 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 +/-1.59%. For the smallest subsample analysis, that involving the 863 who had been redeployed, the precision level for a proportion of 50% was +/- 3.39% (95% Confidence intervals)

2.3 Format of the report

Sections 3.1 – 3.10: Findings for overall sample.

Section 4.1: Psychological wellbeing data by organisation

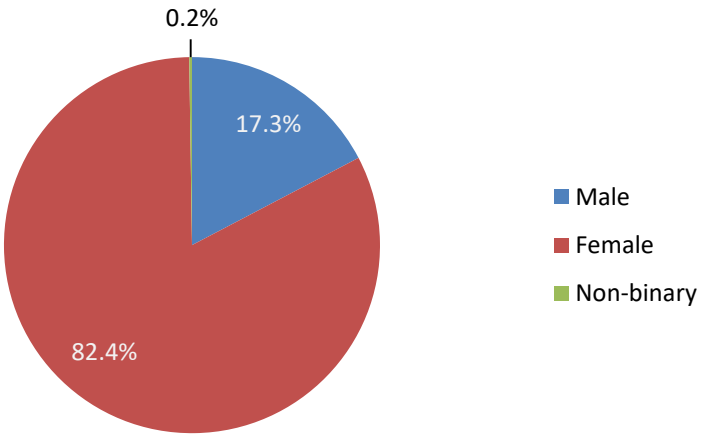
Section 5.1: Recommendations

3.1 Who took part?

Age and Gender

Of the 3,834 health and social care staff that took part, the vast majority of respondents were female (82%; Figure 3). This pattern is in keeping with annual HSCNI Staff surveys (e.g. Quality Health, 2016) where females have consistently comprised four fifths of the sample. The average age of respondent was 44 years, and the sample included individuals aged 16-75 years.

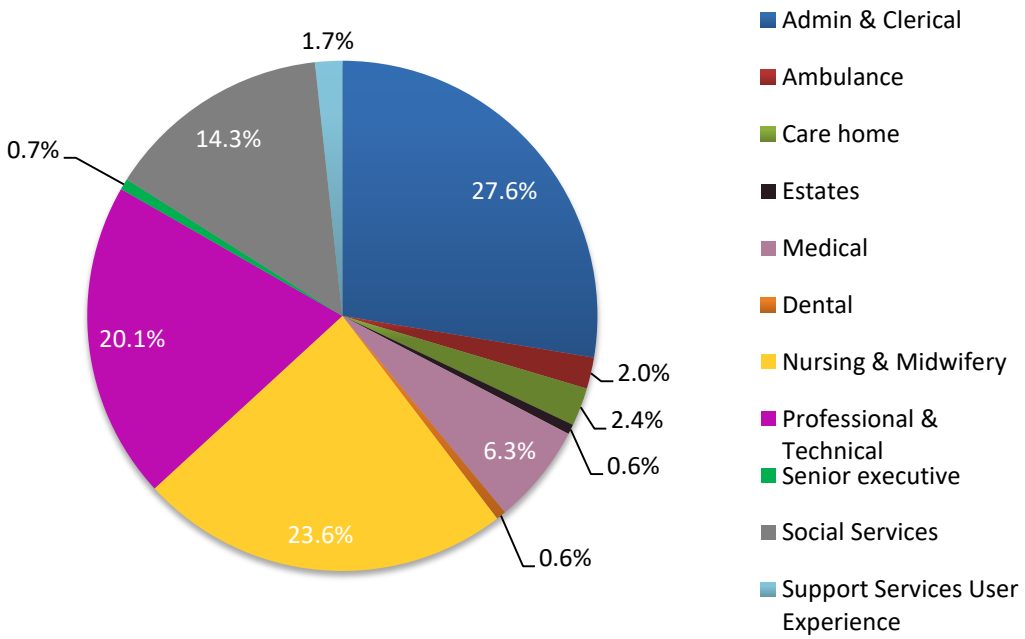
Figure 3: Gender breakdown of respondents



Occupation

Figure 4 shows that a large proportion of the sample worked in *administrative and clerical* (28%), *nursing and midwifery* (24%), and *professional and technical* (20%) roles. Compared to occupational distribution data for Northern Ireland health and social care staff (e.g. Quality Health, 2016; *figures exclude care home and senior executives*) the achieved sample has good representation from most sectors. However, *support services/user experience* are somewhat underrepresented in the present sample; this sector typically comprises approximately 9% of the health and social care workforce, five times the proportion achieved in Time 1 of the COVID-19 Wellbeing survey. In HSCNI staff surveys that were run pre COVID-19, response rates have tended to be lowest in this sector, as they can be particularly hard to reach (i.e. no trust email addresses). Engaging with this group during COVID-19 has become even more challenging due to infection control rules (e.g. no postal option possible, strict rules on use of posters).

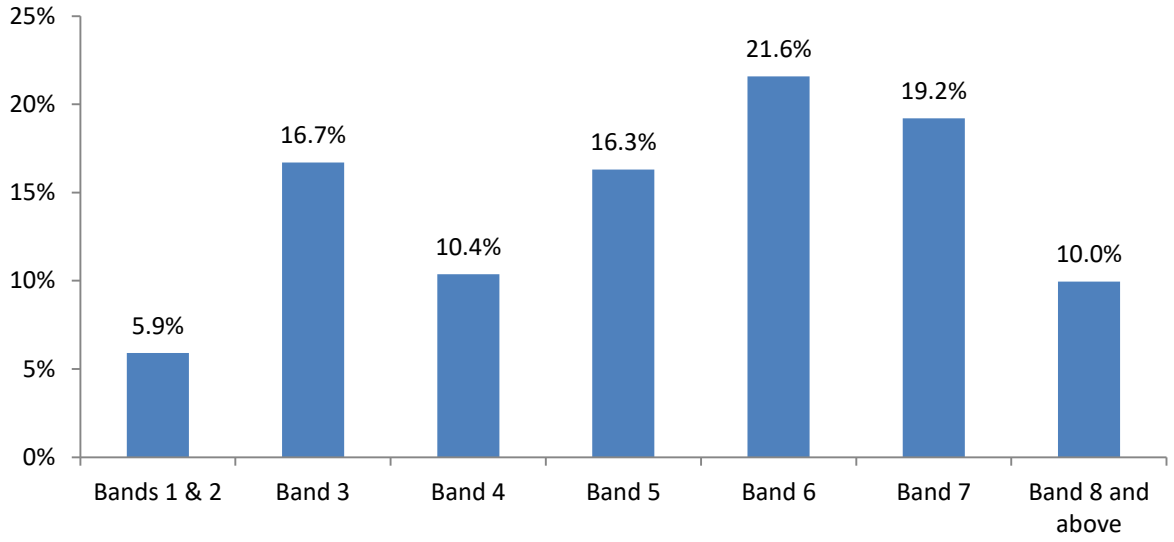
Figure 4: Occupation breakdown of respondents



Agenda for Change (AfC) Banding

The majority of respondents (89%) reported being paid on the Agenda for Change payscale. The AfC banding breakdown for those paid on this scale is shown in Figure 5.

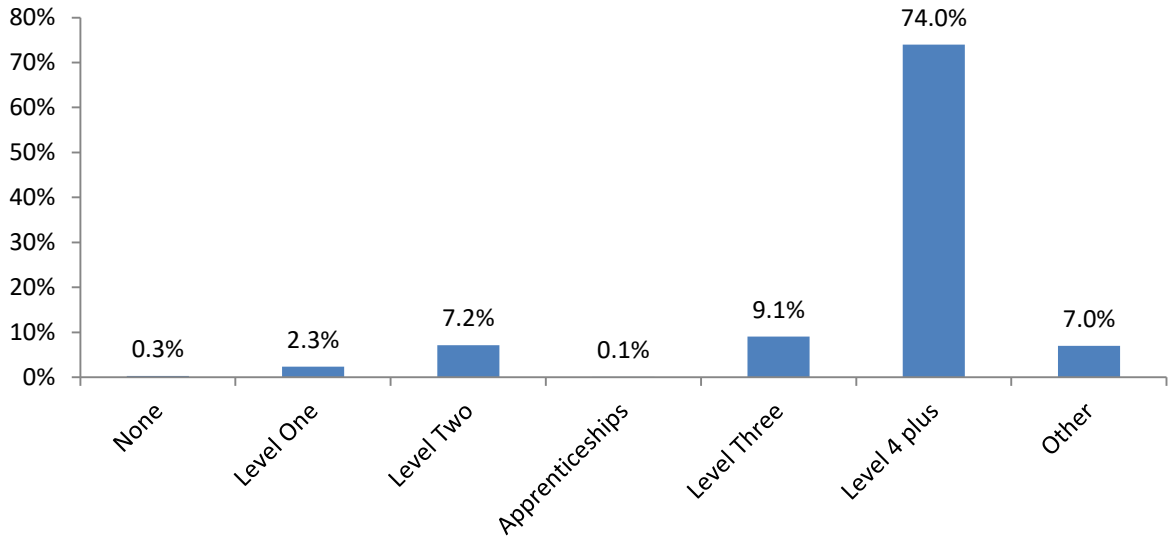
Figure 5: AfC banding of respondents



Highest qualification achieved

Overall the sample reported being highly educated (Figure 6), with nearly three quarters (74%) having achieved a level 4 qualification or above (e.g. Degree, NVQ level 4-5).

Figure 6: Highest qualification of respondents

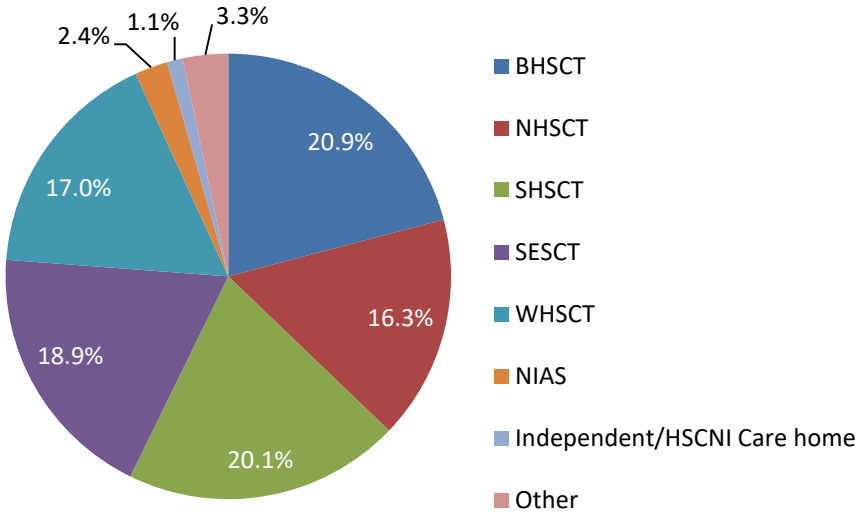


HSCNI Trust/Organisation

The HSCNI Trust/Organisation that the respondents reported belonging to is shown in Figure 7. 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, NIAS had the highest response rate (7.0%), followed by SHSCT (6.0%), SEHSCT (5.9%), WHSCT (5.6%), NHSCT (4.8%), and BHSCT (3.4%).

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

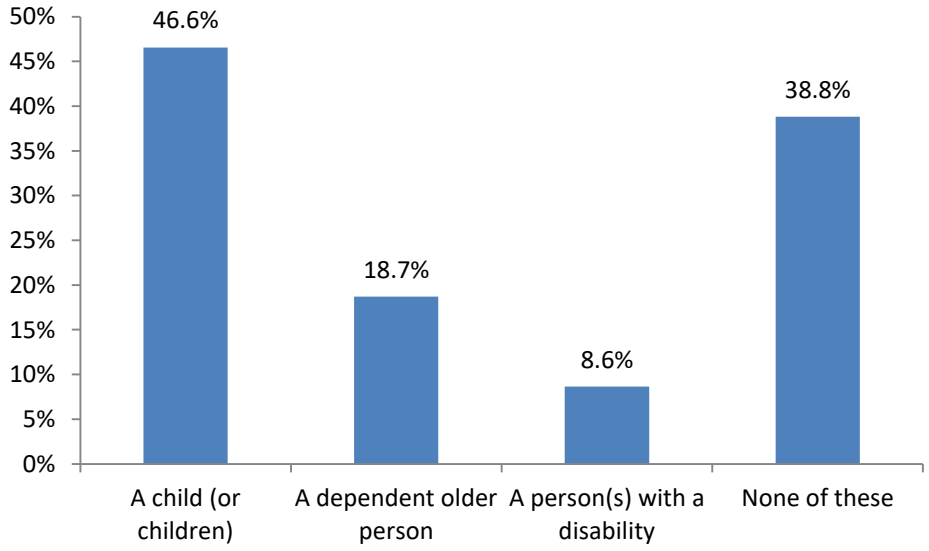
Figure 7: HSCNI Trust/Organisation of respondents



3.2. Looking after Dependants during the COVID-19 outbreak

The majority of respondents (61%) identified at least one dependant that they had caring responsibilities for (Figure 8).

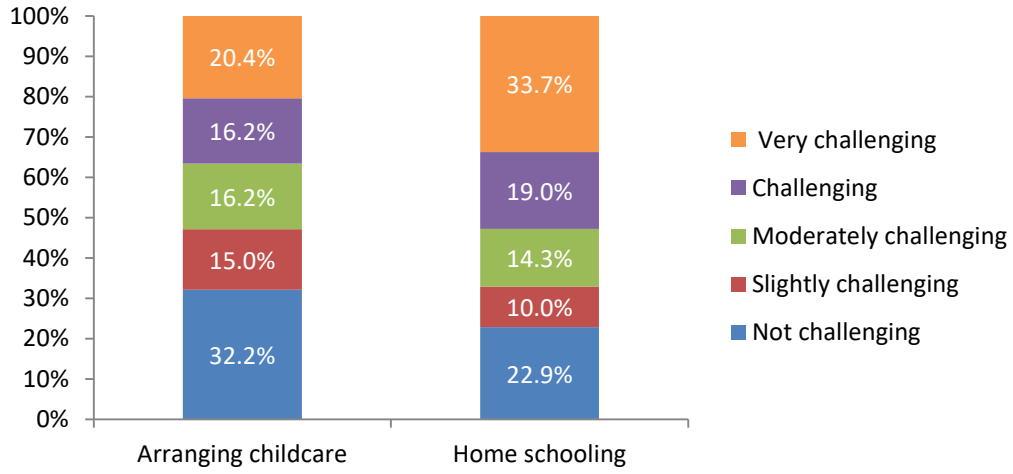
Figure 8. Caring responsibilities of respondents



Amongst those with children, 57% had difficulty arranging childcare, and 77% had to home school their children.

For those who had to arrange childcare, 37% found this challenging or very challenging to sort out (Figure 9). Home schooling was challenging or very challenging for the majority (53%) of health and social care staff who had to provide this.

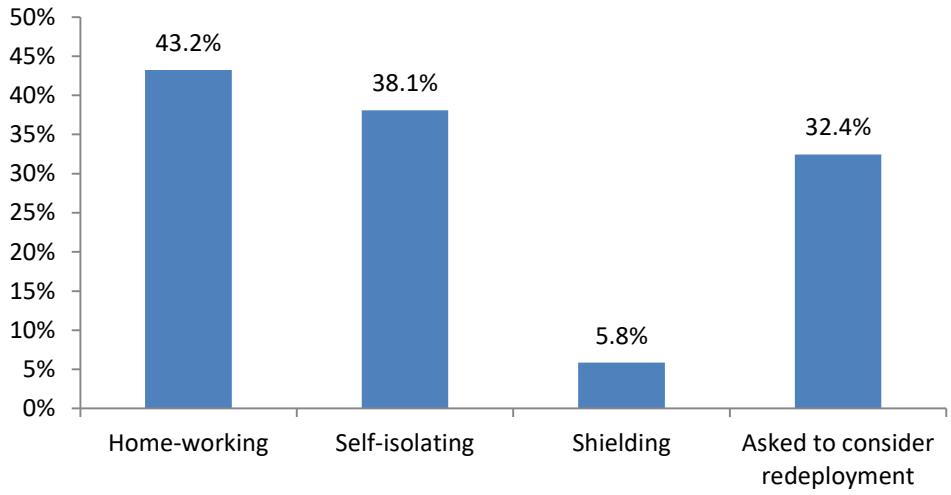
Figure 9. Experiences of arranging childcare and homeschooling



3.3 Changes in work patterns

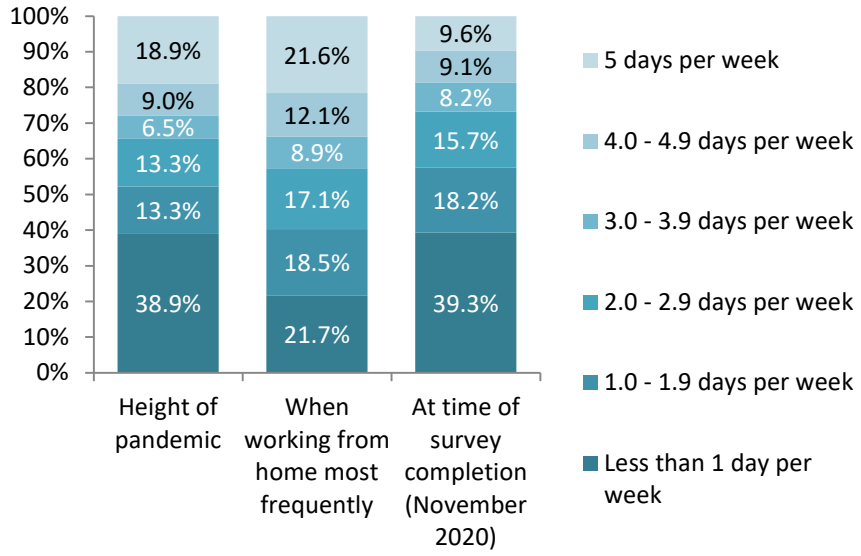
The survey looked at the impact of the COVID-19 pandemic on health and social care staff work patterns, including if at any stage since the outbreak they had had to work from home, self-isolate, shield, or consider a redeployment opportunity (Figure 10).

Figure 10. Working arrangements during the COVID-19 outbreak



Those who reported working from home (n = 1657; 43%) were asked to say what proportion of their working week was spent working from home at various points during the COVID-19 pandemic. The results are presented as days worked per week (full time equivalent) in Figure 11. The proportion of people who spent more than half their time (3 or more days per week FTE) at home varied from 43% when they were working from home most frequently, to 34% at the height of the pandemic and 27% when they completed the survey in November 2020.

Figure 11: Proportion of time spent working from home at various phases of the COVID-19 pandemic



Around half (49%) of individuals who were asked to consider redeployment felt worried or very worried about the prospect of having to take up new duties as a result of the COVID-19 outbreak (Figure 12).

Figure 12. Views on redeployment

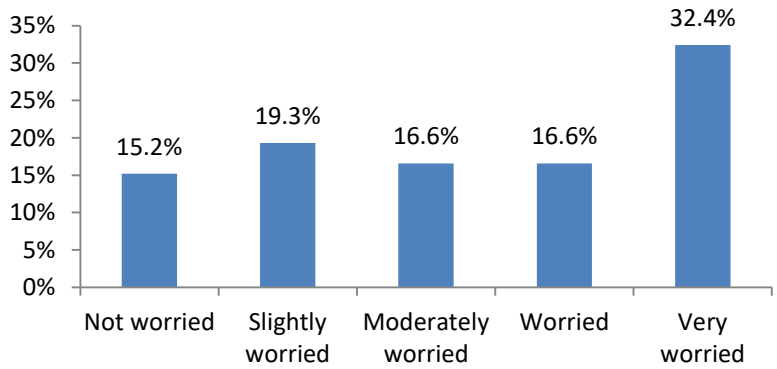
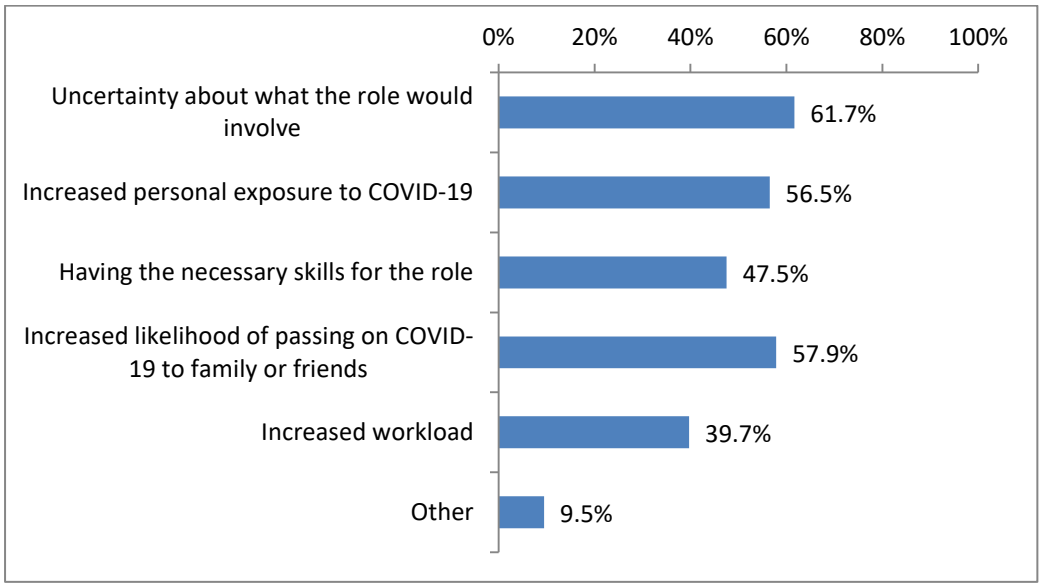


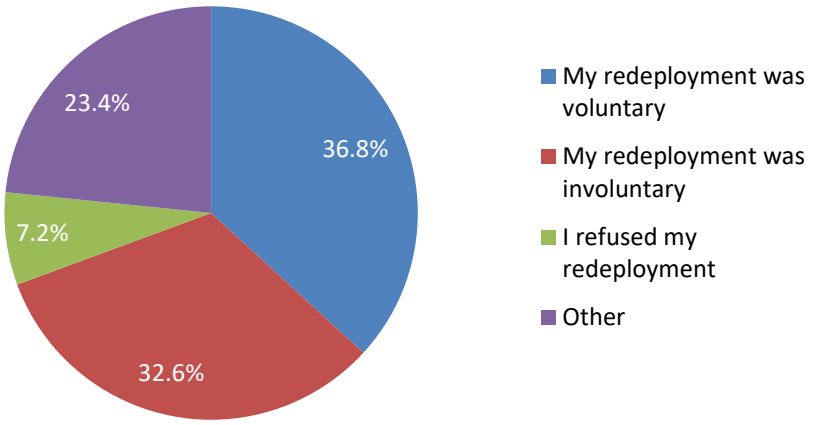
Figure 13 shows that redeployment concerned staff in many ways including uncertainty about what the role would involve (62%), increased personal exposure to COVID-19 (57%), having the necessary skills for the role (48%), increased likelihood of passing on COVID-19 to family or friends (58%), and increased workload (40%).

Figure 13. Concerns about redeployment



The majority of staff asked to consider a redeployment opportunity ended up in that role either on a voluntary or involuntary basis (69%; Figure 14).

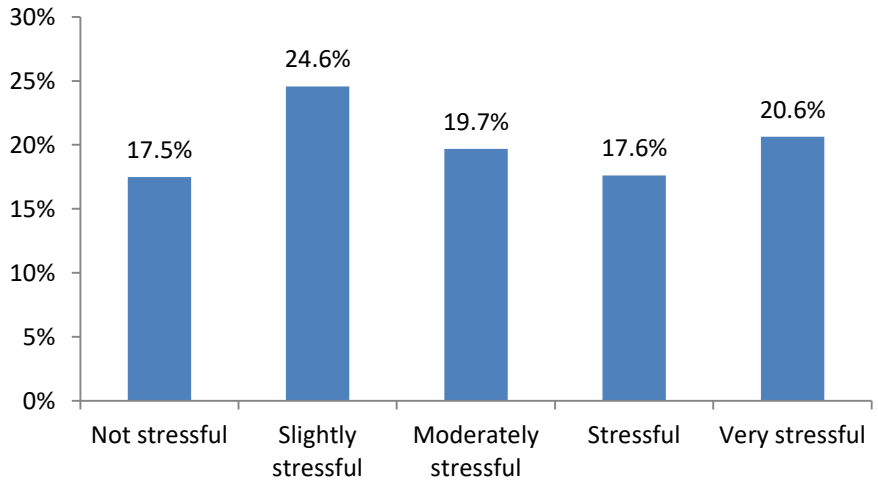
Figure 14: Outcome of redeployment request



Of those who were redeployed (n = 863), 38% found their new role stressful or very stressful (Figure 15).

Around half (53%) reported being redeployed for 100% of their working week, while the other 47% reported that their redeployment only took up part of their working week. The median length of time each staff member reported being redeployed for was 10 weeks

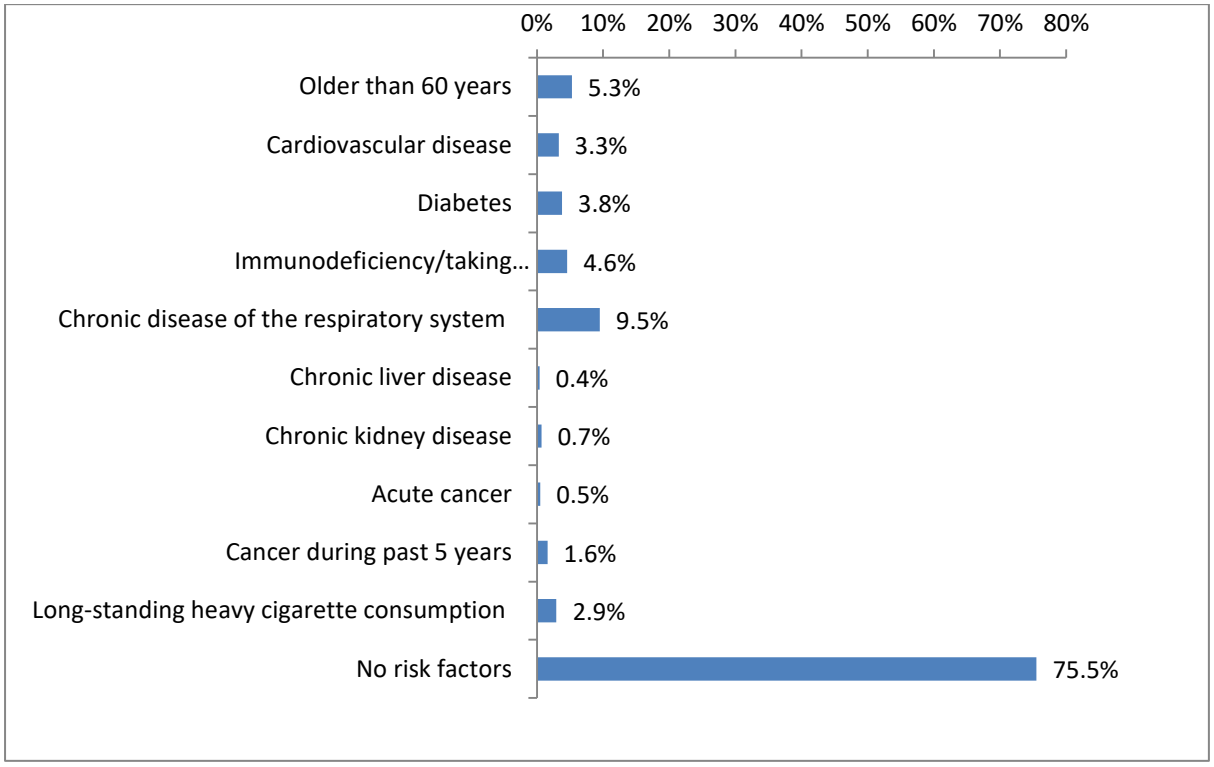
Figure 15. Experience of being redeployed



3.4 COVID Risk Factors and Exposure

COVID risk factor questions from the COVID-19 Pandemic Mental Health Questionnaire (CoPaQ; Rek et al., 2020) were included in the survey. Participants were asked asked to indicate if any of ten COVID-19 risk factors (e.g. older than 60 years, diabetes) applied to them (Figure 16). Three quarters (75%) stated they did not have any of the risk factors presented to them, while the other 25% indicated that at least one COVID-19 risk factor applied to them. *Chronic diseases of the respiratory system (e.g. asthma, chronic bronchitis)* was the risk factor affecting the greatest proportion of the sample (10%). *Longstanding cigarette consumption, cancer during the past 5 years, immunodeficiency/taking immunosuppressants, diabetes, cardiovascular disease*, and being *older than 60* affected 2-5% of respondents. All other conditions presented in less than one percent of the sample.

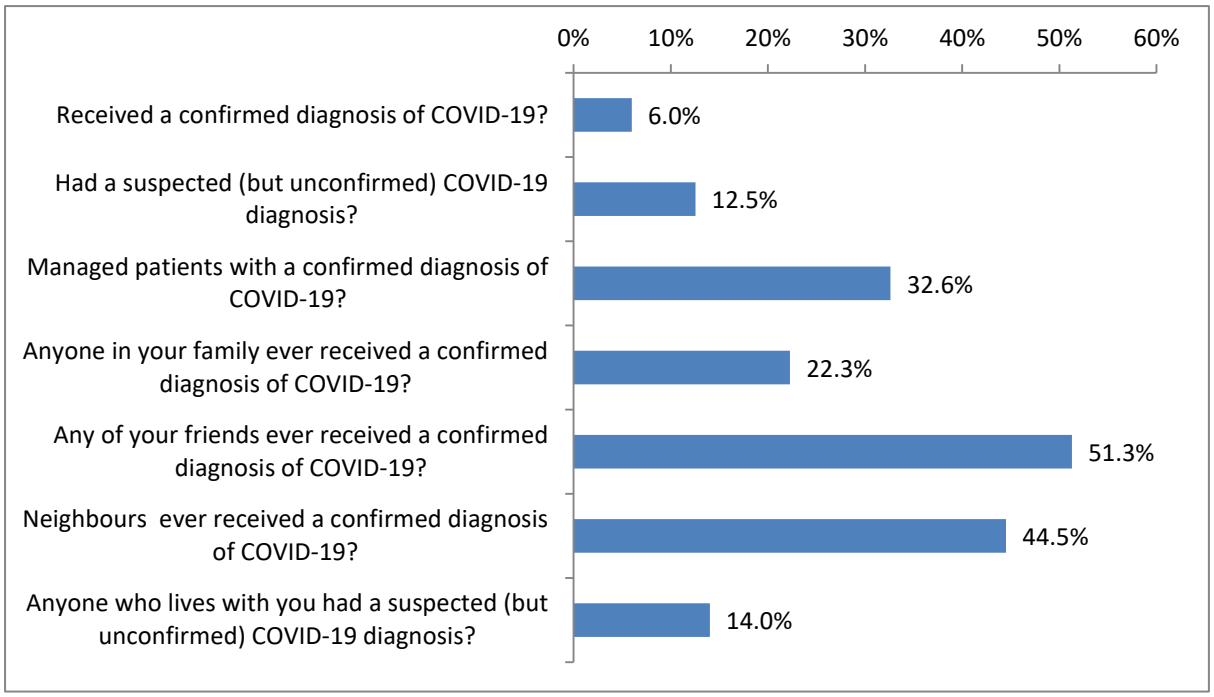
Figure 16. Proportion of sample affected by COVID-19 risk factors



COVID-19 Exposure

Amongst the respondents, 6% reported having received a confirmed COVID-19 diagnosis, while more than double that number (13%) suspected (no cofirmation) that they had had COVID-19 (Figure 17). A third of the sample (33%) managed patients with confirmed COVID-19 diagnoses. Participants also commonly reported knowing friends (51%), neighbours (45%) and family members (22%) with confirmed COVID-19 diagnoses.

Figure 17. Exposure to COVID 19



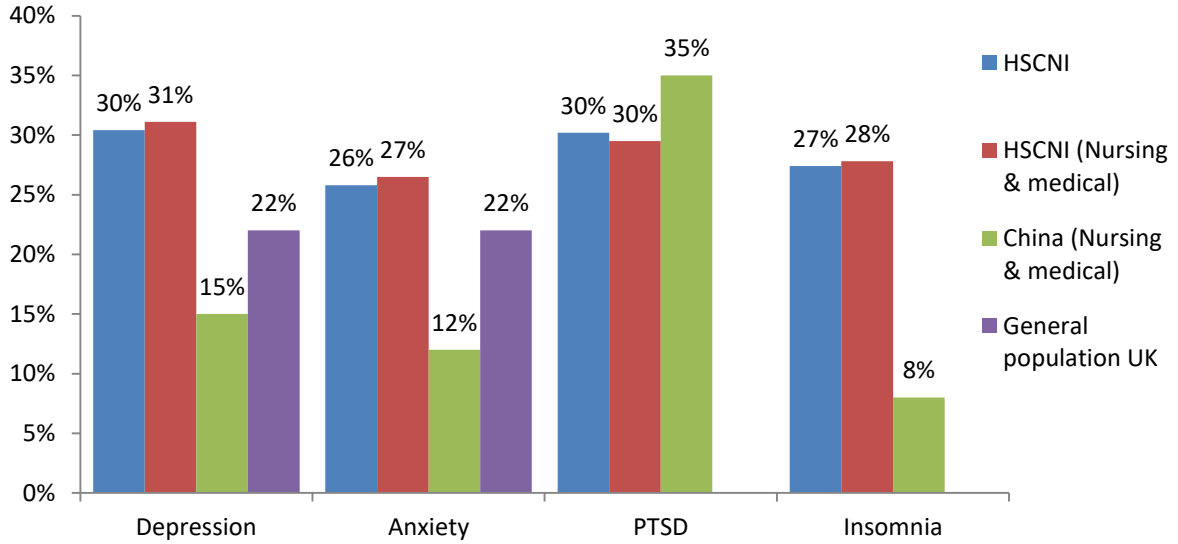
Over one fifth of the sample (22%) reported personally knowing someone who had died as a result of COVID-19.

3.5 Psychological wellbeing

Prevalence of moderate and 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. With the exception of PTSD, the levels of moderate to severe difficulties amongst HSCNI staff in the present survey (depression 30%; anxiety 26%; PTSD 30%; Insomnia 27%) were generally higher than those reported in healthcare staff in China during the first wave of COVID-19 (Lai et al., 2000; depression 15%; anxiety 12%; PTSD 35%; Insomnia 8%). As the China based study was run on a more restricted sample (i.e. limited to medical and nursing staff), results were also produced for nursing and medical HSCNI staff (n = 1146) – these were very similar to those for HSCNI staff as a whole. The prevalance of moderate to severe anxiety and depression was higher amongst the HSCNI staff in the present study, than that reported in the general population in the UK post-COVID (Shevlin et al. anxiety 22%; depression 21%). Proportions broken down by organisation are in Section 4.1

Figure 18. Proportion of sample self-reporting moderate to severe psychological wellbeing symptoms



Predictors of psychological wellbeing

Statistical analyses (Regression summary tables are available upon request) were run to look at the relationship between a number of demographic and COVID-19 related predictors and psychological wellbeing (depression, anxiety, PTSD, and insomnia). The predictors examined included:

- *Occupation*
- *Gender*
- *Age*
- *Sum of seven Covid-19 exposures variables: knowing a friend, neighbour or family member with COVID-19, or having had a confirmed or suspected diagnosis yourself, knowing someone who died from COVID-19; living with someone with a suspected diagnosis of COVID-19)*
- *If managed patients with COVID-19*
- *If asked to consider a redeployment opportunity*
- *If they have one or more risk factors for COVID-19 (e.g. diabetes)*
- *Perceived effectiveness of communication by their organisation on COVID-19 related matters*

The amount of variation on the four psychological wellbeing measures explained by the demographic and COVID-19 variables was quite small (10-12%). This means that most of the variation (88-90%) in psychological wellbeing is attributed to other factors. For all four measures of psychological wellbeing the perceived effectiveness of communication by their organisation on COVID-19 related matters was the strongest predictor of wellbeing; specifically, more effective communication was associated with lower self-reported levels of depression, anxiety, PTSD, and insomnia. All occupations were compared against those in *nursing and midwifery* roles, as this was one of the largest occupational groups in the sample and many of these staff would have been in frontline roles during the COVID-19 pandemic. Generally speaking *nursing and midwifery* staff had similar levels of wellbeing to *ambulance, carehome, estates, dental, senior executive*, and *social services* staff. *Nursing and midwifery* staff tended to had poorer psychological wellbeing compared to *medical* and *professional and technical* staff, but better psychological wellbeing than *administrative and clerical* and *support services* staff. For most of the

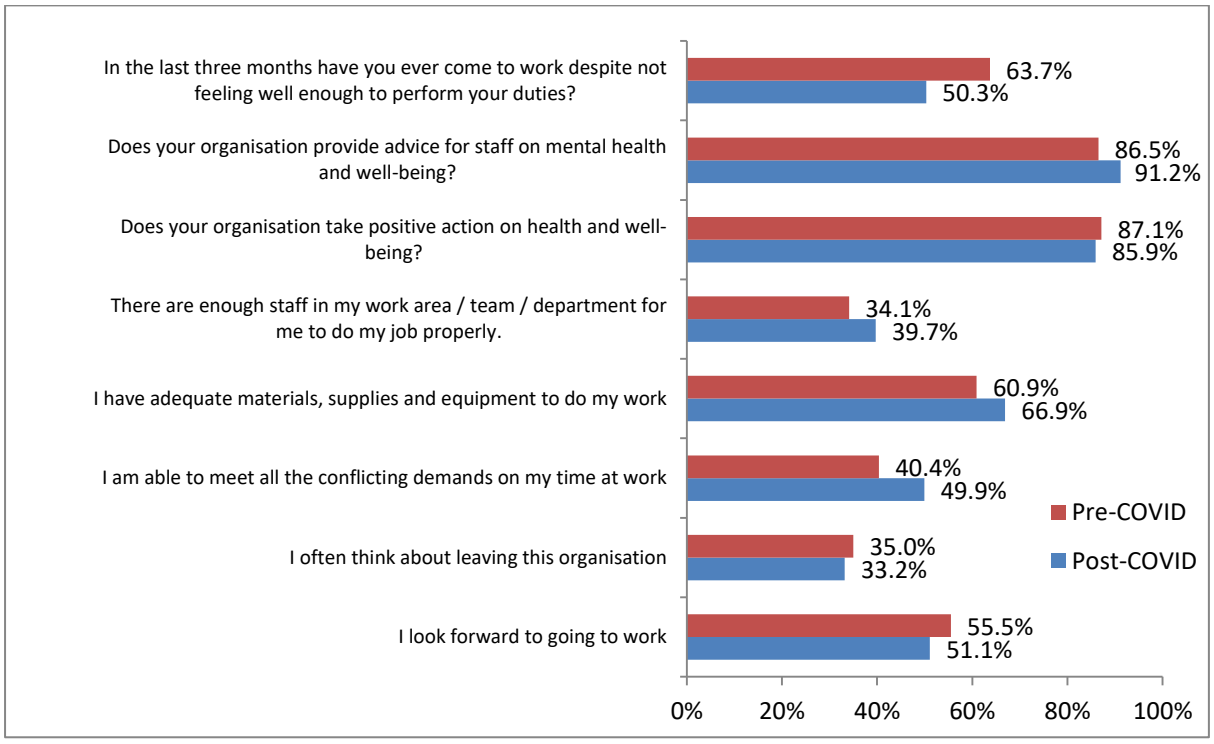
psychological wellbeing measures, those who managed COVID-19 patients, had higher exposure to COVID-19, had at least one COVID-19 risk factor, and had been asked to consider a redeployment opportunity had worse psychlogical wellbeing.

3.6 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).

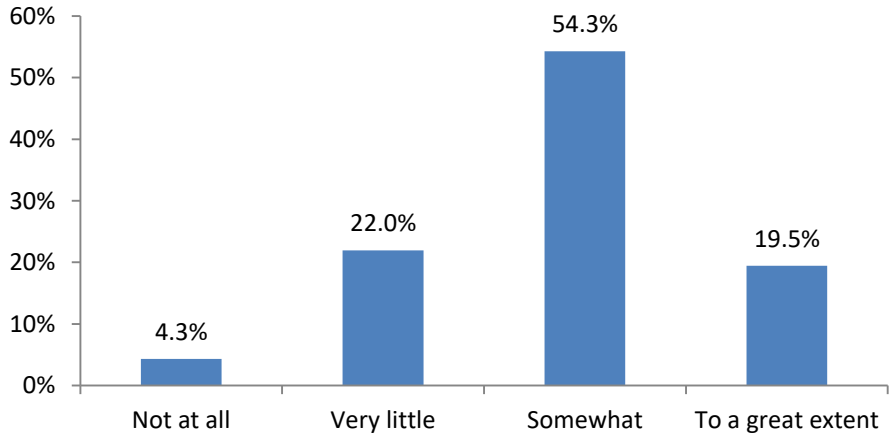
Compared to pre-COVID 19 levels, the proportion of people who look forward to going to work dropped by 4 percentage points. However, for other questions, the post COVID-19 results are similar or better compared to pre COVID-19 levels. Indeed, since the COVID-19 outbreak, the proportion of people coming to work despite not feeling well dropped by 13 percentage points. Improvements were also evident for meeting conflicting demands (+ 10 % pts), access to materials, supplies and equipment (+ 6 % pts), having enough staff (+ 6 % pts), and provision of advice for staff on mental health and wellbeing (+ 5 % pts).

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). Nearly three quarters (74%) felt that their wellbeing had been affected somewhat/to a great extent.

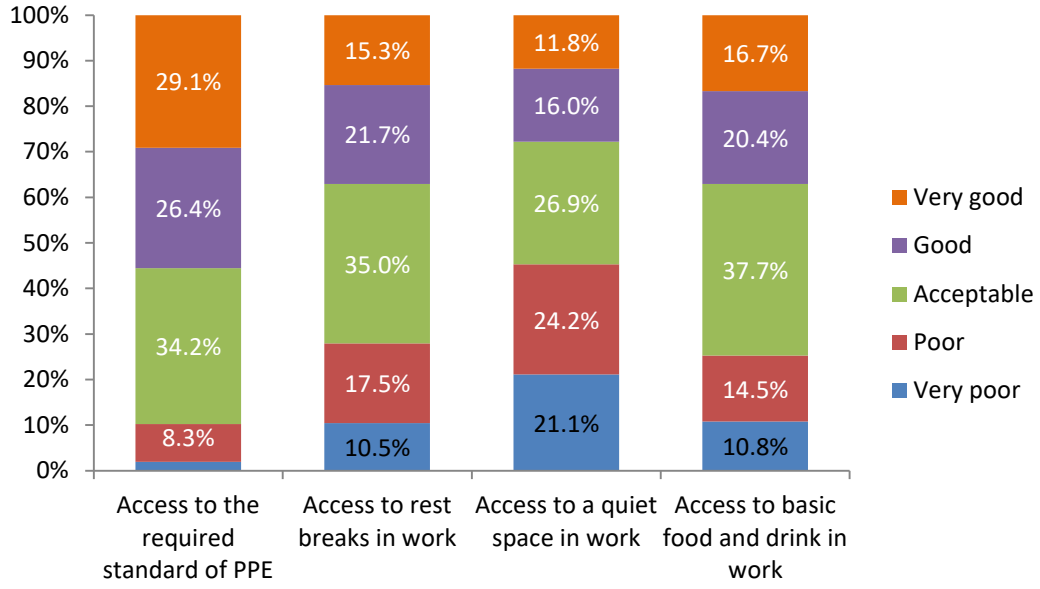
Figure 20. Effect of COVID-19 pandemic on psychological wellbeing



3.7 Environmental needs

Acceptable or higher ratings were given by the majority of respondents regarding access to: the required standard of PPE (90%); rest breaks in work (72%); a quiet space to work (55%); and basic food and drink in work (75%; Figure 21).

Figure 21. Access to basic needs during the COVID19 outbreak

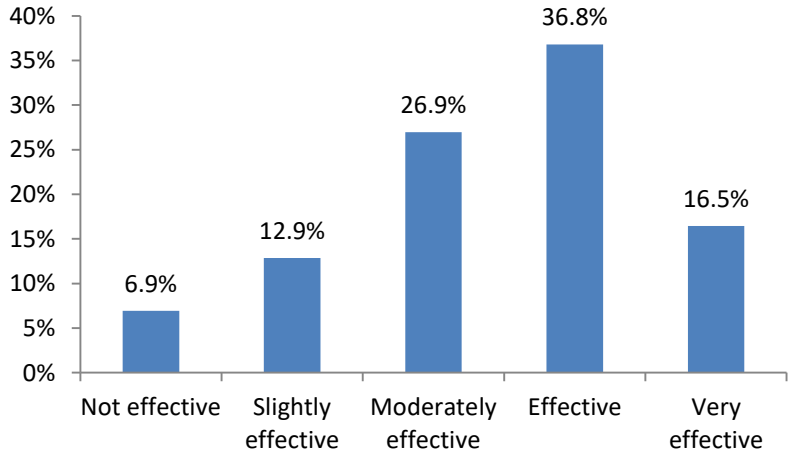


31% of staff had been given information and training to recognise dehydration, fatigue and exhaustion while wearing the required PPE.

3.8 Communication

Around half (53%) of respondents felt that the communication from their organisation on COVID-19 related matters had been effective or very effective (Figure 22).

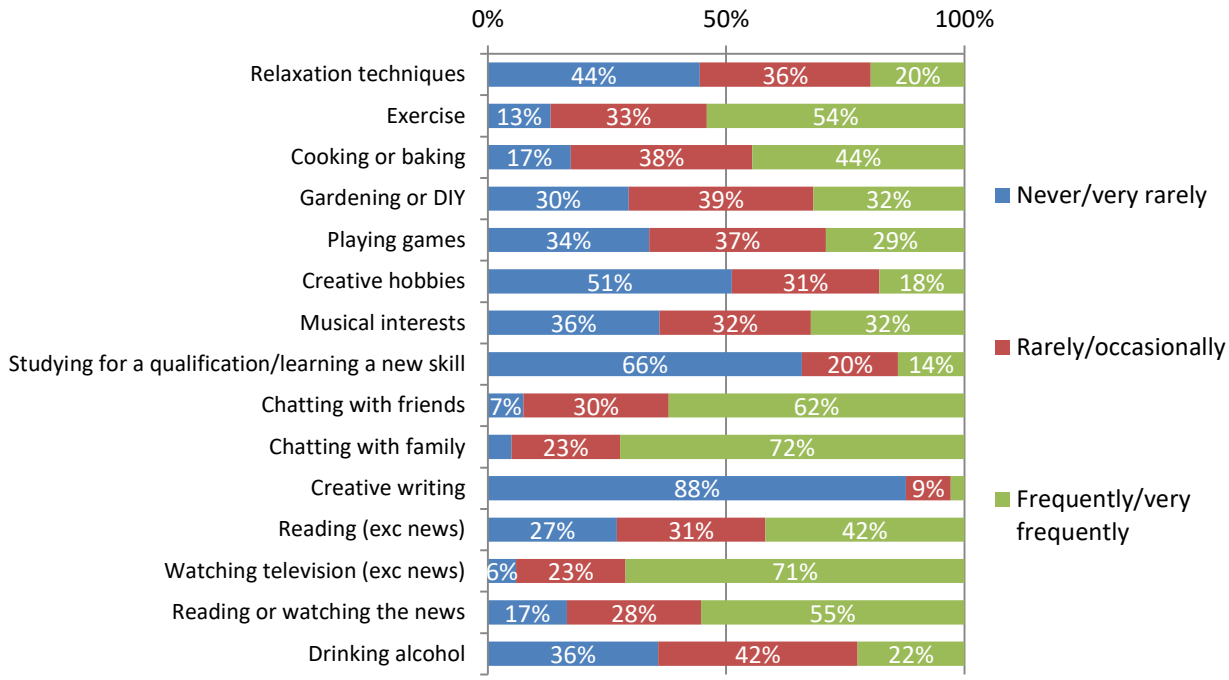
Figure 22. Communication effectiveness in relation to COVID-19 related matters from respondents organisation



3.9 What activities did staff engage in during the COVID-19 outbreak?

Participants were asked how often had they engaged in 15 different activities during the COVID-19 pandemic. (Figure 23). More than half the sample reported frequently or very frequently chatting with friends or family, watching TV (excluding the news), watching or reading the news, and exercising. Only around one fifth (22%) reported frequent consumption of alcohol.

Figure 23. Frequency of engagement in activities

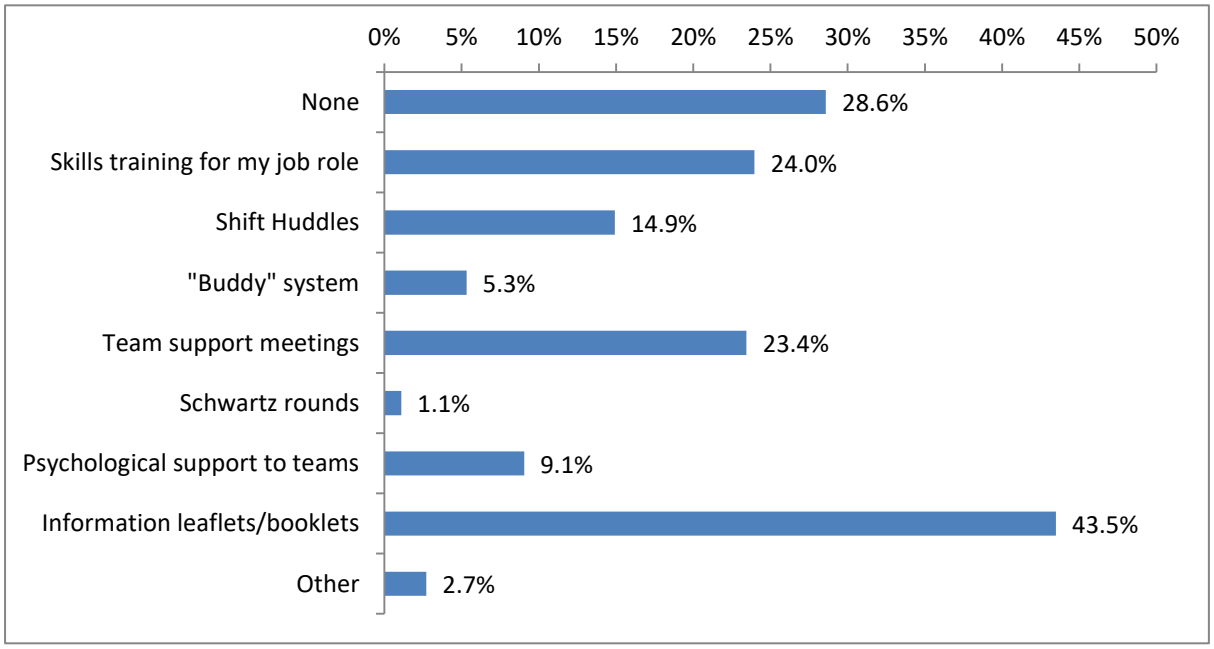


3.10 Support

Team supports

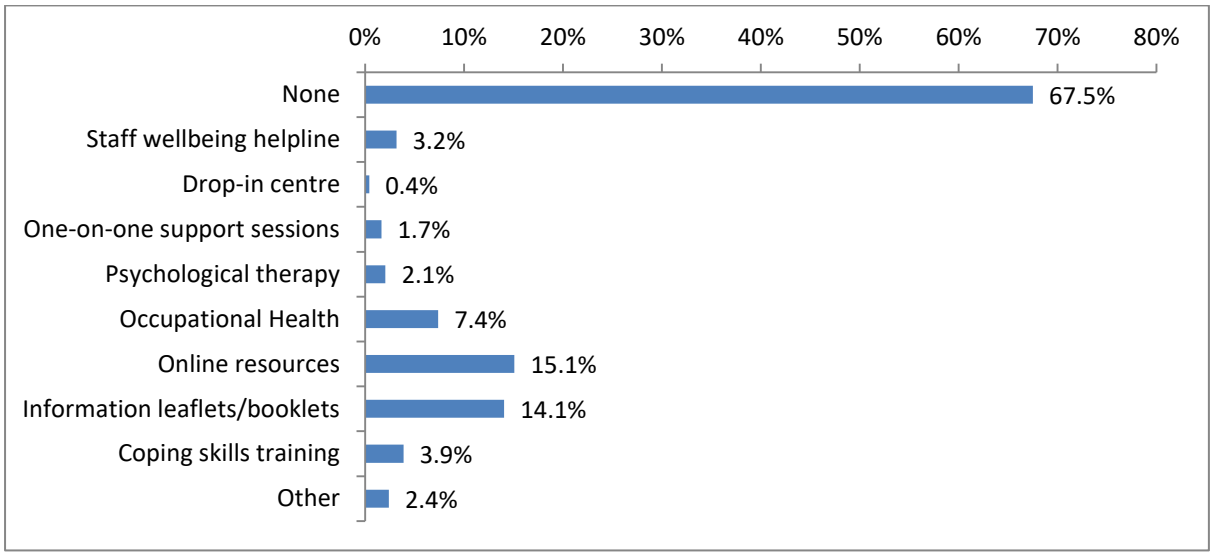
The participants were asked which team supports were made available within their service during the COVID-19 pandemic (Figure 24). Information sheets/booklets were commonly provided (43%), and around a quarter reported receiving skills training for their role (24%) or team support meetings (23%).

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



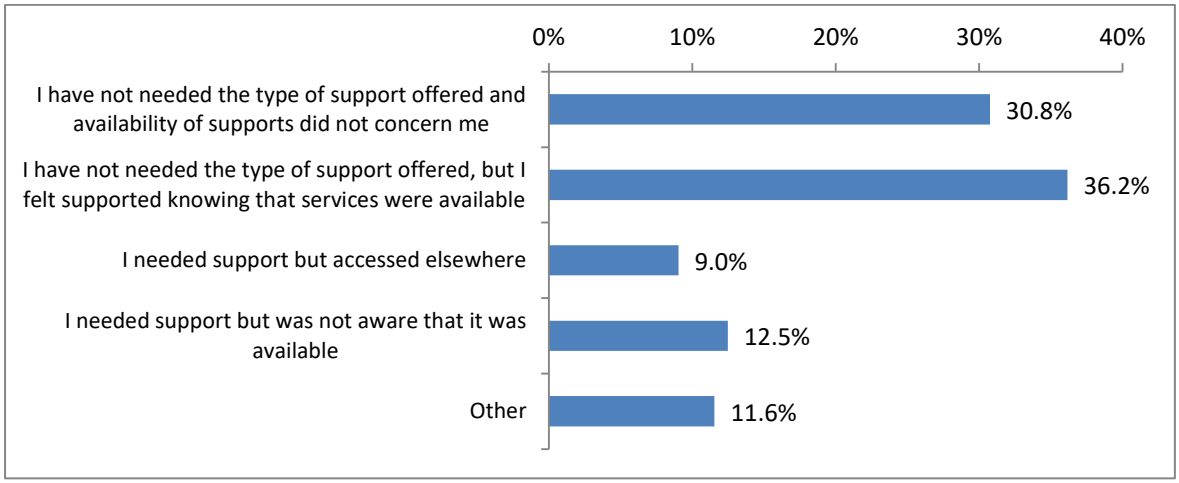
The particpants were then asked if they used any staff wellbeing supports during the COVID-19 pandemic (Figure 25). More than two thirds (68%) said they had used none of the supports offered. For those who did use some form of support, online resources and information leaflets/booklets where the most common types of support used

Figure 25. Staff wellbeing supports used during the COVID-19 pandemic



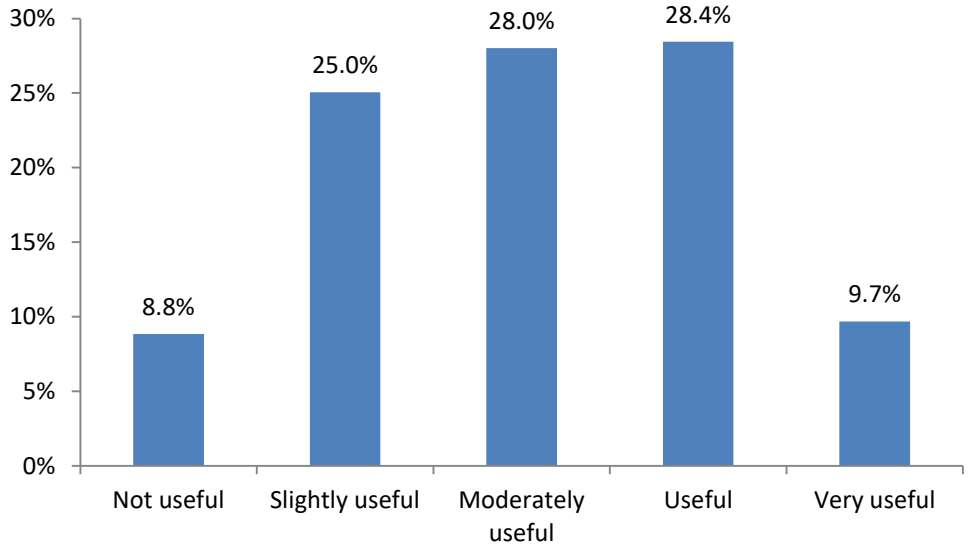
Those who ticked 'none' were asked why they did not use any supports (Figure 26). Most participants reported not needing support or being able to get support elsewhere when needed. It is interesting to note that 36% did not need any support but felt reassured just by knowing that support was available. However, it is concerning that some respondents did say they needed support but were not aware that it was available (13%).

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



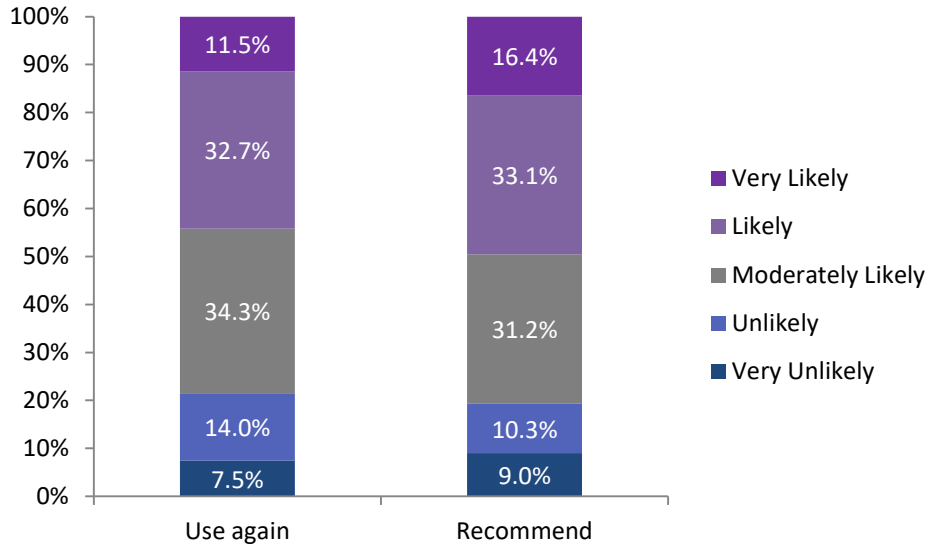
Amongst those who had used some form of support (n=1178), 38% found it useful or very useful (Figure 27).

Figure 27. Usefulness of support used.



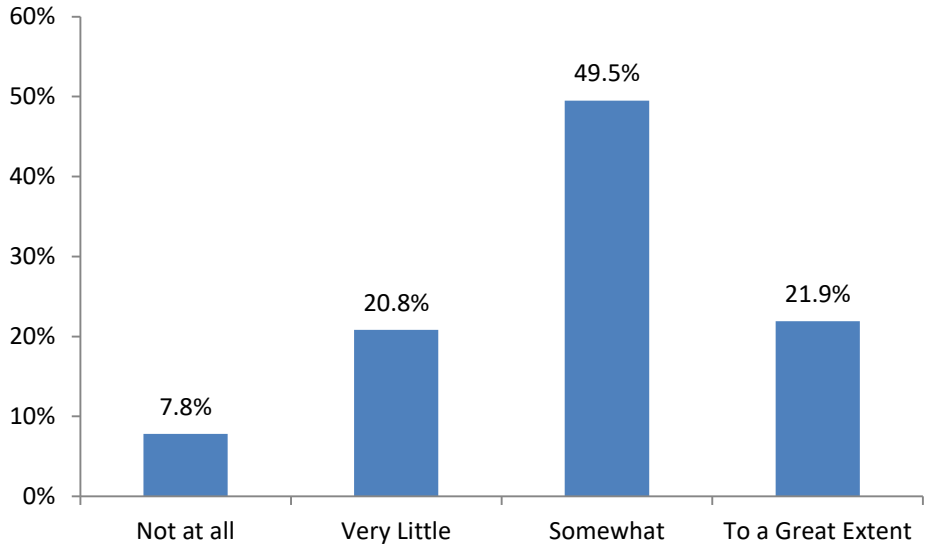
After using the supports, many were likely or very likely to say they would use them again (44%) or recommend them to a friend or a work colleague (50%; Figure 28).

Figure 28: Likelihood of using supports again or recommending them



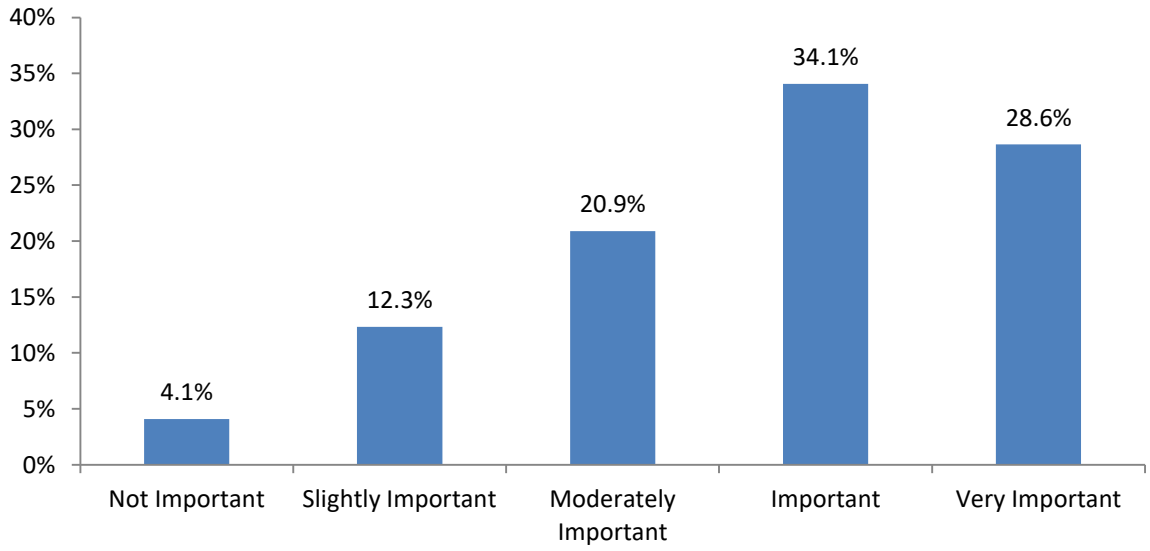
The majority (71%) of health and social care staff were somewhat or greatly aware of the staff wellbeing supports available to them within their Trust (Figure 29).

Figure 29: Awareness of staff wellbeing support available within their Trust



Having staff wellbeing support available within their Trust was important or very important for 63% of staff (Figure 30).

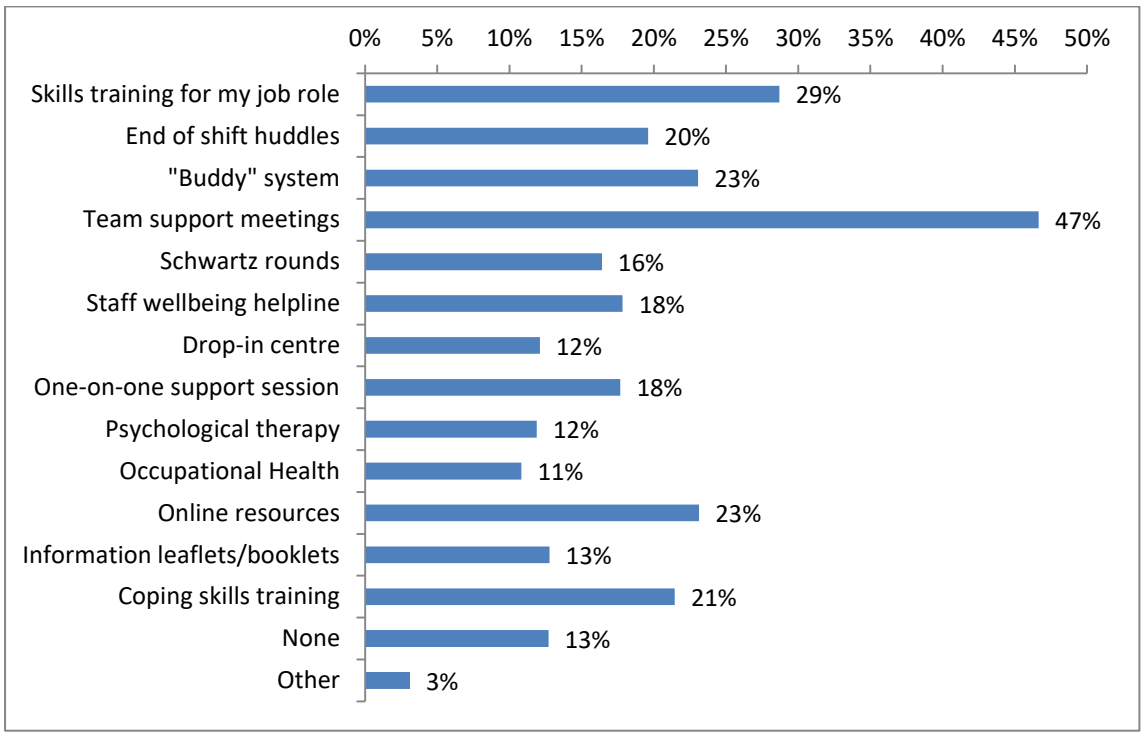
Figure 30: Importance of support



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



4.1. Psychological wellbeing by organisation

The proportion of staff with moderate to severe self-reported depression, anxiety, PTSD, and insomnia is shown by organisation in Figures 32-34. 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

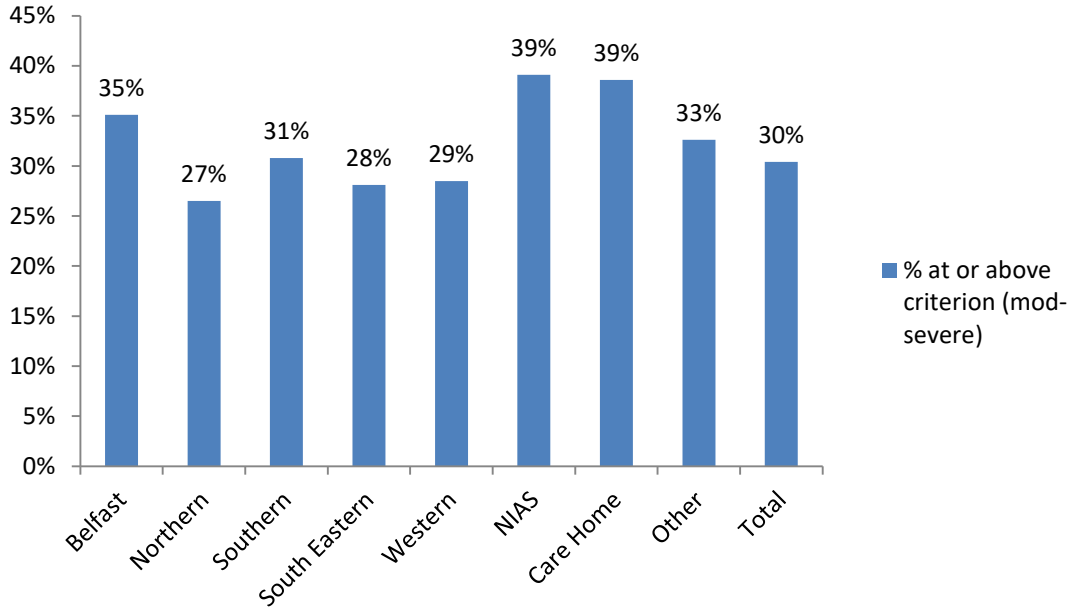


Figure 33: Proportion of HSCNI staff with moderate to severe self-reported anxiety

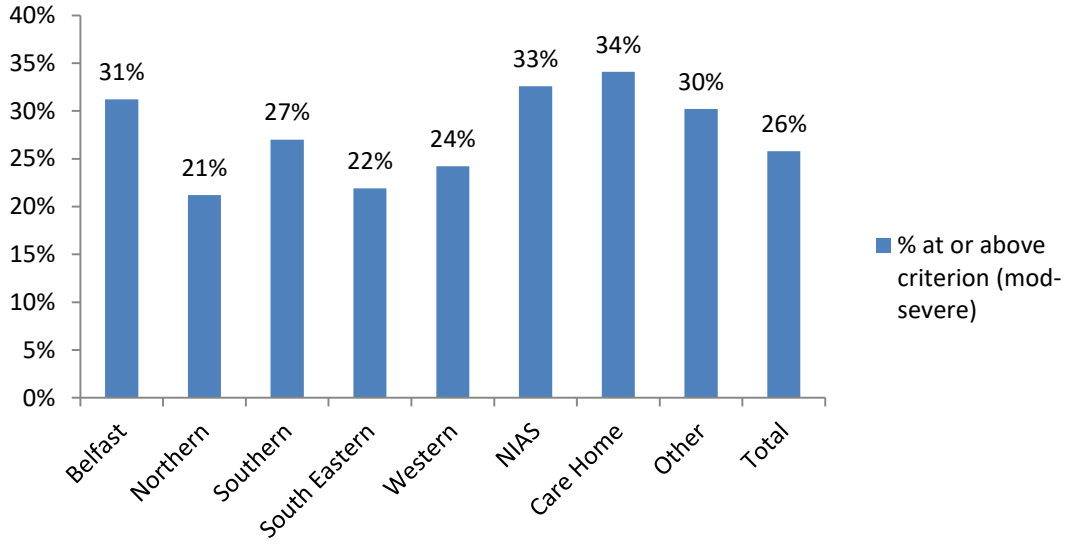


Figure 34: Proportion of HSCNI staff with moderate to severe self-reported PTSD

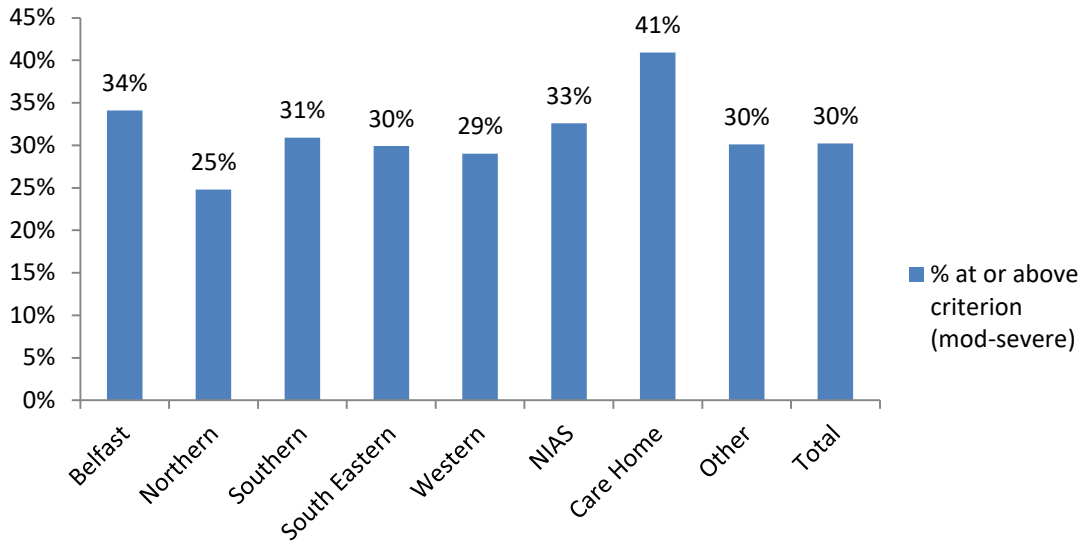
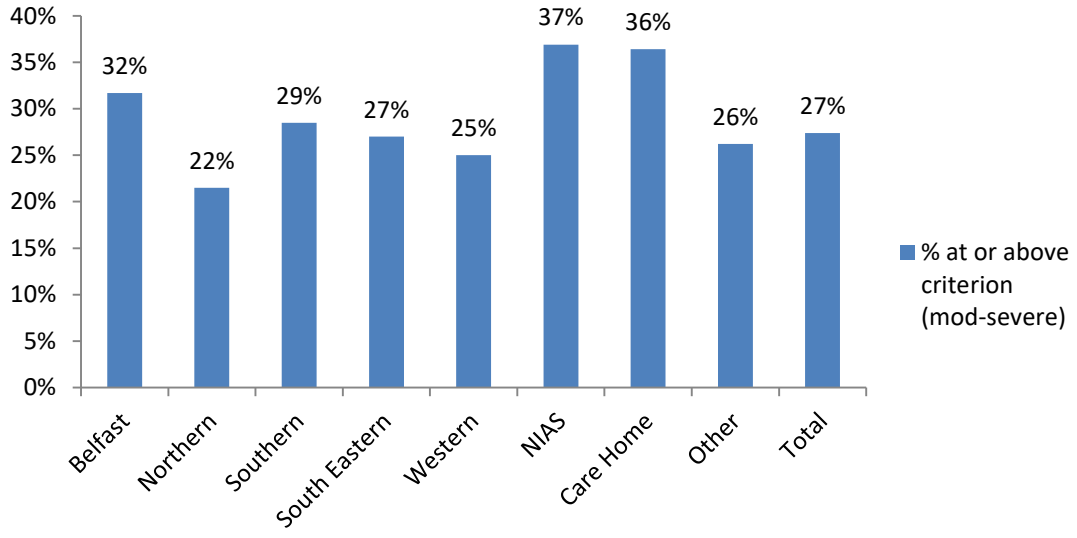


Figure 35: Proportion of HSCNI staff with moderate to severe self-reported insomnia



5.1 Recommendations

1. The high levels of distress within the staff group further highlights the importance of a regional coordinated approach to staff wellbeing and supports. We recommend the continued working of the regional staff support group.

2. The report highlights the importance of clear, frequent and transparent communication throughout all levels in HSC organisations (our biggest predictor of distress). Organisations need to pay particular attention to this aspect of dealing with their workforce during this pandemic.

3. Staff clearly value the range of supports implemented (information, helplines etc) and it is clear that continued provision of a broad range of supports is needed throughout all organisations involved in the survey. It is clear that 2020 has been a difficult year for all HSC staff and robust methods of staff support are much needed.

4. However, it is also clear that we need to innovate in reaching more staff in need. High levels of distress with low levels of uptake of formal support mechanisms does suggest services need to adapt in order to reach staff in need.

5. Our report has clear implications for redeployment:

a. Very clear communication about expectations and workload of new role in any communication.

b. Reassurance it does not increase personal or family risk (current prioritisation of the vaccine is likely to be of considerable help here).

c. It is important that any redeployment is appropriate and that staff have the necessary training and skills to carry out any new roles.

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:
Email: user.feedback@northerntrust.hscni.net
Telephone: 028 9442 4655

Northern Health and Social Care Trust

@NHSCTrust

www.northerntrust.hscni.net

IMPACT Research Centre contact details
Email: Ciaran.Shannon@northerntrust.hscni.net
Telephone: 028 9441 3476

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